BMJ

BMJ 2013;346:f1520 doi: 10.1136/bmj.f1520 (Published 21 March 2013)

PERSONAL VIEW

Drug users need more choices at addiction treatment facilities

The brothers **Arash and Kamiar Alaei**—internationally celebrated doctors who advanced treatment for drug users in Iran but were imprisoned, to the vociferous protest of the international medical community (*BMJ* 2009;338:b109, doi:10.1136/bmj.b109)—set out their experiences and hopes for harm reduction

Arash Alaei, Kamiar Alaei *University at Albany, Albany, New York, USA*

The patient first arrived at our clinic in 2001, complaining of a persistent cough and feverish chills. His cheeks were sunken, and his weathered clothes hung loosely from his frail body. He nervously wiped away beads of sweat that formed on his pale forehead, and his yellowed eyes looked warily past us while we spoke.

The patient did not admit it then—and we, as a policy, did not ask—but he was one of the one or two million drug addicts in Iran at that time,[1] out of a population of about 67 million in the late 1990s.[2] We had opened our first clinic of this kind in the Iranian city of Kermanshah. It served the needs of three overlapping target groups: those infected with HIV; individuals with other sexually transmitted infections; and injecting drug users.

We invited the patient to come into the office. He had learnt about our clinic from other drug users through our peer to peer advocacy programme, which brought more clients into our programmes and expanded our reach for harm reducing education and supplies. These peer advocates had informed him that we offered no-cost medical services in a safe environment where drug users would not face punishment for their habits.

At that time the response by law enforcement was to deter drug use harshly through imprisonment.[3] This approach was both callous and ineffective: the rate of drug addiction increased; the spread of HIV infection increased; drug related deaths increased; and drug users were further marginalised, heightening barriers to their access to care, and diminishing their hopes for meaningful engagement in society.

We treated the patient for a severe infection at his chosen injection site; this infection would have soon landed him in the hospital with septicaemia if left untreated. Finally, we asked him whether he would like clean syringes and alcohol swabs. He was hesitant at first, but finally accepted the offer.

His test results came back positive for HIV, tuberculosis, and hepatitis C. The cough, chills, and sweating were caused by tuberculosis, and his yellowed eyes were likely a sign of the liver malfunction that had resulted from the hepatitis. Fortunately, the patient returned soon; his visit may have been merely to pick up more clean needles, but it meant we were able to start him on medical treatment and psychosocial support programmes. This approach was beneficial both for the early patient management and to prevent the spread of infection to society.

The patient joined our peer support group, a community resource that improved adherence to medical and addiction treatments and promoted a culture of respect and encouragement, which was largely unfamiliar to injecting drug users, who were typically shunned and stigmatised. Through other members, the patient became aware of other clients' success with opioid substitution therapies. Clients receiving long term maintenance therapies were not susceptible to the risks of related infections, and they were better able to engage productively in society. Furthermore, it gave us ongoing access to these clients to follow up not only their medical needs but also their psychological and social needs and, in some cases, to work with them to become completely drug-free.

Soon after beginning therapy, the patient's weight went up, and his mood brightened. He became more active in the community and soon after began working. In the time we knew him he never stopped the maintenance therapy, but he successfully avoided heroin use and lived a vibrant and engaged lifestyle.

The results of these comprehensive programmes were a marked decrease in drug use, the spread of disease, crime, drug dealing, inpatient medical visits, and addicts sentenced to prison. They improved the number of patients treated, and promoted better understanding and a positive relationship with target groups, resulting in better access, more trust, and a better ability to meet their needs.

We cannot control people's behaviour; we can only help them to make choices that are best for them and for society. To

Correspondence to: A Alaei aalaei@albany.edu

For personal use only: See rights and reprints http://www.bmj.com/permissions Subscribe: http://www.bmj.com/subscribe

optimise outcomes we must be flexible in our approach and strive to meet the needs of our target population. We refer to our programmes as the "restaurant approach." If you want more people to come to your restaurant, you need to meet the diverse culinary tastes of your clientele. If you want to attract more people who are addicted to drugs, they need to feel that they have choices. With this approach, clients could choose from a range of programmes, from needle exchange to opioid substitution therapy.

Many addiction centres throughout the world provide only one path to treatment or rehabilitation and pay no attention to harm reduction. Similarly, in some harm reduction programmes they either offer needle exchange or methadone therapy, but not both. Any one programme may work for a subset of the drug addicted population or at a certain point in a person's recovery, but to reach more people and to achieve the desired results we must have a more comprehensive programme, offering a wide range of options for treatment, harm reduction, and recovery.

We thank Elizabeth Gray for editorial support.

Competing interests: We have read and understood the BMJ Group policy on declaration of interests and have no relevant interests to declare.

Commissioned; not externally peer reviewed.

Patient consent not required (patients anonymised, dead, or hypothetical).

1 Mokri A. Brief overview of the status of drug abuse in Iran. *Arch Iranian Med* 2002;5:184-90.
2 United Nations Department of Economic and Social Affairs, Population Division. The twenty most populous countries in 1999. www.un.org/esa/population/pubsarchive/india/20most.htm#1999
3 Amnesty International. *Addicted to death: executions for drugs offences in Iran* . Amnesty International, 2011. www.amnesty.org/en/library/asset/MDE13/090/2011/en/0564f064-e965-4fad-b062-6de232a08162/mde130902011en.pdf.

Cite this as: *BMJ* 2013;346:f1520

© BMJ Publishing Group Ltd 2013

For personal use only: See rights and reprints http://www.bmj.com/permissions Subscribe: http://www.bmj.com/subscribe