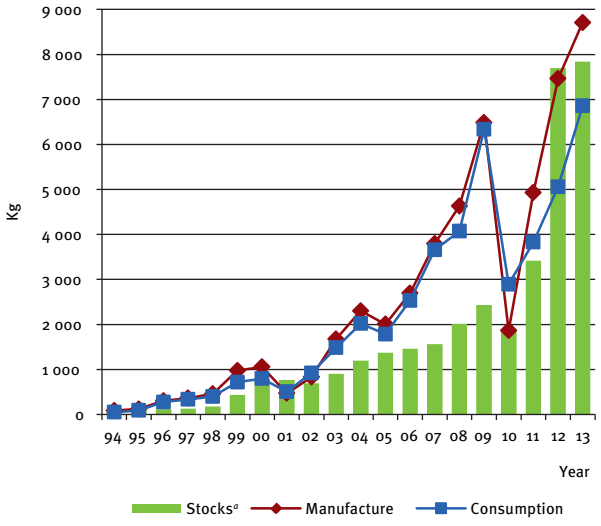
Chapter IV.

Availability of internationally controlled drugs for the treatment of opioid dependence

254. Methadone and buprenorphine are used in the management of pain, but they are also extensively used in the treatment of opioid dependence. In some countries, other controlled substances, such as opium, opium tincture, heroin and morphine, are used for the treatment of opioid dependence. The data reported by countries to INCB do not indicate the purpose of use, but estimates for methadone and buprenorphine are mainly submitted in relation to programmes for the treatment of opioid dependence.

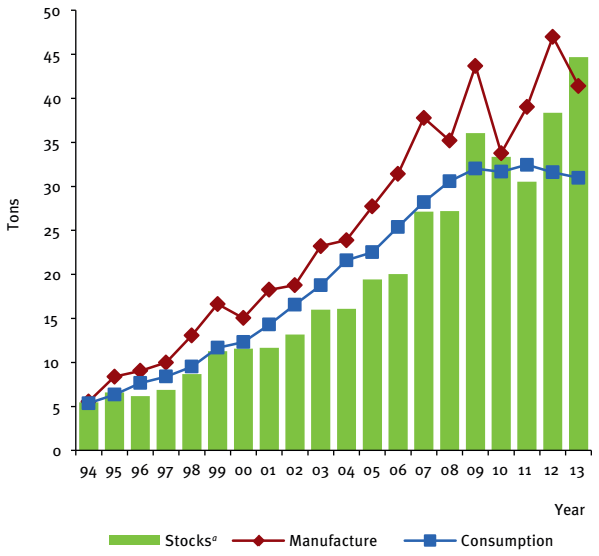
255. An analysis of the trends related to the consumption, manufacture and stocks of both substances shows a steady increase over the past 20 years. The global manufacture of buprenorphine has increased steadily (with the exception of 2010, when there was a sharp decrease), reaching a peak of 8.7 tons in 2013. Similarly, the global manufacture of methadone also increased steadily during the same period, with some fluctuations, and decreased slightly in 2013 to 41.4 tons (5.5 tons less than in 2012) (see figures 69 and 70). As mentioned in relation to other opioid analgesics, it seems that there is no problem with the supply of these substances.

Figure 69. Reported manufacture and stocks of buprenorphine, 1994-2013



Source: International Narcotics Control Board.
Note: Approximate calculated global consumption, determined on the basis of statistical data submitted by Governments.
[a] Stocks as at 31 December of each year; data are provided on a voluntary basis and may therefore be incomplete.

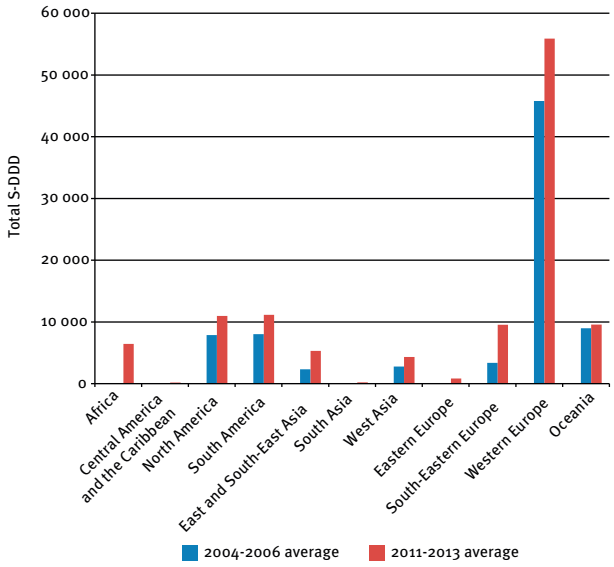
Figure 70. Global manufacture, consumption and stocks of methadone, 1994-2013



Source: International Narcotics Control Board.
[a] Stocks as at 31 December of each year.

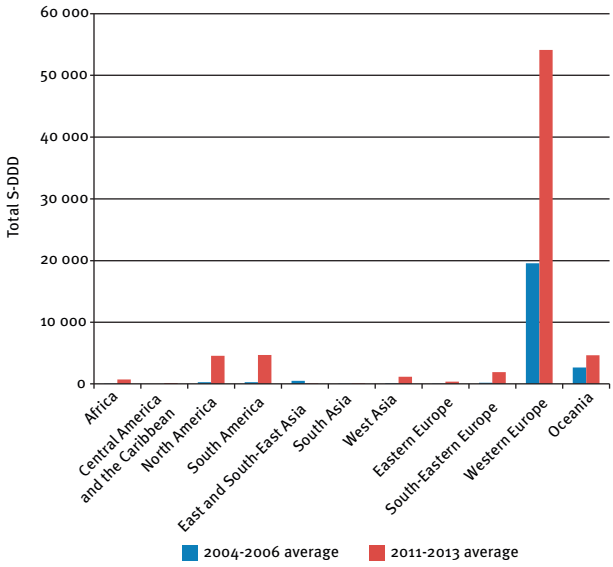
256. However, there are large differences in the patterns of consumption at the global level, as shown in maps 29-33. In some cases, the different level of consumption (expressed in S-DDD, see figures 71 and 72) is related to the presence or absence of people who inject drugs. In other cases, despite the existence (more or less prevalent) of that phenomenon, it seems that the consumption of methadone and buprenorphine, and also the presence of opiate substitution treatment services, are limited or not present. This is sometimes because of government policies that do not recognize the effectiveness of these kinds of services in the treatment of opioid dependence, political and cultural resistance, or simply inaction by the responsible authorities or incapacity to recognize the problem. In the survey carried out by the Board in 2014, 67 per cent of countries indicated that they were using narcotic drugs for the treatment of drug dependency with substitution therapy.

Figure 71. Variations in the consumption of methadone between 2004-2006 and 2011-2013



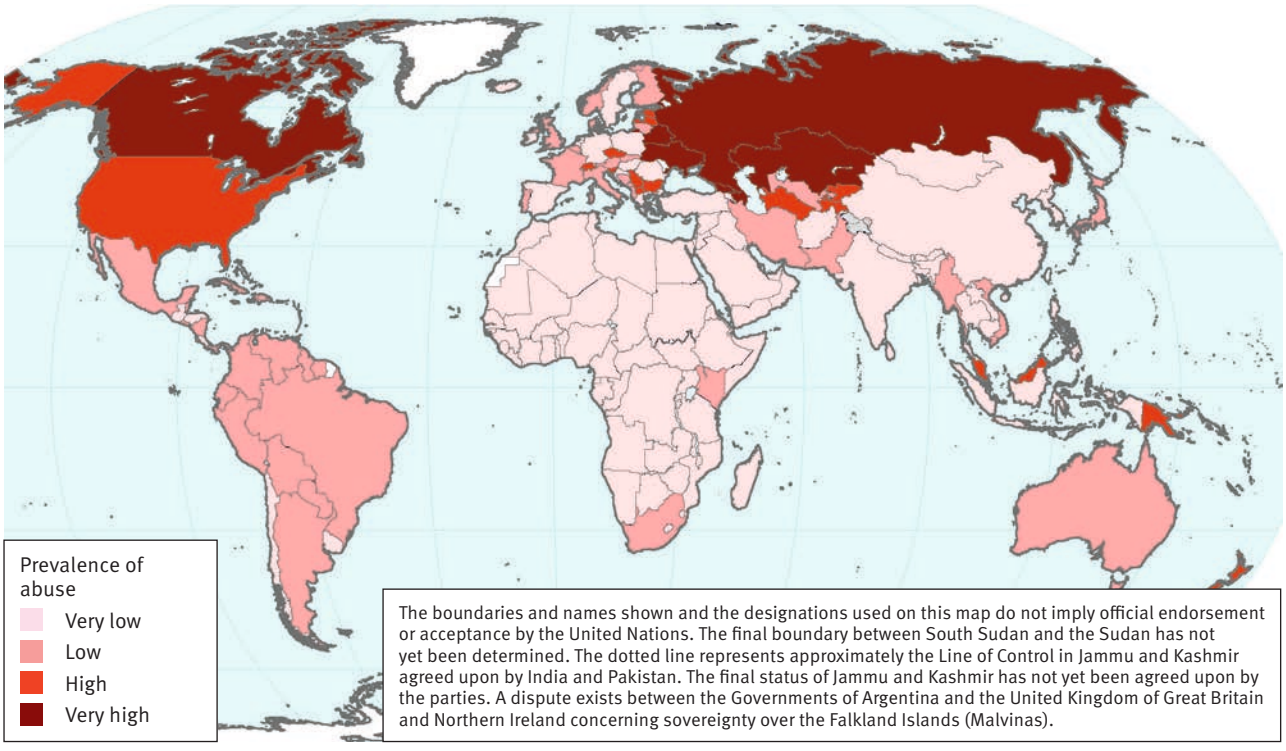
Source: International Narcotics Control Board.

Figure 72. Variations in the consumption of buprenorphine between 2004-2006 and 2011-2013



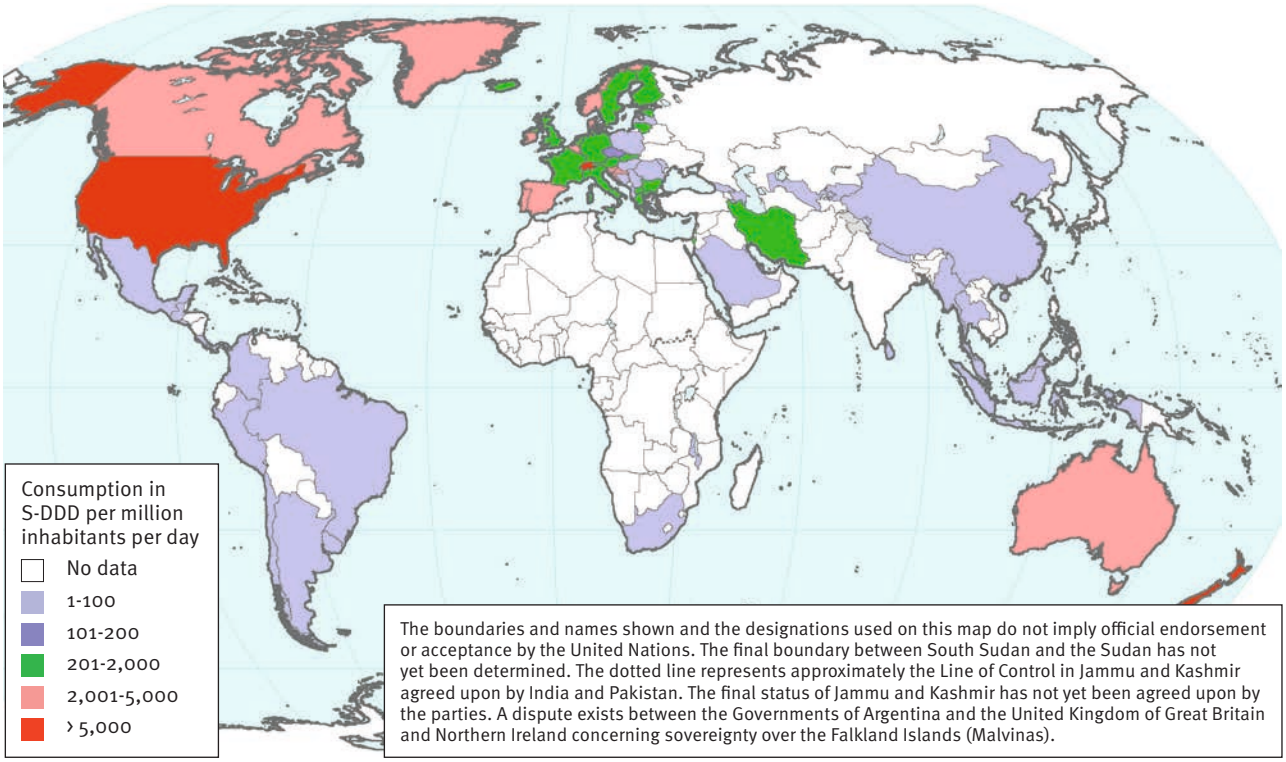
Source: International Narcotics Control Board.

Map 29. Prevalence of people who inject drugs, 2013



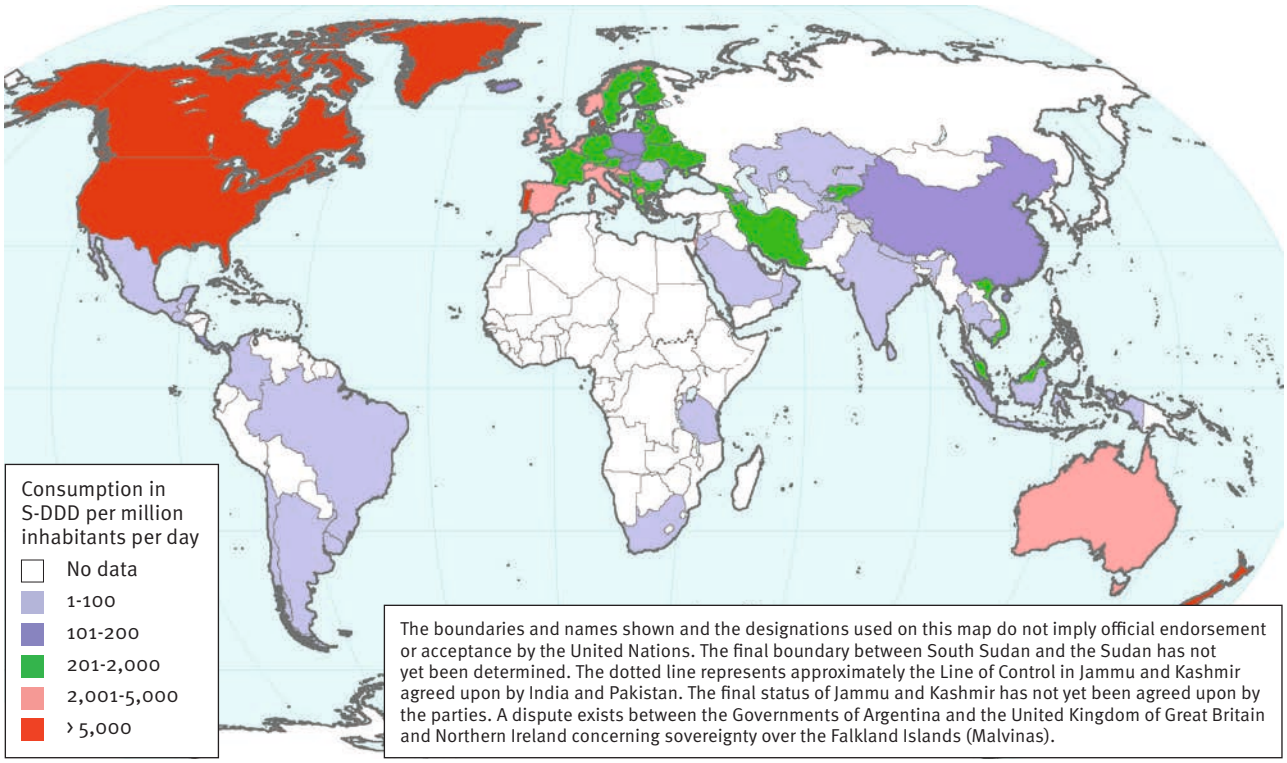
Source: UNODC.

Map 30. Consumption of methadone, 2004-2006



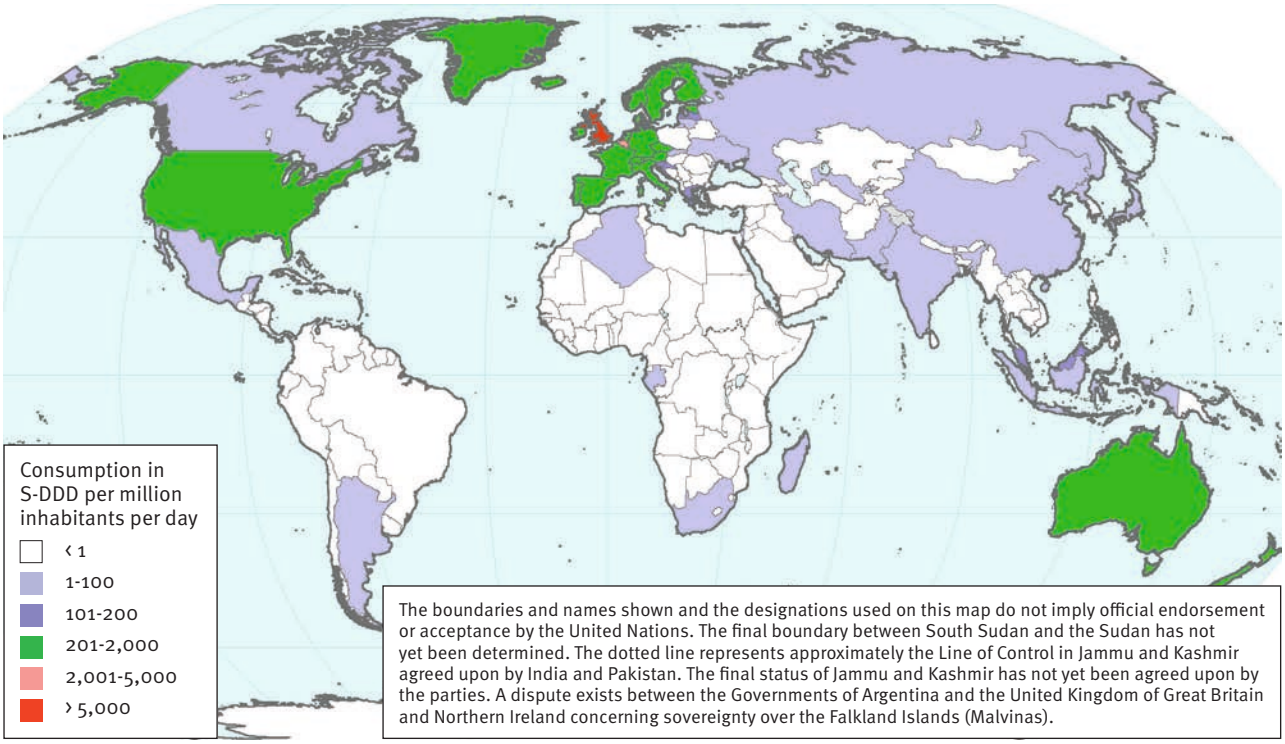
Source: International Narcotics Control Board.

Map 31. Consumption of methadone, 2011-2013



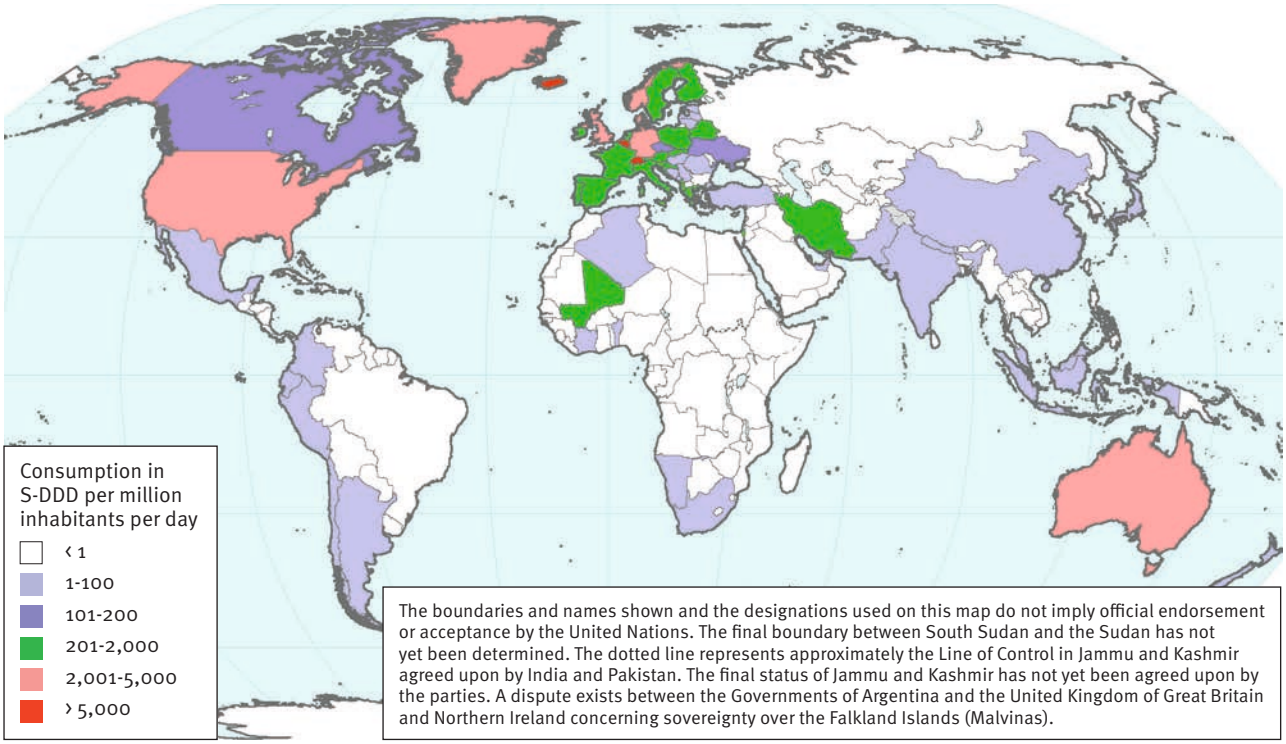
Source: International Narcotics Control Board.

Map 32. Consumption of buprenorphine, 2004-2006



Source: International Narcotics Control Board.

Map 33. Consumption of buprenorphine, 2011-2013

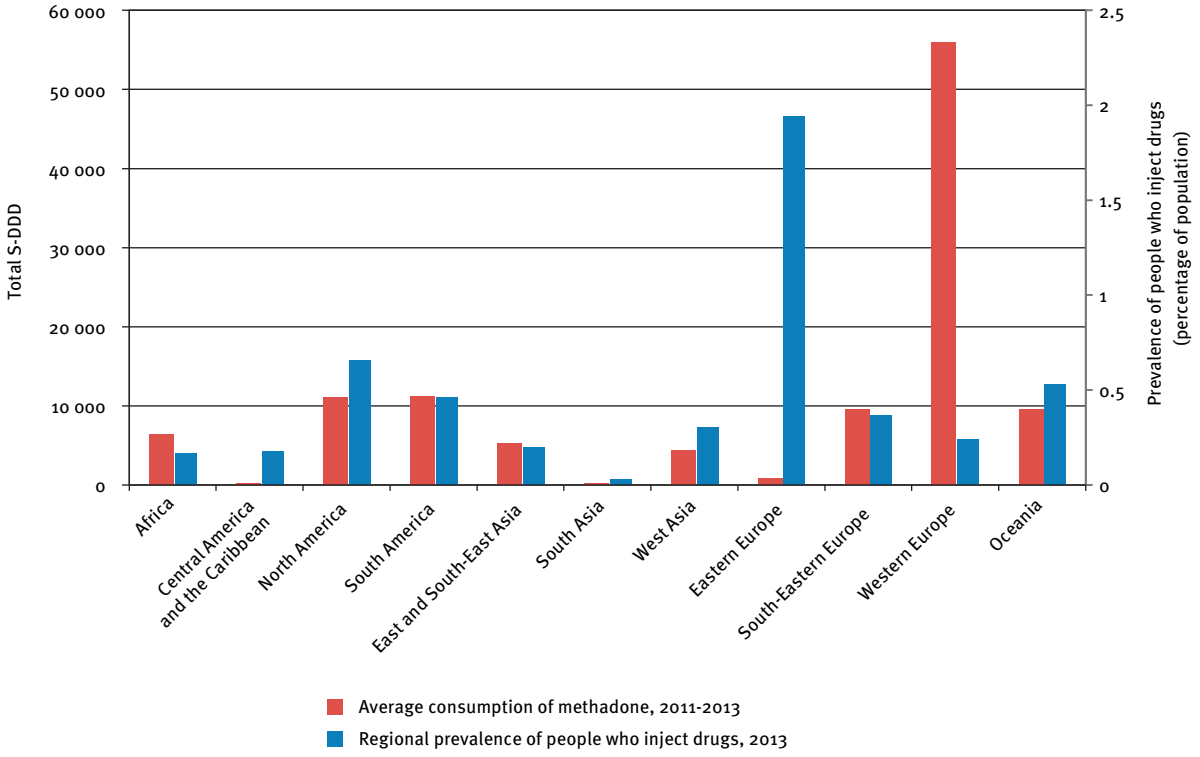


Source: International Narcotics Control Board.

257. For methadone, it is important to note the increase in consumption in Africa and South-Eastern Europe, which corresponds to the expansion of opioid substitution treatment services in some countries in those regions. For buprenorphine, there was a large increase in consumption in Western Europe. The increase in the consumption of buprenorphine registered in some regions may be the result of various factors: aggressive marketing by producing companies; easier accessibility due to the less strict control regime of the 1971 Convention compared with the 1961 Convention (under which methadone is controlled); and increasing use for pain relief. In Central and South America, methadone is used for pain management and not for opioid substitution treatment, because the prevalence of people who inject drugs in the region is relatively low.

258. A comparison of the level of consumption of methadone and the prevalence of people who inject drugs in various regions indicates an imbalance in that regard in Eastern Europe (see figure 73). As mentioned above, the use of methadone is not recognized in some of the countries of that region. In Western Europe, there seems to be a very high level of methadone consumption despite a lower prevalence of people who inject drugs. This may be due to the fact that the opioid substitution treatment services provided in the region reach a large number of people who inject drugs.

Figure 73. Comparison between consumption of methadone, 2011-2013, and prevalence of people who inject drugs, 2013



Source: International Narcotics Control Board and UNODC.