3.3 Treatment for drug dependence

Drug dependence should no longer be considered as a crime but should be thought of as a health issue. Treatment for drug dependence has proved effective in tackling drug dependence, reducing drug-related harms and minimising social and crime costs.

Why is evidence-based treatment for drug dependence important?

On 24 June 2009, the then Executive Director of UNODC, Antonio Mario Costa, launched the 2009 World drug report, stating that ‘people who take drugs need medical help, not criminal retribution’.¹

Recent estimates suggest that 210 million people use controlled drugs.² The factors that lead experimental or occasional drug users to become drug dependent are complex. According to the UNODC/WHO definition, drug dependence is the result of a ‘complex multi-factorial interaction between repeated exposure to drugs, and biological and environmental factors’.³ In other words, social, cultural and psychological issues, combining with biological factors (possibly including a genetic component), are all involved in drug dependence. The WHO International Classification of Diseases, with a focus on symptoms, defines drug dependence as a strong desire or sense of compulsion to take drugs, difficulties in controlling drug use, a physiological withdrawal state, tolerance, progressive neglect of alternative pleasures or interests, and persisting with drug use despite clear evidence of overtly harmful consequences.⁴

Only a minority of all people who use drugs – estimated by the UN at between 15 and 39 million globally⁵ – will develop dependent patterns of use, for which a treatment intervention is required. It is vital, especially in times of economic austerity, that interventions should be directed where they are most needed and will be most effective. Treatment systems should therefore prioritise scarce resources on these dependent users. This requires the establishment of mechanisms to accurately identify the target population, and to communicate to them the availability and goals of treatment. Both health and legal services have a role to play in improving access to evidence-based drug-treatment options for people dependent on drugs.

The impact of drug use on an individual depends on the complex interaction between the innate properties of the drug used, the attributes/attitudes of the user, and the environment in which they use.⁶ Interventions need to consider each of these factors and how they interact. In all societies, the prevalence of drug dependence has been concentrated among marginalised groups, where rates of emotional trauma, poverty and social exclusion are highest.⁷ Given the many factors that drive...
Offering treatment to people dependent on drugs is a more effective strategy than imposing harsh punishments.

A growing number of governments have now accepted that offering treatment to people dependent on drugs is a more effective strategy than imposing harsh punishments (for more information, see Chapter 2: Drug law reform). Studies in a range of social, economic and cultural settings have confirmed that a variety of drug-related health and social challenges – including family breakdown, economic inactivity, HIV and petty street crime – could be tackled in a cost-effective manner through the widespread provision of evidence-based treatment for drug dependence.

However, in many countries, treatment systems for drug dependence are non-existent or under-developed or pursue models that are inconsistent with human rights standards or global evidence of effectiveness. Research, experience and international human rights instruments indicate that certain treatment practices should not be implemented. Some governments, for example, have introduced treatment regimes that rely on coercion, either to force individuals to accept treatment or to force their compliance once in the programme. Many of these compulsory treatment regimes also include ill-treatment, denial of medical care and treatment, or forced labour (see Box 1).

**Box 1. Compulsory centres for drug users in South East Asia**

In certain parts of the world, the use of compulsory centres for drug users is an accepted practice. South East Asia represents the main case in point, where countries including China, Vietnam, Cambodia, Malaysia, Thailand and Lao People's Democratic Republic have established such facilities. These compulsory centres are generally run by the police or military rather than medical authorities, and inmates are assigned compulsorily, frequently without due legal process or judicial oversight, often for several years. They are denied scientific, evidence-based drug treatment, and are subjected to forced labour, which is either unpaid or paid well below minimum wage levels, as well as a number of punishments such as physical, psychological and sexual abuse, and solitary confinement. General medical health care is often non-existent, and diseases such as HIV and tuberculosis are widespread among detainees.

These conditions violate scientific, medical and human rights norms. Compulsory centres are also very costly and ineffective – re-offending rates are very high (in Vietnam, for example, from 80% to 97%). Governments often recognise this fact, but some have responded by increasing the length and severity of the ‘treatment’.

Although certain governments in the region have recently introduced new drug laws that have modified the status of people who use drugs from ‘criminals’ to ‘patients’, such as China’s 2008 Anti-Drug Law and Thailand’s 2002 Narcotic Addict Rehabilitation Act, the humanitarian rhetoric of legal texts is unrepresentative of the reality of life in the compulsory centres, which impose cruel and dangerous punishments under the guise of treatment.

WHO, UNODC and a number of international NGOs, including Human Rights Watch and Open Society Foundations, have condemned the use of compulsory centres for drug users.
Treatment approaches must respect human rights and the fundamental principle of individual choice to enter a treatment programme or not, and whether to comply and continue with it. This not only fulfils human rights obligations but also ensures programme effectiveness. Evidence shows that long-term behaviour change only comes about when individuals decide to change of their own free will. Treatment systems therefore need to be organised so that they encourage individuals to accept treatment and lay down rules and expectations for programme compliance (for example, scheduled and regular attendance in a drug-treatment programme), but do not cross the line into covert or overt coercion (see Box 2). As such, there is considerable ethical debate as to whether users should be coerced into treatment by the criminal justice system or other means.14 Advocates of coercion schemes point to the successes of criminal justice referral schemes that retain an element of coercion (for example, where drug treatment is considered as an alternative to a prison sentence). Opponents point to the right of human beings to choose their own treatment.15 In either case, treatment systems will be ineffective if they do not respect the principles of self-determination and motivation.

**Box 2. The ‘Cure & Care’ model in Malaysia**16

For decades, Malaysia’s main policy concerning people who use or are dependent on drugs consisted of arresting them and sending them to compulsory centres for drug users. In July 2010, Malaysia’s National Anti-Drugs Agency (NADA) initiated an important transformation of its drug rehabilitation centres across the country. The new policy implies first and foremost that such centres will only accept voluntary admissions unless individuals are referred through application of the Drug Dependents (Treatment and Rehabilitation) Act.

The ‘Cure & Care’ model acknowledges that there should be a variety of treatment approaches tailored to the individual needs of the person dependent on drugs. This implies that centres will strive to provide a range of prevention, counselling, treatment (including OST), rehabilitation and support services for people who use drugs in the country.

The establishment and expansion of Cure & Care centres indicates an important change in approaches, values and strategies. First, the fact that this change emanates from Ministry of Home Affairs and NADA is a landmark position in the region, where law enforcement and drug control agencies have initiated changes in their activities to accommodate the needs of people who use drugs. Second, the programmatic implications of this change indicate that health systems integration is a viable and effective strategy to scale-up comprehensive and mutually supportive interventions to address HIV prevention, treatment, care and support. The appreciation of the imperative for the client to be able to choose health interventions based on each individual’s needs is an element that is rarely integrated or articulated in South East Asia. Cure & Care services are accessible without conditions of completion or universal achievements: i.e. all clients are able to set their own objectives, and their progress and success is measured against those.

Although it is too early to assess the effectiveness of the Cure & Care centres in terms of health outcomes, the shift of the Malaysian drug policy from compulsory treatment to voluntary treatment is a highly positive development in South East Asia.
Key elements for an effective treatment system

In most countries, the delivery of treatment for drug dependence started with the experimental implementation of a particular model, which was expanded or complemented with other models over time. Although a single intervention, or a series of separate interventions, can deliver individual successes, governments should be encouraged to create integrated national, regional and local treatment systems for a wider and more demonstrable impact, while making the most effective use of resources.

A treatment system will have a limited impact if the individuals it targets are unable to access the services. The first challenge is therefore to identify people dependent on drugs and encourage them to engage with social and healthcare services. In addition, it is likely that hidden populations of target individuals will exist, and therefore gateways must be available through which these individuals can approach services. There are a number of potential routes through which this can happen:

- **self-referral** by the individual

- **identification through general health and social service structures.** Existing health and social care services will often be in an excellent position to recognise symptoms of dependent drug use and encourage the user to ask for specialist help. For example, general practitioners are often trusted by their patients and can play a key role, provided they are themselves educated regarding drugs and drug consumption.

- **identification through specialist drug advice centres or street outreach services.** These services can offer food, temporary housing, harm reduction services, and the encouragement and motivation to engage with drug treatment – at which point direct access to a more structured treatment can be facilitated. The existence of drop-in centres with a flexible and informal approach is essential in providing a gateway for those caught up in the time-consuming business of dependence, who are often wary of more rigid institutions and unlikely to attend appointments in what may appear a remote future (such as next week or next month).

- **identification through the criminal justice system.** Through the illicit nature of their drug use, and the need to fund it, dependent drug users may come into contact with the criminal justice system. There have been a number of successful models of intervention that use this criminal justice system contact to identify and motivate dependent users to accept treatment: for example drug courts in the USA, arrest referral schemes in the UK (see Section 2.2: Effective drug law enforcement), and the social work ‘panel’ system in Portugal (see Section 2.1: Drug law reform).

Different systems will place different priorities on these routes of identification. However, an efficient system should make sure that all these potential sources of referral can rapidly assess the individual’s circumstances and offer them the right form of treatment. This requires a geographical spread incorporating rural and urban settings, and services must be culturally relevant and approachable, sensitive to issues of gender and ethnicity, and so on.

Different systems can be used to identify people dependent on drugs and offer them evidence-based treatment.

There should also be a mechanism within the treatment system that manages each individual’s progress through treatment (this is often described as a care plan). This ultimate goal should be made clear, and processes of monitoring and review, which must be ongoing, should measure performance against this target. It is important to recognise that dependence is a complex phenomenon that may require more than one treatment episode.
to address it. This is especially the case where clients leave treatment and return to the same setting, and points to the necessity of an integrated approach that brings social support in the form of housing, education and employment together as a comprehensive package.

Methods of treatment for drug dependence

The complexity of drug use is such that the response, setting or intensity of treatment will need to be tailored to each person dependent on drugs. It is therefore essential that a menu of services be made available to suit the differing characteristics, needs and circumstances of each person wishing to access treatment. In addition, the range of drugs available is itself increasing, and a model that is effective for one (e.g. opiates) will not be effective for another (e.g. crack cocaine, methamphetamines, etc). Some countries have established extensive treatment systems over many decades, while others are just starting to develop experience and understanding of this policy area. However, all countries have some way to go to achieve a sufficiently integrated range of treatment services for drug dependence that makes efficient use of available resources to maximise health and social gains.

Treatment methods

Over the last 60 years a wide range of models and structures for treatment of drug dependence have been implemented, tested and evaluated. These can be categorised broadly by method, setting and intensity. Although a number of national and international publications have produced guidelines for drug treatment, these are incomplete and do not apply to each of the socially and culturally specific national settings in which treatment may be required. The development of systems for drug treatment should combine researching international evidence together with knowledge of what will work most effectively, based on each country’s history of drug treatment, socio-legal situation, culture, resources and workforce.

Experience and evidence demonstrate that NGOs and civil society groups are important actors in the provision of treatment services to people dependent on drugs. Their work should be clearly supported and facilitated by government authorities.

Treatment responses can be based on detoxification, substitution treatment, psychosocial therapies, and/or mutual aid support groups.

Detoxification

Detoxification is defined by WHO as follows: ‘(1) the process by which an individual is withdrawn from the effects of a psychoactive substance; (2) as a clinical procedure, the withdrawal process is carried out in a safe and effective manner, such that withdrawal symptoms are minimised. The facility in which this takes place may be variously termed a detoxification centre, detox centre or sobering-up station’. Many people dependent on drugs manage withdrawal without assistance from detoxification services. Others may be assisted by family or friends, or other services.

Opioid substitution therapy

OST is used to treat dependence on opiates. There is a significant global evidence base in its favour as the most closely studied treatment response for drug dependence. Substitution therapy can be defined as: ‘The prescription of a substitute drug for which cross-dependence and cross-tolerance exist. A less hazardous form of the drug normally taken by the patient is used to minimise the effects of withdrawal or move the patient from a particular means of administration. The evidence base however suggests that for the most successful outcomes these therapies are delivered in tandem with psychosocial interventions’. The most common drug substitutes include methadone, buprenorphine and naltrexone. Other governments are now using heroin assisted treatment (HAT) to treat heroin dependence (see Box 3).
OST can reduce the risks of contracting or transmitting HIV and other blood-borne diseases, by reducing the incidence of injecting, and therefore the sharing of injection equipment; people dependent on drugs from ‘black market’ origins are switched to drugs of known purity and potency, which reduces the motivation and need of people who use drugs to commit crimes to support their drug habit, minimises the risks of overdoses and other medical complications, maintains contact with people who use drugs and helps them stabilise their lives and re-integrate in the wider community.\textsuperscript{22}

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\textbf{Box 3. Heroin-assisted treatment (HAT) – the example of the UK} \\
An estimated 5\% of opiate users in substitution treatment do not respond well to methadone. They are often among the most marginalised of users and suffer severe health and psychosocial problems, and may have high associated costs in terms of engagement with the criminal justice and welfare systems. \\
In the UK, there was a history of prescribing injectable heroin to opiate-dependent individuals. However, in the 1960s and 1970s, this practice became politically very controversial, mainly because users collected take-away doses from pharmacies and there was very little supervision. It was probable that this prescribing fed an illicit market. The prescribing of heroin then ceased almost entirely. Nonetheless, there continued to be an unmet therapeutic need among a highly vulnerable section of the drug-dependent population. \\
In recent years, a new and politically more acceptable regime of heroin treatment was developed in Europe, especially in Switzerland.\textsuperscript{23} The UK began scientific trials of this method, in which most clients received doses of injectable heroin in special clinical facilities, under controlled conditions, with close supervision and support from medical staff in a clean and secure setting.\textsuperscript{24} \\
Many of these clients found it to be a life-changing experience, and there was significant improvement in their health and social well-being, alongside large reductions in drug use and criminal activity. The trials involved service users in peer support and research assistant capacities. HAT enabled a hard-to-reach and hard-to-treat population to access health care and support services, as well as meeting political objectives and the requirements of clinical safety. \\
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\textbf{Psychosocial interventions}  \\
Psychosocial interventions refer to any non-pharmaceutical intervention carried out in a therapeutic context at an individual, family or group level. A wide variety of psychosocial interventions can be used, including cognitive-behavioural therapy, motivational interviewing, group therapy and narrative therapy. Assistance and support can be offered to cover a range of issues such as relapse prevention, coping skills, management of emotional well-being, problem solving, skills training, assertion skills, and mutual aid (self-help; see below) approaches – all of which cover different life domains, such as housing, personal financial management, skills for employment, etc.\textsuperscript{25} \\
Psychosocial interventions are exemplified by the therapeutic community approach. Generally, therapeutic communities are drug-free residential settings that use a hierarchical model with treatment stages that reflect increased levels of personal and social responsibility. Therapeutic communities differ from other treatment approaches because they use members of the community as treatment staff and the clients as key agents of change. These members interact in structured and unstructured ways to influence the attitudes, perceptions and behaviours associated with drug use. However, the therapeutic communities approach to drug dependence has been criticised for its high relapse rates.
**Mutual aid support groups**

As a complement to formal treatment or a stand-alone option, mutual aid support groups are perhaps the most widespread response to drug dependence. Participation in these groups, particularly when supporting others, can have successful outcomes. Most research focuses on ‘12-step’ models, such as those used by Narcotics Anonymous and Alcoholics Anonymous. However, other models should be encouraged that suit a variety of people. The aim is to provide mutual support structures that offer therapeutic benefits both for those offering and for those receiving support.

**Treatment setting**

As well as offering a range of evidence-based interventions, an effective treatment system will also deliver interventions in a range of environments. These can be broadly categorised as street (involving activities such as outreach and drop-in centres), community (such as regular attendance at a clinic where clients receive prescribed medications, counselling, etc) or residential settings. It is difficult to be prescriptive about which should receive the greatest emphasis, as this will vary according to the particular needs of the local drug-using population; the tolerance of communities and the legal system towards visible treatment centres; and the availability of a competent workforce and funding.

Community settings tend to be most appropriate where there is strong social, family and community support for the person dependent on drugs. However, it can be better for the client to be treated away from his/her home area when these supports are absent, and they may be susceptible to pressure to return to drug dependence by dealers and associates. Such decisions must be made on an individual basis, by the client and therapist working in a therapeutic partnership. Moreover, the chain of care must be thoroughly integrated; in practice, clients may move across all three of these settings in their treatment career, and need assistance to achieve re-integration into society. This requires that interventions be developed that help dependent drug users access other forms of care that may not address their drug use directly, such as housing, education and employment services.

**Treatment intensity**

The intensity of drug treatment refers to the amount, nature and type of intervention delivered over a specified time. The intensity depends on the therapeutic needs of the individual rather than a defined amount based on resource, moral, philosophical or other foundations. In general, research indicates that the more entrenched and severe the level of dependence, the more intensive and long term the treatment intervention should be. This does create a dilemma for governments, as, with limited resources available, they may wish to try to treat the maximum number of people for the minimum cost. This can often lead to low-intensity interventions being offered to severely dependent people. Many countries have been disappointed with the high relapse rates from their treatment programmes. However, this is most likely to be the result of an inappropriate intensity or methodology in the interventions rather than any factor related to the individual. It must also be borne in mind that drug treatment, however well designed and delivered, cannot provide all the answers. Where structural, intergenerational unemployment exists alongside poverty, inequality and social exclusion (for example), a high prevalence of drug dependence in a community may be understood as an indicator of underlying issues that can only be dealt with by determined political, economic and social intervention.

**A cost-effective system**

There is a clear public expenditure case for expanding investment in treatment of drug dependence, and small investments in treatment can lead to multiple savings in health, social and crime costs. A 2010 study by the UK Home Office estimated that for every £1 spent on drug treatment, society benefits to the tune of £2.50. In the USA, the benefit return for methadone maintenance treatment is estimated to be around four times the treatment cost. Indeed, according to the US National Institute on Drug Abuse, ‘Research
has demonstrated that methadone maintenance treatment is beneficial to society, cost effective and pays for itself in basic economic terms'.

As governments have limited resources to invest in this area of health and social care, it is important that resources are carefully prioritised towards those who experience symptoms of drug dependence and wish to undergo treatment. Efficient management of the treatment programme should enable clients to access treatment easily, move between the different aspects of the system as their circumstances change, and re-integrate into society. This is why the treatment system promoted in the Guide consists of a ‘menu’ of services of different models, settings and intensity. Many countries have also invested in specific case-management systems, where health, social care or criminal justice workers assess the treatment needs of the individual, encourage and motivate them to change, and place them in the most appropriate treatment facility. Where these case-management systems are well designed, they have the potential to increase the efficiency and effectiveness of treatment by making sure that the right people are getting the right treatment at the right time.

An effective re-integration process

Many people dependent on drugs are economically vulnerable and socially excluded, mainly because of the high stigma and discrimination resulting from the criminalisation of drug use. A crucial objective of treatment is to improve each individual's ability to function in society. This means raising levels of education, facilitating access to employment, and offering other social support. A key element of this process is the strengthening of social and community ties. Family and community support is important, and in many countries support groups for former users play a key role in maintaining their commitment to a non-dependent lifestyle. The appropriate engagement of current and former users in treatment settings can do much both to enhance feelings of self-empowerment and to improve the quality and responsiveness of services.

The goal of drug treatment should be, if possible, to assist a person dependent on drugs to achieve a high level of health and well-being and facilitate their participation in society. In this context, it is necessary to recognise that some people may find it impossible or undesirable to attain abstinence. However, this need not preclude the main objective of treatment, that of helping clients to live happily and productively. Many people are, in fact, able to successfully achieve this while remaining on OST. The processes of education regarding drug treatment must, therefore, extend beyond the individuals in treatment to reach their fellow members of the community, who may entertain prejudices regarding OST.

Recommendations

1) The primary objective of treatment systems for drug dependence is to enable individuals to live fulfilling lifestyles.

2) All governments should make a long-term investment in treatment of drug dependence, in order to respond to drug dependence and reduce the associated health and social costs.

3) This investment in treatment of drug dependence should demonstrate a systemic approach rather than a series of isolated interventions: it should identify those most in need of treatment; offer a balanced menu of evidence-based treatment services for drug dependence; and develop smooth mechanisms for individuals to move between different elements as their circumstances change.

4) Treatment approaches that breach human rights standards should not be implemented. Not only are these unethical, they are also highly unlikely to achieve the desired aims and are certainly not cost effective.
5) It is necessary to constantly review and evaluate national treatment systems to make sure that they are operating effectively and in accordance with global evidence. Services can be made more effective and responsive if they include the meaningful involvement of clients in their design and delivery.

**Key resources**


**Endnotes**


6 This model is known as Zinberg’s Model of Dependence: http://www.yapa.org.au/youthwork/aod/effectsubstanceuse.php


15 The human right to informed consent to medical procedures and the ethical requirement to secure informed consent are well established. The right to freedom from medical intervention without informed consent derives from the right to security of the person – that is, to have control over what happens to one’s body. See article 9 of the International Covenant on Civil and Political Rights and the interpretation of ‘bodily security’ as a foundation principle of informed consent at Canadian HIV/AIDS Legal Network HIV Testing, Info Sheet 5 – Consent, www.aidslaw.ca/testing. The right also derives from the right to full information about health and health procedures, which arises from General Comment No.14 para. 34


