3.1 Prevention of drug use

Drug prevention programmes involving mass social marketing and school-based interventions focused on the deterrence paradigm are not efficient in reducing levels of drug use. More efficient drug-prevention initiatives include community-based interventions that seek to address the underlying socio-economic causes for drug use, and peer-based interventions.

Why is effective drug prevention important?
Drug use is a widespread global phenomenon. While drug use occurs among diverse subpopulations, young people consistently report higher than average levels of drug use compared with other subpopulations. Data suggest that young people most often initiate cannabis use, and a minority of young people who use drugs also report using a variety of other illicit substances, including methamphetamine, cocaine, and heroin, among others.

Drug use may lead to a number of preven health consequences, including the transmission of blood-borne infections such as hepatitis B and C and HIV through use of non-sterile injection equipment, death from overdose, and exacerbation of existing psychiatric or physical illnesses. Given the potential for the manifestation of such health harms, a key objective of international and national drug control strategies is focused on the prevention of drug use.

Drug prevention is codified within the mandate of the UNODC. However, despite a consistent allocation of substantial government resources towards drug-prevention interventions, available evidence indicates that the rates of drug use among young people remain at high levels, and are largely unaffected by the prevention approaches tried to far. It is therefore necessary to move away from ineffective drug-prevention interventions, and focus on those interventions that have had more positive outcomes on levels of drug use and reducing harms.

The effectiveness of current prevention approaches
As explained in detail in Chapter 2 of the Guide, most national drug policies have traditionally been guided by the principle of deterrence – the belief that tough law enforcement and severe sanctions against people who grow and use drugs will reduce drug production and use. Programmes for drug
prevention have been based on the same principle of deterrence, which assumes that people who use drugs will stop consuming drugs if they are told about the negative effects of use and the penalties they risk by using them.

As demonstrated throughout this Guide, there is no evidence that suggests that drug policies based on deterrence have resulted in a reduction in the initiation of drug use among young people, or in a reduction in the production of crops destined for the illicit drug market.8

A similar observation can be made in terms of drug prevention, although some prevention approaches have been shown to be more promising than others.

### Ineffective prevention approaches

Despite their popularity with politicians wishing to ‘send a tough message’ about the risks of drug use, mass social marketing interventions and school-based prevention programmes have been expensive and ineffective in reducing drug use among the population groups they sought to target, and may even have negative effects on the prevalence of drug use. Evidence suggests that such prevention approaches should be avoided.

### Social marketing interventions

One of the most popular approaches to preventing drug use among young people is the implementation of social marketing campaigns. These campaigns can take a variety of forms, although they most commonly feature the dissemination of anti-drug public service announcements via the television and radio. Recently, however, social marketing campaigns have expanded in scope to take advantage of new media. For example, internet-based videos and web pages devoted to conveying anti-drug messages have become an increasingly important and sophisticated aspect of prevention interventions.9

The vast majority of social marketing interventions, including anti-drug public service announcements, are based on social cognitive theory and its derivations,10 including the theory of reasoned action,11 and the theory of planned behaviour,12 all of which are based on a specific contiguous relationship between intention and behaviour.

The bulk of scientific research on drug prevention conducted to date has focused on social marketing and school-based approaches. With respect to social marketing, a recent systematic review of all scientific evaluations of anti-drug public service announcements found that these interventions had been largely ineffective, and may in fact encourage drug use (see Box 1).13

### Box 1. The National Institute on Drug Abuse’s anti-drug social marketing campaign

An evaluation commissioned by the United States’ National Institute on Drug Abuse (NIDA) on a national anti-drug social marketing campaign that has cost US$1.3 billion since 1998,14 found that:

- this campaign had no effect on young people who had already started using cannabis
- higher exposure to the campaign may have significantly increased the rate of initiation of drug use among targeted young people
- the campaign may have weakened the perception of anti-cannabis norms among targeted young people

It is necessary to move away from ineffective drug-prevention interventions, and focus on those that have more positive outcomes on levels of drug use.


- while other favourable and unfavourable changes in drug-using behaviour were observed among targeted young people, there was no indication that the campaign itself was responsible for these changes.\(^{15}\)

While the United States’ Office of National Drug Control Policy disputed these findings, a United States Government Accountability Office audit declared the initial evaluation sound.\(^{16}\)

**School-based prevention interventions**

School-based anti-drug interventions have been evaluated extensively, particularly in the USA, since at least the 1970s,\(^{17}\) though their inclusion in the education system of the USA dates back as far as the 19th century, according to some researchers.\(^{18}\) The most popular of such prevention interventions is no doubt the Drug Abuse Resistance Education programme, commonly known as DARE (see Box 2).

**Box 2. Drug Abuse Resistance Education and the ineffectiveness of school-based prevention**

Drug Abuse Resistance Education, also known as DARE, was introduced in 1983 and is the largest of the school-based programmes, now operating in over 75% of all American school districts, as well as in 43 countries internationally.\(^{19}\) DARE and similar school-based interventions are based on the gateway theory of drug use, which claims that the use of drugs such as alcohol, tobacco or cannabis predicts the subsequent use of ‘harder’ drugs such as heroin, cocaine and amphetamines,\(^{20}\) as well as on theories of self-efficacy, which promote the development of interpersonal and social skills that reduce the vulnerability of young people to peer influence for the initiation drug use.\(^{21}\)

A number of evaluations investigating the effects of DARE have observed limited effects of the programme in the long term. One 5-year randomised controlled trial, which observed the drug habits of high school seniors exposed to DARE in the seventh grade as compared to a control group, found no significant differences between the DARE-exposed group and the non-exposed group in terms of the frequency, recency and prevalence of use of a variety of drugs after 5 years; the only statistically significant exception was the rate of hallucinogen use in the last 30 days among the DARE-exposed group, which was almost triple that of the non-exposed group.\(^{22}\) Another 6-year DARE randomised controlled trial carried out across 36 elementary schools and 300 high schools found no statistically significant relationship between young people’s drug use and exposure to the DARE programme when measured over the entirety of the 6-year study period.\(^{23}\) Other studies have corroborated these results.\(^{24}\)

Finally, multiple meta-analyses of DARE studies have concluded that the programme’s positive effects are negligible or non-existent.\(^{25}\) The fact that DARE is still so widely implemented despite clear evidence of its ineffectiveness is a good illustration that many policy makers are more interested in the symbolism of drug prevention campaigns, rather than their impact.
Promising prevention approaches

Although the interventions presented below need to be further evaluated, they do show promising results in terms of drug prevention.

**Community-based interventions**

Community-based prevention programmes often involve a number of stakeholders and multiple components, applied either in sequence or simultaneously. These programmes generally seek not only to change specific behaviours, but have broader goals oriented towards comprehensive community empowerment and change, focusing on strengthening the protective factors (e.g. strong and positive family bonds, success in school performance, good social skills, opportunities for employment, etc) that will reduce the problem of drug use among communities, especially young people. In this sense, they are technically not only drug-prevention programmes but wider social and community-development approaches. This broad set of goals is consistent with the large set of stakeholders needed to implement such a programme. While the makeup of those involved varies between communities, a number of young people and family organisations, media, community groups, schools, law enforcement, faith-based organisations and government are all often involved as stakeholders in many of these programmes. The creation of such coalitions enables the pursuit of community-empowerment goals that seek to create agency among community participants, in contrast to the notion of community members as passive recipients of public health prevention programmes.

Community-based approaches have become increasingly popular to prevent drug use among young people. It should be recalled that, because the interventions are concerned primarily with building skills that can be used towards community empowerment, it is often difficult for evaluators to identify specific outcomes that can be analysed within the usual timeframes allotted for evaluation. Indeed, community empowerment is a long-term outcome that can be difficult to evaluate. Community-based prevention strategies also often include a complex set of components, which will interact to prevent drug use, adding to the complexity of evaluation of these interventions. However, these long-term programmes have shown encouraging results in addressing the risk factors that lead to drug use, and strengthening the protective factors that reduce the risks of use within a community.

One example of a community-based programme in the UK is discussed in Box 3.

**Box 3. The Positive Futures programme in the UK**

One example of a community-based intervention targeting broad socio-environmental factors is the Positive Futures programme, which was implemented in the UK by Sport England, The Youth Justice Board and the United Kingdom Anti-Drugs Co-ordination Unit in 2000. This programme utilised sport and other activities to engage with young people aged 10–19 years, identified as at risk of initiating drug use.

An evaluation of Positive Futures reported that young people enrolled in the programme reported improved social relations, higher educational performance, and higher levels of employment. The Positive Futures programmes have been widely expanded and welcomed in many UK communities, and are popular with participants and politicians alike. However, despite broadly positive qualitative evaluations, no statistical analyses have been conducted about the programmes’ outcomes, and little is therefore known regarding the mechanism of change, and the effect of the intervention was never quantified. For instance, no data on the effect of Positive Futures on patterns of drug use among young people have yet been reported.
**Peer-based interventions**

Peer-based prevention interventions seek to engage directly with affected community members in order to connect with marginalised individuals at risk of drug use. While peer-based components have become increasingly integrated into social marketing preventive interventions through social networking, stand-alone peer-based preventive interventions are nevertheless present in a number of different settings. All peer-based preventive interventions involve engaging members of a specific group (‘peers’) to act as educators. In principle, peers simply need to belong to the same group in order to act as, and be perceived as, peer educators. In practice, peer educators can be co-workers, schoolmates, team-mates, or people who use drugs within a drug-using network, among others. Peer-based approaches are often perceived to have an increased capacity to convey preventive messages to otherwise hard-to-reach groups. To date, little scientific research has been undertaken on peer-based drug prevention.

The small number of evaluations of peer-based interventions for drug prevention may partly be a result of the fact that, similar to community-based preventive interventions, peer-based interventions often have outcomes such as information delivery or increases in general self-confidence that do not necessarily constitute the primary objective of drug prevention. Further, evaluations of peer-based preventive interventions undertaken among people who use drugs have typically focused on interventions for the prevention of drug-related harm rather than preventing drug use itself. Despite the limited evidence base, research has indicated that peer-based interventions may be successful in reducing rates of drug use (see Box 4).

**Box 4. A peer-based intervention programme among young Thai amphetamine users**

There has been a proliferation of amphetamine use in Thailand since the 1990s, particularly among young people. Simultaneously, risky sexual behaviours among this population group have increased. A randomised behaviour trial study was conducted to evaluate the effects of a peer network intervention and a life-skills intervention on methamphetamine and HIV risk behaviours among 18–25 year olds in Chiang Mai, Thailand. The study found that a peer-educator, network-oriented intervention was associated with reductions in methamphetamine use, increased condom use and reductions in incident STIs. The study concluded that small group interventions were an effective means of reducing methamphetamine use and sexual risk among Thai younger generations.

**Conclusions**

Despite the availability of a variety of preventive interventions implemented so far, rates of drug use (i.e. cannabis, cocaine, heroin and amphetamines) have remained steady or increased in major markets across the world, and do not seem to have been influenced by the drug-prevention campaigns implemented by governments. This may be the result of a primary focus on fear and deterrence for drug prevention, as is the case for most drug control policies focusing on harsh law enforcement and severe punishment mechanisms. This has led to a preference for prevention approaches that do not have a resonance with young people’s lived experience, and that do not target the factors that mostly impact on individuals’ decisions around drug use – fashion, peer pressure, emotional welfare and social and community equality and cohesion.

Evidence demonstrates that mass social marketing campaigns and school-based programmes seeking to sensitise the population and young people about the harms caused by drugs have been ineffective in reducing drug use or raising the age of initiation to drug use. Some studies have even shown that such prevention programmes could, on the contrary, increase the prevalence of drug use among the target population group, by raising awareness or curiosity around particular drugs.
Studies analysing the effects of community-based interventions or peer-based prevention programmes have shown more optimistic results, although more research is needed to truly assess the impact of these interventions on the prevalence of drug use.

**Recommendations**

A re-oriented drug-prevention paradigm should prioritise the following drug-related outcomes:

1) drug-prevention interventions should both identify the underlying social causes of drug use and work to address them through health and socio-economic programmes, in particular through community-based prevention intervention programmes

2) drug prevention interventions should prioritise education and information provision through peer-based programmes

3) governments should explore new drug-prevention programmes based on evidence.

4) implementation plans for drug-prevention interventions should systematically include scientific evaluation of process and outcomes, in order to measure the effectiveness of drug-prevention programmes.

**Key resources**


Endnotes


3.2 Harm reduction

Harm reduction refers to public health interventions that seek to reduce the negative consequences of drug use and drug policies. Harm reduction has been rigorously evaluated and shown to be effective at reducing the transmission of blood-borne infections as well as morbidity and mortality related to drug use.

Why is harm reduction important?
A broad definition of harm reduction was presented in Chapter 1. This chapter focuses primarily on harm reduction as a set of health interventions, while touching on related efforts to shape public policies in ways that promote the well-being of people who use drugs.

Drug use, particularly in the context of the current drug control regime, may lead to a number of preventable health consequences, including soft tissue infections and transmission of blood-borne infections such as hepatitis B and C and HIV, through use of non-sterile injection equipment, death from overdose, and exacerbation of existing psychiatric or physical illnesses. Harm reduction is equally concerned with the harms caused by public policies and attitudes directed at people who use drugs. In many countries, most harms result directly or indirectly from the criminalisation and mass incarceration of people who use drugs, but also include discrimination in medical settings and subsequent problems with access to health care, barriers to employment, housing or social benefits, or denial of child custody. As such, harm reduction is often conceived as both a public health and a human rights concept.

There are around 16 million people who inject drugs worldwide, and it is estimated that 10% of all HIV infections occur through injection drug use, with 30% of new infections occurring outside sub-Saharan Africa. In many countries in Eastern Europe, the Middle East, North Africa, Central, South and Southeast Asia, and Latin America, the largest share of HIV infections occurs among people who inject drugs. Injection-related transmission has more recently become an important part of HIV epidemics in sub-Saharan Africa as well, where the prevalence of injection drug use now approaches the global average.

The EMCDDA identified drug overdose as a major cause of mortality in EU countries. An international study supported by the EMCDDA found that in seven European urban areas, between 10% and 23% of all deaths among those aged 15 to 49 years could be attributed to opioid use. In the USA, overdose is the leading cause of injury-related mortality among people aged 35–54 years. Studies have found
that 89% of heroin users had witnessed at least one overdose in their lifetime in San Francisco (USA), personal experience of overdose has ranged from 51% of heroin users in Australia to 66% in Yunnan province, China, and 83.1% in North Vietnam. In Russia, overdose caused 21% of all deaths among people living with HIV in 2007, and the country reported a total of 9,354 overdose deaths the previous year, which is almost certainly an undercount.

Non-opioid and non-injecting drug use can also be related to negative health outcomes. Many parts of the world have seen an increase in use of cocaine and amphetamine-type stimulants such as methamphetamine, and in the non-medical use of pharmaceutical medications. Non-injection drug use has been found to be associated with an increased risk of sexual transmission of HIV in some contexts. It has been speculated that sharing crack-smoking paraphernalia may increase the risks of hepatitis C transmission. Stimulant drugs may cause hyperthermia, acute psychiatric disorders, and other harms, and inhaled drugs may cause lung infections and possibly leukoencephalopathy. Box 1 provides examples of effective harm reduction services for people who use non-injectable drugs.

**Box 1. Harm reduction services for people who use non-injectable drugs**

Although sometimes less visible because of the emphasis on HIV within public financing around drugs and health, services supporting people who use non-injectable drugs are a crucial part of harm reduction. In response to the harms associated with non-injection drug use, organisations such as DanceSafe in North America have promoted education, pill testing, and other services to ensure that ‘party drug’ users are well informed about safer use and know what they are consuming.

Harm reduction groups in Canada and elsewhere have promoted kits for safer crack use that include education and smoking paraphernalia made out of materials that do not emit toxic chemicals when heated, and that have resulted in adoption of less risky drug-using behaviour among participants. Similarly, in Latin America and the Caribbean, where powder cocaine and crack use predominate, harm reduction services for people who use non-injectable drugs, such as counselling, housing services, linkages to drug dependence treatment, etc, have existed alongside NSPs since the early 1990s. ‘Safer-inhalation facilities’, where people may smoke or sniff drugs in a medically supervised environment have also been established alongside safer injecting facilities in several countries.

While sharing non-sterile injecting equipment has been a major source of HIV infections in North America and Western Europe, implementation of harm reduction services has increasingly controlled the epidemic. For example, in 2009 New York City, which had been supporting harm reduction services for nearly 20 years, reported that only 5% of new HIV cases were transmitted through injecting drug use. Similarly, Australia, the first country to have incorporated harm reduction into its national HIV strategy, has maintained an extremely small HIV epidemic among people who inject drugs, and as a result had net healthcare cost savings of more than US$820 million in the years 2000–2009 alone. The UK, the Netherlands, France, Spain and other European countries have seen similar success in reducing HIV incidence among people who inject drugs through widespread availability of NSPs, OST and related services. On the contrary, countries like Russia and Thailand, which have refused to develop harm reduction interventions, have a high prevalence of HIV infections among people who inject drugs.

Harm reduction programmes have always had a commitment to evidence-based practice. Core harm reduction services have been exhaustively
evaluated and found to be effective at reducing the transmission of HIV and other blood-borne diseases, broadly improving health, and have been found not to be associated with increased drug use. As a result, harm reduction has become the leading public health approach to drug use, and has been endorsed by numerous international health agencies, professional associations, including the UN system, the International Federation of Red Cross and Red Crescent Societies, the International AIDS Society, and the American Medical Association. At least 82 countries support harm reduction in policy and/or practice.

Principles of harm reduction

This chapter uses the definition of harm reduction principles espoused by Harm Reduction International (HRI) and describes how these principles are applied in practice.

Harm reduction is targeted at risks and harms, evidence based and cost effective, incremental, rooted in dignity, respectful of human rights, challenges policies that maximise harm, and values transparency, accountability and participation.

According to HRI, harm reduction refers to ‘policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits drug users, their families and the community’. At its roots, harm reduction recognises that despite the negative consequences associated with drug use, many people are unwilling or unable to stop using drugs; that most harms associated with drug use are preventable; and that drug use has positive aspects for many people, which must be considered in the frame of reducing drug-related harm. Harm reduction strives to respond to each individual’s unique experience of drug use, and at the community level to integrate with primary care and specialist medicine, drug treatment, housing services, the criminal justice system, and other relevant areas. At local, provincial and national levels, harm reduction is concerned with orienting government policy toward health promotion and away from criminal justice approaches to drug use.

Harm reduction:

- **is targeted at risks and harms** – harm reduction begins from the standpoint of identifying what specific risks and harms are occurring with an individual’s or population’s drug use, defining the causes of those risks and harms, and determining what can be done to reduce them. In Thailand, this could involve encouraging methamphetamine users to smoke methamphetamine rather than injecting it, in order to avoid the harms associated with injection. In Ukraine, for example, this has led harm reduction practitioners to identify unequal access to reproductive health care for women who use drugs and to develop innovative services in response. In the USA, harm reduction programmes have used geographic mapping to determine ‘hot spots’ where people who inject drugs most frequently run out of new, sterile syringes, in order to better target NSP services.

- **is evidence based and cost effective** – harm reduction approaches are founded on public health science and practical knowledge, and employ methods that are most often low cost and high impact. New evidence on the efficacy of syringe-cleaning methods, for example, has led to renewed attention to how to support people who reuse syringes. There is a growing body of literature on the cost effectiveness of harm reduction intervention – particularly regarding needle exchange and OST.

- **is incremental** – as HRI explains, ‘Harm reduction practitioners acknowledge the significance of any positive change that individuals make in their lives. Harm reduction interventions are facilitative
rather than coercive, and … are designed to meet people’s needs where they currently are in their lives. This principle plays out in countless ways in the day-to-day work of harm reduction service providers, from working with individuals to reduce immediate harms associated with chaotic crack cocaine use in Rio de Janeiro, to helping people who use drugs to find housing in New York.

- **is rooted in dignity and compassion** – a harm reduction approach views people who use drugs as valued members of the community, as well as friends, family members and partners, and consequently rejects discrimination, stereotyping and stigmatisation. The COUNTERfit harm reduction project in Toronto used this principle to develop widely influential, drug-user-friendly workplace guidelines. Early harm reduction programmes in Iran propagated a caring, open environment and made a strong case for harm reduction in Islamic terms, in order to reach out to an extremely marginalised population of people who inject drugs.

- **acknowledges the universality and interdependence of human rights** – the UN High Commissioner for Human Rights, Navanathem Pillay, declared that ‘People who use drugs do not forfeit their human rights, including the right to the highest attainable standard of health, to social services, to work, to benefit from scientific progress, to freedom from arbitrary detention and freedom from cruel inhuman and degrading treatment’ (see Section 1.2: Ensuring compliance with fundamental rights and freedoms).

- **challenges policies and practices that maximise harm** – the political environment in which drug use occurs plays an important part in creating the harms linked with drug use. Harm reduction thus seeks to reduce harm associated with drug use, just as it seeks to reduce harms resulting from drug use. In much of Western and Central Europe, this insight has led governments to decriminalise drug use, which in some countries, such as Portugal, has resulted in substantial public health gains. In other countries, the objective has been to remove policies that prevent people who inject drugs from accessing HIV treatment, OST and other life-saving medical care.

- **values transparency, accountability and participation** – harm reduction staff, donors, public officials, and other relevant people are ultimately accountable to people who use drugs. Harm reduction seeks to ensure such accountability by prioritising participation and leadership by people who use drugs in the design and implementation of policies and programmes that affect them. Examples of this principle include the central role of people who use drugs in conceiving and building the US harm reduction movement, requirements by harm reduction organisations that people who use drugs be represented on their boards of directors, the 2006 ‘Vancouver Declaration’ and founding of the International Network of People Who Use Drugs (INPUD).

### Box 2. The Community Action on Harm Reduction project
The Community Action on Harm Reduction (CAHR) project is an example of how harm reduction principles can be incorporated into a comprehensive programme. The CAHR project seeks to expand access to harm reduction services for people who inject drugs in Kenya, China, India, Indonesia and Malaysia. The project is unique in its approach to develop and expand services to people who inject drugs by supporting grassroots community initiatives, building pragmatic partnerships with local authorities, public health facilities, and academics, and addressing the policy and structural barriers to programme sustainability.

The project places a strong emphasis on building the local capacity of community-based organisations and sharing knowledge and experiences in order to introduce essential harm reduction interventions in Kenya, improve access to community-based support services in China,
increase the quality of behavioural change programming in India and Malaysia, and expand quality harm reduction services to new communities within the injecting drug using population in Indonesia.

There is a strong policy agenda that is defined by the pragmatic objective of developing effective HIV and drug use services based on available evidence. Experiences of the project on the ground are captured to influence policy debates both at the national and international level. Finally, CAHR objectives include the full and meaningful participation of people who use drugs in policy and programme design and a strong commitment to protecting and promoting human rights.41

A wide range of interventions

Harm reduction entails a holistic approach to dealing with the health of people who use drugs. WHO recommends a comprehensive package of harm reduction interventions42 and recognises that such interventions mutually reinforce each other and maximise effectiveness in terms of health outcomes. Evidence also shows that harm reduction services lead to an increase in access to general healthcare interventions. The following, while not exhaustive, is an indication of evidence-based and cost-effective harm reduction interventions.

Needle and syringe programmes (NSPs)

The most recognisable harm reduction intervention is the supply of sterile injecting equipment to reduce the spread of HIV and other blood-borne infections. Such programmes also prevent skin and soft tissue infections (such as abscesses and cellulitis) that may result from using non-sterile injection equipment. NSPs also serve as a bridge by which people may access a wide array of other health and social services, including primary health care, drug treatment, etc.

The success of NSPs depends on a wide range of factors. These include the involvement of people who use drugs in the design and implementation of the service; accessibility and breadth of coverage; adaptability of the service to moving local drug use patterns;43 engagement with law-enforcement agencies not to interfere with the services;44 and consultation with the wider community.45

While many early NSPs were developed primarily for heroin and cocaine injectors, today harm reduction addresses the complete spectrum of drug use. Similar in concept to NSPs, Canada and the USA, for example, pioneered the development of safer crack-smoking materials to reduce the potential for burns, lung infections and possible transmission of hepatitis or other infections through blood–blood contact from sharing pipes.46 Methamphetamine-oriented programmes like Crystal Clear in Vancouver, Canada have used peer-based programming to adapt the approach to both injecting and non-injecting use (see Box 4).

Drug-consumption rooms

Some governments, such as Australia, Canada, Spain, Germany and Switzerland, have established drug-consumption rooms.47 These are supervised facilities where people may bring their own drugs and inject (or in some places smoke) them without fear of arrest, and where overdoses or other health problems can be addressed by medical staff. They have been especially successful at reducing overdose mortality: deaths in the neighbourhood around Vancouver’s Insite facility dropped by 35% in the year after it opened.48
Treatment for drug dependence

Opioid substitution therapy (OST) using methadone or buprenorphine is currently the most widely used evidence-based method of treatment for opioid dependence. Some countries also prescribe pharmaceutical heroin (diacetylmorphine) as a substitute for street heroin, which is usually adulterated. OST programmes have been shown to reduce or eliminate injection drug use, reduce criminality, and improve a wide range of measures of health and social well-being.\textsuperscript{49} OST plays a crucial role in supporting adherence to HIV,\textsuperscript{50} hepatitis C and tuberculosis\textsuperscript{51} treatment among opioid-dependent people, and is a potent tool for overdose prevention.\textsuperscript{52} Although substitution therapies are not yet available for non-opioid drugs, alternative forms of treatment, such as cognitive-behavioural therapy and other psychosocial approaches, are supported by public health evidence. For more information, see Section 3.3: Treatment for drug dependence.

Overdose prevention

Overdose is experienced by a substantial portion of opioid users over their lifetime, and is a leading cause of death among people who inject drugs, and young people generally, in many countries. In the 1990s, programmes in the UK, the USA (see Box 3) and elsewhere began educating heroin users and their friends and families about overdose prevention and response, and distributing naloxone, a medication that quickly and safely blocks the effects of opioids, thereby reversing the respiratory depression that may lead to death. Such programmes have recently become more widespread, from Vietnam to Tajikistan and Puerto Rico to Slovakia, and there is growing evidence that they have contributed to significant reductions in mortality.\textsuperscript{53,54} Drug-consumption sites and OST facilities are also important tools for overdose prevention (see above). Cocaine overdose, which is implicated in a large number of deaths in some countries,\textsuperscript{55} poses a challenge in that there is no medication equivalent to naloxone that could be administered by lay people. Other policies that support overdose prevention include improving emergency medical services for overdose, ‘good Samaritan’ laws protecting people who respond to overdoses from potential liability, and increasing overdose surveillance and research.

Box 3. The first overdose-prevention programmes in New York City

After years of increasing overdose mortality and the deaths of many harm reduction participants, and inspired by colleagues in Chicago, San Francisco and New Mexico, three community-based harm reduction programmes launched New York City’s first overdose-prevention programmes in 2004 that included naloxone distribution to people who use opioids. The three groups covered a geographically diverse section of the city, included one programme of harm reduction services for young people, and quickly moved from an initially small-scale, periodic service to one that expanded to street-based training and saturated communities with information and tools to prevent and reverse overdose. In mid-2006, following an evaluation of the first projects, the New York City government picked up the programme, contributing enough funding to support overdose programmes at all of the city’s harm reduction organisations and to hire a full-time medical director for the programme. In the two years that followed, overdose mortality dropped by 27% citywide,\textsuperscript{56} and unpublished data indicate that this trend has continued. Hundreds of similar projects have since proliferated around the world, based on the simple model pioneered in the USA and parts of Western Europe.

Prevention, testing and treatment of HIV and other sexually transmitted infections

As with anyone else at risk of sexual transmission of HIV or other STIs, condoms and sexual health education and services should be made available to people who use drugs, and their sexual partners. STI testing and treatment is often linked to harm reduction services, in part because STIs – particularly
those that cause genital lesions – may increase the risk of HIV transmission. Voluntary HIV counselling and testing is also a core harm reduction activity, and should be tied to efforts to connect newly diagnosed individuals to care and treatment services. Research has found that people with a history of injecting drug use have comparable success with HIV treatment to non-drug users.\textsuperscript{57}

**Prevention, testing and treatment of viral hepatitis**

Vaccines for hepatitis A and B are highly effective and should be made available to all people at risk of hepatitis infection, especially people who inject drugs. Globally, some 90\% of new hepatitis C cases are related to injecting drug use, and while there is no hepatitis C vaccine available, hepatitis A and B immunisation may improve clinical outcomes for people with hepatitis C. There have recently been major advances in treatment for hepatitis C and it should be made available to any eligible person, regardless of their drug-use status.\textsuperscript{58}

**Prevention and treatment of tuberculosis**

People who have compromised immune systems, such as people living with HIV, are at high risk of active tuberculosis infection, particularly in closed environments such as prisons and in countries with endemic tuberculosis.\textsuperscript{59} Tuberculosis is the leading killer of people living with HIV worldwide, including people living with HIV who use drugs, and notably in Eastern Europe and Central Asia, where multidrug-resistant strains have proliferated. Harm reduction programmes like the Anti-AIDS Foundation in Tomsk, Russia, have responded by leading surveillance efforts, educating people who use drugs about tuberculosis prevention, and supporting people in tuberculosis treatment.

**Mental health, social welfare, and other services**

While sometimes not considered to be core harm reduction strategies, a number of other services are often offered to people who use drugs. Psychiatric illness, for example, is more prevalent among people dependent on drugs than among the general population.\textsuperscript{50,61} Major depression, post-traumatic stress disorder, and other illnesses may exacerbate drug-related risk behaviour, and drug use may complicate psychiatric care. Chronic stress related to social, economic and other circumstances may also impact drug use and psychiatric comorbidity (for more information, see Section 3.1: Prevention of drug use).\textsuperscript{62} New York’s Lower East Side Harm Reduction Centre has, for example, established a team of mental health professionals to support clients living with psychiatric illness, as well as housing services, legal support, and case management to co-ordinate health and social services.

**Supporting groups at higher risk of drug-related harm**

Some groups, including women, young people and minorities, are at higher risk of drug-related harm because of discrimination, power relationships, and other factors. Harm reduction programmes consequently have a responsibility to identify people in their communities who may face unique challenges in terms of drug use, and develop appropriate services.

**Young people**

Although many young people use drugs,\textsuperscript{63} most harm reduction services are designed for adults. Most obviously, young people often have shorter drug-use histories than adults, and may also have different risk behaviours and different social, economic and legal circumstances, and may be at risk of exploitation by adults. For all these reasons, youth-specific harm reduction programmes are needed (see Box 4), yet are absent in many countries. Many barriers also exist that prevent young people from accessing harm reduction services, including parental consent. These barriers should be removed. Successful youth-oriented harm reduction programmes,
such as The Way Home in Odessa, Ukraine, and the Homeless Youth Alliance in San Francisco, USA, have given young people a leading voice in the design and administration of programmes, and grow out of a rights-based approach to health. Other interventions have targeted young people in nightlife settings, with interventions ranging from drug-information leaflets to drug-checking services, information sharing through websites, etc.\textsuperscript{64}

\textbf{Box 4. Harm reduction services for young people}

Established in 2003, Vancouver, Canada’s Crystal Clear harm reduction project began as a three-month, peer-based training course for street-involved young people concerned about their methamphetamine use. With support from the national and city health agencies, Crystal Clear expanded to become an ongoing programme that includes peer outreach, support and leadership development, harm reduction education and health services, and engagement with other civic and governmental organisations, to represent young people who use methamphetamine. The project has also produced a manual published by the Vancouver Coastal Health Authority, \textit{Crystal Clear: a practical guide for working with peers and youth}.\textsuperscript{65}

Similarly, YRISE, a membership-based international harm reduction network of young people, was established in 2006 to advocate for high-quality harm reduction services and policies for young people. Rooted in peer-based leadership and human rights, including application of the Convention on the Rights of the Child to harm reduction, among other work, YRISE piloted a series of workshops on harm reduction for young people in Romania, India, Mexico and Canada, subsequently producing a training manual with Espolea, a Mexico City-based youth AIDS, gender and drug policy organisation.\textsuperscript{66}

\textbf{Women}

Although women represent a minority of people who inject drugs in most countries, they often face specific social stigma and marginalisation due to their drug use, because of cultural perceptions. A range of factors increase women’s risk of drug-related harm, including misogyny; unequal social and economic power relationships with men; discrimination, extortion, or sexual violence perpetrated by law-enforcement officers or others; discrimination by healthcare providers, especially towards pregnant drug-using women; and a preponderance of harm reduction and treatment programmes that are primarily directed at men. Women who use drugs are often less likely than men to buy drugs themselves, know how to inject properly, or access harm reduction services. Pregnant and parenting women who inject drugs are particularly vulnerable.\textsuperscript{67} Some harm reduction programmes have addressed these issues in numerous ways (see Box 5 and 6), including by creating women-only spaces and support groups, adapting outreach models to better suit women, and developing a range of sexual and reproductive health services specific to the needs of women who use drugs. Global networks have also been formed to advocate for the rights of women who use drugs, including the International Network of Women Who Use Drugs and the Women’s Harm Reduction International Network.
Box 5. Building services for women who use drugs in Ukraine and Russia

In response to the particular issues facing women who use drugs, harm reduction organisations in Ukraine and Russia have made important progress in establishing model services in recent years. After discovering that some two-thirds of drug-using women in their city had no access to health services, the Tomsk Anti-AIDS Foundation in Western Siberia established a women-only space that has resulted in better linkages to medicine and uptake of harm reduction services by women, and a more than 100% increase in the number of women tested for HIV. Similarly, St Petersburg’s Humanitarian Action Foundation operates an outreach bus exclusively targeting female sex workers, as well as one of Russia’s few crisis centres for women with young children.68

Simple efforts to focus more attention on outreach to women can have a dramatic effect on access to services: by doing so, the organisation Virtus, in Dnipropetrovsk, Ukraine, saw a 50% increase in the number of women clients and an 80% increase in the number of women clients with children. The MAMA+ program in Kyiv, meanwhile, offers a more intensive service model for women living with HIV. MAMA+ has increased the proportion of clients who use drugs, and provides HIV and STI testing and treatment, counselling, family planning, gynaecological care, child care, and nutritional services, multidisciplinary support for pregnant women, home visits, and legal assistance.69

Box 6. Reaching out to women who inject drugs in Manipur, India

Although women only constitute a small proportion of people who inject drugs in Manipur, India, they are highly vulnerable to blood-borne infections, especially HIV. In partnership with the Social Awareness Service Organization (SASO), the International HIV/AIDS Alliance India developed a programme to meet their immediate needs, enhance access to harm reduction services for women who inject drugs and their partners.70

A drop-in centre was established as part of the project where women receive support such as NSP, free condoms, health check-ups (including basic healthcare, clinic-based detoxification, OST, counselling and referrals to other institutions for reproductive health and HIV care and support. The drop-in centre also offers recreational opportunities

including watching TV, reading newspapers and magazines, and a space for chatting with friends and staff. Women can also bathe and use make-up kits provided by the centre. Finally, the centre acts as a venue for meetings for self-help and support groups as well as for educational classes. As women who use drugs constitute a particularly marginalised group of society, the main objective of the centre is to reach out them and encourage them to access harm reduction and general healthcare services.71

Minority groups

Some minority groups, including lesbian, gay, bisexual, transsexual, transgender and intersex and queer (LGBTTIQ) people, racial or ethnic minorities, immigrants, or refugees, may be at increased risk of drug-related harm due to discrimination, legal or economic pressures, and barriers to accessing services. Local harm reduction services should be explicitly designed so as to be accessible by minority groups, and should be undertaken as collaborative projects between policy makers and affected communities. They should also be accessible to minorities in their own language and be culturally sensitive.72 Numerous positive examples exist (see Box 7), such as NSP services targeting Uzbek minority communities in Osh, Kyrgyzstan or Roma in Bucharest, Romania, and peer-based amphetamine-type stimulant harm reduction counselling at the San Francisco AIDS Foundation.
Box 7. Protecting the health of minority groups in Australia and Romania

From London to Chiang Mai to Zanzibar, racial and ethnic minorities often have relatively poor access to harm reduction services, and services that are less culturally appropriate when they do gain access.

In Australia, rates of drug use, HIV, viral hepatitis, and related health issues are significantly higher among Aboriginal (indigenous) communities than Australians of European descent. While some drug services for Aboriginal Australians are longstanding, efforts to expand them are more recent, and have included engagement by the governmental National Council on Drugs and partnerships between key organisations such as the National Aboriginal Community Controlled Health Organisation and the Australian Injecting and Illicit Drug Users League.

In Romania, Roma are a significant minority group that is overrepresented in terms of poverty, poor health and drug use. From the time the first harm reduction programmes were founded in Bucharest in the late 1990s, such services have targeted Roma communities, employed Roma staff, and developed materials in the local Romani dialect. Roma communities deeply stigmatise drug use, which has created barriers to services. In response, in 2009 the first Roma-led harm reduction initiative was launched in Bucharest’s Ferentari district by Sastipen, a Roma health services organisation. Among other tactics, Sastipen’s basic preventive health services were made available to the entire community, as a means of increasing acceptance of the harm reduction programme.

Recommendations

1) Based on public health, economic, and other evidence, a package of harm reduction services and policies should be adopted in all locations where injecting drug use is prevalent, in order to promote access to healthcare services and commodities and reduce unintended negative consequences of criminal, health and social policies.

2) Harm reduction should not be conceptualised as a standalone service but as an integrated approach that complements, and is complemented by, all levels of health, social and other services that people who use drugs come into contact with. Harm reduction should therefore be integrated whenever possible with drug treatment, primary and relevant specialist health care, social services and justice systems.

3) Harm reduction aims to empower people who use drugs to improve their health and manage, reduce, or eliminate the negative consequences of drug use. Programmes should therefore be evaluated in terms of harm reduction’s core objective – to lead to any positive change. While abstinence is a potential outcome of harm reduction approaches, reducing ‘success’ to abstinence-only goals runs counter to scientific evidence about drug dependency and ignores the great value to individuals and society of countless incremental positive steps.

4) Harm reduction services should be as comprehensive as is feasible in a given setting, at minimum seeking to address the following either directly or through referral networks: prevention of HIV, hepatitis, STI and tuberculosis, and links to care and treatment; promotion of safer drug-use practices; overdose prevention and response; and basic mental health and social welfare needs.
5) Harm reduction programmes that target women, young people, and minorities who use drugs should be established, improved or scaled-up to ensure that such groups have equal access to appropriate services.

6) Harm reduction programmes and drug policies gain legitimacy when people who use drugs are meaningfully involved in their development, implementation and evaluation. Harm reduction and allied organisations, and government bodies should encourage the development of community-based organisations of people who use drugs, and should ensure that people who use drugs are represented at all levels of decision making and policy implementation and in ways that actively support participation.

7) It is critical that all these harm reduction interventions be extended to prison settings (for more information, see Section 2.4: Effective drug interventions in prisons).

Key resources


Endnotes


3 Ibid.


12 Ermak, T.N., Kravchenko, A.V., Shakhgildyan, V.I. & Ladnaya, N.N. (2009), ‘Causes of death among people living with HIV in Russia: Presentation at the All-Russian Congress on Infectious Disease; Moscow, Russian Federation, 30 March to 1 April, 2009.


20 Ibid.

In 2011 US dollars; the Australian government report estimates roughly AUD 800 million in savings.


Ibid.


Stuijlyte, R. & Schonnin, S. (2008), ARV4IDUs in Central and Eastern Europe: Barriers to access and ways to overcome them (Brussels: European AIDS Treatment Group), http://www.etag.org/etag/Press-Room/Positions/ARV4IDUs-in-Central-and-Eastern-Europe-Barrriers-to-access-and-ways-to-overcome-them

Talking Drugs. The Vancouver Declaration: Why the world needs an international network of people who use drugs (2006), http://www.talkingdrugs.org/vancouver-declaration

The CAHR project is funded by the Dutch Ministry of Internal Affairs (BUZA) and led by the International HIV/AIDS Alliance and Alliance Ukraine in collaboration with project partners: Alliance China, International HIV/AIDS Alliance in India, Rumah Cemara in Indonesia, the Kenyan AIDS NGOs Consortium, the Malaysian AIDS Council, IDPC, HRI, INPUD, the AIDS Foundation East/West and Prevention, Information et Lutte Contre le Sida. For more information: http://idpc.net/policy-advocacy/special-projects/cahr-project


64 EXASS Net (May 2009), Safer nightlife – 5th Meeting of EXASS Network in Budapest, Hungary, 4–6 May 2009


70 India HIV/AIDS Alliance & Social Awareness Service Organisation (2011), In the shadows: the Chanura Kol baseline study on women who inject drugs in Manipur, India, http://idpc.net/sites/default/files/library/In%20the%20Shadows.pdf


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’.

Recent estimates suggest that 210 million people use controlled drugs. 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’. 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.

Only a minority of all people who use drugs – estimated by the UN at between 15 and 39 million globally – 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. 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. Given the many factors that drive
drug dependence, no single approach to treatment is likely to produce positive outcomes across society. Therefore, governments should work towards a treatment system that encompasses a range of models that are closely integrated and mutually reinforcing. The impact of the legal and physical environment means that effective drug-treatment interventions will ideally offer psychosocial services but also take into account the impact of the social and cultural setting in which they do so. Such interventions, as part of an effective treatment system, can enable an individual to live a healthy and socially constructive lifestyle.

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 underdeveloped 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.\textsuperscript{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.\textsuperscript{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\textsuperscript{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}

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.

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.\(^{26}\) 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\(^{27}\) (such as regular attendance at a clinic where clients receive prescribed medications, counselling, etc) or residential settings.\(^{28}\) 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.\(^{29}\) 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.\(^{30}\) In the USA, the benefit return for methadone maintenance treatment is estimated to be around four times the treatment cost.\(^{31}\) 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.\textsuperscript{32}

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.\textsuperscript{33}

\textbf{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.

\textbf{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/effects substanceuse.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


