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Drug demand reduction

Optimizing systems for collecting information and identifying the best practices to counter the demand for illicit drugs

Report of the Executive Director**

Addendum

Guidelines on best practices in drug demand reduction

* E/CN.7/2003/1.

** For technical reasons the present report was submitted after the date required by the 10-week rule.

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I. Introduction

1. At its forty-fifth session, the Commission on Narcotic Drugs adopted resolution 45/13, entitled "Optimizing systems for collecting information and identifying the best practices to counter the demand for illicit drugs", in which it called upon the Executive Director of the United Nations International Drug Control Programme (UNDCP) to summarize, in a series of papers to be presented to the Commission at its forty-sixth session, the current state of implementation of activities for the reduction of demand for illicit drugs throughout the world, incorporating flexible guidelines on best practices and taking into account cultural specificities. The present report is submitted pursuant to that request.

2. Drawing on basic research, evaluation reports and field experience, the work of UNDCP on best practices in drug demand reduction aims at offering the most promising current thinking about policy, programme and methodology development in the areas of data collection and analysis; prevention; treatment and rehabilitation; and prevention of the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) as linked to drug abuse.

3. Identifying best practices involves processing knowledge from different sources to produce a better understanding of what constitutes effective action in drug demand reduction. Best practices should be seen as a synthesis of technical and scientific research results, the lessons learned from previous programmes and projects and an understanding of the impact of cultural and social factors. Such lessons can be extracted from external evaluations, project monitoring and/or the knowledge resulting from learning by doing in the course of project execution. Such "silent knowledge" needs to be documented in a systematic way to allow for self-evaluation and sharing of experience. However, best practices always have to be adapted and assessed within the environment where they are to be applied and must be sensitive to cultural specificities and the financial and human resources available.

4. The present report summarizes some main principles of best practices identified by UNDCP in the relevant areas of demand reduction as reflected in the Declaration on the Guiding Principles of Drug Demand Reduction (General Assembly resolution S-20/3, annex). More information is available in a number of publications produced by the Programme and a list of references and web sites is provided.

II. Data collection

5. Although there are countries that can claim some success in controlling and reducing the demand for illicit drugs, drug abuse throughout the world continues to spread. In particular, drug abuse in some developing countries has increased dramatically. However, knowledge of the scale of drug abuse is still inadequate and understanding of patterns and trends limited.

6. In order to develop and implement effective policies and strategies to reduce drug abuse, Governments need data about when, where and why people use illicit drugs. Patterns of illicit drug use transcend national borders as users in all regions of the world gain access to a greater variety of drugs and as social trends, in

particular among young people, spread more rapidly than before as a result of better communications. The globalization of drug abuse means that demand reduction policies and strategies also have to be global, as must the information systems on which they rely.

7. At its twentieth special session, in 1998, the General Assembly adopted a Political Declaration (resolution S-20/2, annex) in which Member States committed themselves to eliminating or reducing significantly the supply and demand for illicit drugs by the year 2008. However, the systematic data needed to monitor and evaluate progress towards those goals are not yet readily available. For that reason, in its resolution 54/132 of 17 December 1999, the Assembly requested UNDCP to provide Member States with the assistance necessary to compile comparable data, to collect and analyse such data and to report thereon to the Commission on Narcotic Drugs.

8. In response to that request and in particular as regards drug demand reduction, the Global Assessment Programme on Drug Abuse was launched. The Global Assessment Programme has been specifically designed:

(a) To support Member States to build the systems necessary for collecting reliable data on drug consumption and drug abuse to inform policy and action;

(b) To encourage regional partnerships to share experience and technical developments in data collection;

(c) To facilitate a better understanding of global drug abuse patterns and trends by encouraging the adoption of sound methods to collect comparable data.

9. These aims reflect the challenge posed in the Declaration on the Guiding Principles of Drug Demand Reduction, in which the General Assembly stressed that:

> "Demand reduction programmes should be based on a regular assessment of the nature and magnitude of drug use and abuse and drug-related problems in the population …. Assessments should be undertaken by States in a comprehensive, systematic and periodic manner, drawing on results of relevant studies, allowing for geographical considerations and using similar definitions, indicators and procedures to assess the drug situation."

A. Interventions

10. Integral to efforts to improve international data on drug consumption is the harmonization of data collection methods and activities. An important first step in achieving such harmonization was taken in January 2000 with a joint meeting of representatives from international bodies, regional drug information networks and other relevant technical experts. The meeting, the purpose of which was to discuss the principles, structures and indicators necessary for effective drug information systems, was hosted by the European Monitoring Centre on Drugs and Drug Addiction in Lisbon and supported by UNDCP under the Global Assessment Programme on Drug Abuse. The discussion paper produced by the meeting (E/CN.7/2000/CRP.3) was endorsed by Member States at the forty-third session of the Commission on Narcotic Drugs, in March 2000.

11. At the meeting in Lisbon consideration was given to the development of a set of core epidemiological demand indicators against which Member States could report on their respective situations. Those indicators, chosen because they addressed areas in which routine data collection was considered possible at least for some countries, were not intended to provide a comprehensive information base for all policy questions, as areas that required dedicated research exercises were not suitable for inclusion in an ongoing information system. The core indicators identified that should guide the development of interventions in the area of data collection were as follows:

(a) *Drug consumption among the general population.* This indicator pertains to prevalence and incidence estimates of drug consumption among the general population (i.e. those aged between 15 and 64 years). Understanding the level of drug consumption in any population is often and indeed should be the starting point for policy discussions. Generating general population prevalence and incidence estimates is therefore a key task of most drug information systems. Attention is often focused on prevalence estimation but incidence levels (new cases) are likely to be equally important for informing policy formulation. With respect to both prevalence and incidence estimation, it should be noted that that area does not lend itself to any single methodological approach. While surveys provide one method for achieving estimates, other estimation methods also exist, such as data from sentinel surveillance systems and indirect statistical estimation techniques. In many countries, conducting national prevalence surveys may currently not be possible for reasons of cost or because of methodological or practical difficulties;

(b) *Drug consumption among the youth population*. This indicator refers to estimates of the prevalence and incidence of drug consumption among youth (those aged between 15 and 24 years). Because drug consumption among young people is a particular concern of policy makers and because age cohorts of young people make a convenient sampling unit, estimates of drug consumption among youth form an important part of many drug information systems. School surveys have been used extensively to generate estimates in this area. However, because school attendance patterns vary between countries and because surveys may exclude important sections of the youth population, other approaches may also be necessary;

(c) *High-risk drug abuse.* This pertains to estimates of the number of injecting drug users and to the proportion of those users engaging in high-risk behaviours as well as estimates of the number of daily users and regular or dependent abusers. Some drug-taking behaviours are especially associated with severe problems and as such merit attention. The most common data collected in this area are the numbers of injecting drug users and the dependent or very frequent users of drugs. Specific methods are needed to gain information on behaviours such as drug injection as their hidden nature and low prevalence usually mean that they are poorly covered by general population estimates. With respect to drug injection and the transmission of various infections, it is also necessary to collect information on rates of high-risk injecting behaviours (e.g. equipment-sharing);

(d) *Service utilization for drug problems*. This indicator refers to the number of individuals seeking help with a drug problem. Drug treatment registers are often used as an indirect indicator of treatment demand. This information is useful for analysis of service utilization and as an indicator of trends in prevalence and patterns of high-risk drug consumption. Such drug treatment registers may however

not be appropriate where general health and social services are the main providers of assistance. It should be remembered that across countries the scale, structure and nature of services for those with drug problems vary greatly. Definitional clarity is therefore particularly important in service utilization reporting, as is an understanding of methodological and analytical issues pertinent to drawing conclusions from service populations to drug problems among the general population;

(e) *Drug-related morbidity*. This refers to cases of disease directly or proportionally attributable to drug consumption and in this context refers principally to rates of HIV, hepatitis B virus and hepatitis C virus infection among drug injectors. Health costs are of obvious importance in informing policy development concerning illicit drug consumption. Common measures include drug-related infections such as HIV, hepatitis B virus and hepatitis C virus and behavioural risk factors among injecting drug users. Conceptual problems do exist in this area, requiring further development work, in particular, in the estimation of the contribution drug consumption has made to cases of disease in which there are other additional attributed causes and in the calculation of the proportion of cases in which drug use is the sole attributed cause when a number of possible causes exist;

(f) *Drug-related mortality*. This indicator refers to data on deaths directly attributable to drug consumption. While potentially useful and important, reliable data on this area are usually not widely available. Diagnostic criteria exist to distinguish between psychiatric morbidity attributed to drug consumption and other psychiatric morbidity. However, this level of detail is often unavailable. There is also considerable debate about the potential of some illicit substances to cause psychiatric problems and the role of pre-existing psychiatric conditions in the development of drug problems. Regardless of the nature of the relationship between drug consumption and mental health problems, co-morbidity remains a major concern as elevated levels of drug consumption are often found among those with mental health problems. This area is currently poorly understood and requires further research;

(g) *Human networks and organizational structures*. The identification of good methods alone is not enough to improve data collection capacity. It is also necessary to develop appropriate human networks and organizational structures to provide the infrastructure necessary to support data collection and to improve capacity to analyse and interpret information on drug consumption.

B. Principles of data collection

12. In addition to the consensus on the core indicators of drug consumption, there is some agreement among experts on the broad principles that should underpin data collection activities, namely:

(a) Data should be timely and relevant to the needs of policy makers and service providers;

(b) While not sufficient in themselves for a comprehensive understanding of patterns of drug consumption, efforts to improve the comparability and quality of

data at the international level should focus on a limited number of indicators and a manageable priority core data set;

(c) Simple indicators of drug consumption must be subject to appropriate analysis before strategic conclusions can be drawn. Analysis and interpretation of basic statistical data are greatly enhanced when combined with research, both qualitative and quantitative, and with broader information on the context of drug consumption;

(d) Multi-method and multi-source approaches are of particular benefit in the collection and analysis of data on drug consumption and its consequences;

(e) Data should be collected in accordance with sound methodological principles to ensure reliability and validity;

(f) Methods need to be adaptable and sensitive to the different cultures and contexts in which they are to be employed;

(g) Data collection, analysis and reporting should be as consistent and comparable as possible in order to facilitate meaningful discussion of changes, similarities and differences in the drug consumption phenomenon;

(h) Sources of information should be clearly stated and open to review;

(i) Data collection and reporting should be in accordance with recognized standards of research ethics;

(j) Data collection should be feasible and cost-effective in terms of the national context where it occurs.

C. Practical guidance on data collection

13. To enhance technical capacity at the national level, the Global Assessment Programme on Drug Abuse is producing a methodological resource known as the *GAP Toolkit* on drug abuse epidemiology. The toolkit consists of a compendium of inter-linked modules, each of which addresses a core aspect of data collection activities. The toolkit has been especially configured around the core indicators agreed upon at the meeting in Lisbon (see para. 10) and reflected in the content of the revised annual reports questionnaire, part II, and is designed to provide practical, accessible guidelines on data collection activities to practitioners. To date, the production of the following modules of the toolkit is under way to support various aspects of data collection:

(a) Developing an integrated drug information system;

(b) Handbook for implementing school surveys on drug abuse;

(c) Prevalence estimation: indirect methods for estimating the size of the drug problem;

(d) Data management and interpretation to support the annual reports questionnaire;

(e) Basic data analysis for drug abuse epidemiology;

(f) Undertaking qualitative research and focused assessment studies;

(g) Ethical issues and principles for drug abuse epidemiology.

14. The first three modules of the *GAP Toolkit*, namely: "Developing an integrated drug information system", "Handbook for implementing school surveys on drug abuse" and "Prevalence estimation: indirect methods for estimating the size of the drug problem", are currently available in electronic form at www.unodc.org/odccp/drug_demand_gap_m-toolkit.html The final printed versions of these documents will be available by mid-2003. Other modules are in preparation and will be tested and are expected to be available in late 2003 or 2004. Further modules on treatment reporting and monitoring of injecting drug use and associated HIV-related factors are being planned and will begin, subject to the availability of funding.

15. The discussion paper produced by the meeting in Lisbon (see para. 10) can be found on the Global Assessment Programme on Drug Abuse web site (www.unodc.org/pdf/drug_demand_gap_lisbon_consensus.pdf).

16. The principles for collecting data on drug consumption identified at the meeting in Lisbon were examined at the Global Workshop on Drug Information Systems: Activities, Methods and Future Opportunities, held in Vienna from 3 to 5 December 2000. The meeting of technical experts representing national and regional drug information systems and relevant international bodies provided a forum for updating important developments in drug consumption trends; reviewing the range of methods used by regional epidemiological networks and identifying opportunities for methodological developments; and for discussing future collaboration and improved working practices. The report of the Workshop is available at www.unodc.org/pdf/gap_global-workshop-report.pdf

III. Prevention

17. Overall drug abuse, in particular among young people, is high in many countries and reported trends and patterns are not positive. However, where consistent and sustained preventive interventions have been undertaken, encouraging results are gradually emerging. The signs of stabilization and even decrease in patterns of abuse reported from the United States of America and Western Europe are a clear indication that comprehensive prevention strategies can and do work. However, it is necessary to invest sufficient resources in prevention strategies and programmes, to allow some time to elapse before results become visible and to use validated principles and approaches in the design and implementation of such strategies and programmes.

18. No single approach or strategy has proved to be consistently effective in reducing drug abuse among young people. The evaluation of various prevention programmes does not allow the identification of a panacea to be followed in all countries and contexts. There are too many factors influencing drug abuse and it is difficult to isolate them from one another. It is therefore necessary to use a range of interventions aimed at strengthening known protective factors and weakening known risk factors and where the individual interventions are part of a broader strategy or programme and complement one another. In addition, there is further consensus among experts, practitioners and youth themselves on the kinds of

interventions and principles that need to be considered when designing prevention programmes.

A. Interventions

19. The lessons learned and the experience of several decades of drug abuse prevention suggest that three general elements should be included in prevention programmes:

(a) Addressing the values, perceptions, expectations and beliefs that the community associates with drugs and drug abuse;

(b) Developing personal and social skills, especially among children and young people, to increase their capacity to make informed and healthy choices;

(c) Creating an environment where people have the possibility to develop and lead healthy lifestyles.

20. In practice, most prevention programmes typically contain two or more of the following kinds of intervention:

(a) *Provision of information on substances and substance abuse*. The mere provision of information on substances and substance abuse has not been found to change substance abuse behaviour. However, accurate information is necessary to make healthy choices and all programmes should be based on scientific evidence and a balanced and an unexaggerated picture of the effects of substances and substance abuse;

(b) *Education in life skills*. The provision of education in life skills, at both the primary and the secondary school level, has been extensively evaluated and shown to be one of the most effective kinds of intervention. “Life skills” refers to the abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life. These would include self-awareness, empathy, communication skills, interpersonal skills, decision-making skills, problem-solving skills, creative thinking, critical thinking, coping with emotions and coping with stress. Such personal and social competencies, together with appropriate information about substances and substance abuse, allow young people to make healthy choices and to explain and reinforce those choices among their peers;

(c) *Alternatives to drug abuse*. Alternatives to drug abuse include activities such as sports, dance, theatre and spiritual and cultural enhancement aimed at providing young people with enjoyable, challenging and healthy ways to employ their free time. This approach has only been evaluated to a limited extent. However, indications are that, when complemented by appropriate drug abuse prevention education (which might include both information and education for development of life skills), alternative activities can have a positive effect on risky behaviours, including substance abuse;

(d) *Family development*. There are indications that prevention interventions providing parents and guardians with accurate information about drug use, as well as opportunities for developing parenting, communication and conflict management skills, may reduce drug abuse among children;

(e) *Media campaigns*. Research indicates that media campaigns, whether delivered through mass or local media, do not change substance abuse behaviour. However, such campaigns can increase awareness and knowledge about such behaviour. Although increased awareness and knowledge are rarely translated into a change in behaviour, they nevertheless can usefully complement and reinforce the messages and actions of other kinds of intervention. Media campaigns might therefore be of use when integrated into a comprehensive prevention programme;

(f) *Providing a supportive environment*. There are indications that suffering from neglect and violence and a lack of adequate education, employment or health and social services are all risk factors for initiating drug use that may lead in turn to drug abuse. Therefore, although such interventions have not been rigorously evaluated, counselling and support to resolve a situation of neglect and violence in the family or in the community, developing vocational skills and provision of vocational counselling and the provision of support to health and social services for them to be able to respond to the needs of their clientele are all interventions that might contribute to preventing drug abuse when integrated into a comprehensive programme.

B. Principles of prevention

21. In addition to the kinds of interventions described above, certain basic principles on how prevention approaches should be implemented have also been identified. Those principles are discussed briefly below and some indications are provided on how they would be applied in the implementation of the various interventions mentioned above.

1. Starting at an early age and sustaining through development stages

22. Research has established that the lower the age of first use of illicit drugs, the higher the severity of the drug problem later. Delaying the initiation into drug abuse might therefore be useful even if entirely preventing the abuse of drugs may be difficult to achieve. Moreover, the age of first experience with drugs has been falling in many regions of the world and this means that drug abuse prevention should start as early as possible. However, the perception of drugs by a child or a young person changes considerably over time. It is thus not enough merely to start early with prevention initiatives. Drug abuse prevention is a continuing process that needs to be reinforced at different stages in the development of children and adolescents, in particular at critical moments of transition in life. Both these points have important implications in the case of drug abuse prevention education in schools. Such education—including both the provision of information and of opportunities for the development of personal and social skills—should start in primary school and be sustained continuously through the secondary level.

2. Promoting healthy lifestyles

23. Prevention should not focus on one drug only, but address substance abuse in general, including the abuse of tobacco, alcohol and inhalants. Indeed, it makes sense to see prevention within the wider concept of health promotion, addressing all practices that cause damage to physical and mental well-being. For example, the

personal and social skills needed to avoid substance abuse are similar to those needed to avoid other kinds of risky behaviour such as unsafe sex. A comprehensive programme could make provision for the development of such skills, with examples addressing a variety of risky behaviours. This might also mean that action aimed at improving the general well-being of young people and the community, including adequate opportunities for education and employment, and the availability of user-friendly social and health services, might contribute to the prevention of drug abuse.

3. Involving the beneficiaries, especially young people

24. There is growing evidence that the effectiveness of drug abuse prevention interventions is enhanced by the involvement of beneficiaries in their planning, implementation and, increasingly, monitoring and evaluation. Since most prevention initiatives are targeted at youth, this means involving young people in particular. An example of how this principle works in practice is with the case of peer education. The principle of peer education is that the message is more likely to be heeded because it appears more credible when it comes from someone who has some things in common with the target audience. This is especially true of young people, for whom peers are a very important reference point. Drug abuse prevention, involving young people in leading and delivering education activities, has been shown to produce good results.

25. As with all interventions, careful planning is essential. It is important to ensure that peer educators are carefully selected on the basis of the target of the intervention and of their communication skills and that they are adequately trained and supported. Peer education is also effective in the workplace and in other environments where it is important to build trust and confidence for the effective conveying of prevention messages.

26. More broadly, in the case of provision of information and of awareness-raising campaigns (using mass or local media), the testing of materials with young people to ascertain their relevance in terms of message and medium of dissemination is essential. The provision of alternative activities has also been shown to benefit from the involvement of young people from the early stages of planning, as they are more familiar with what would attract the interest of their peers.

4. Involving a range of stakeholders

27. Research shows that the involvement of a range of stakeholders in the planning and implementation of prevention interventions enhances the chances that such interventions will be effective, because it allows interventions to draw on community resources and thus be more easily sustained and because it decreases the chances of contrasting messages being promoted. The situation is similar as regards the development of drug education prevention programmes in schools. A comprehensive programme will always need to include a policy on the abuse of both licit and illicit substances in the school. Such a policy is best developed through a collaborative effort that includes teachers, parents and students. Not all stakeholders need to be involved to the same degree at the same time. However, mechanisms to at least keep all stakeholders informed about the interventions and to address the concerns that they might have should be in place.

5. Targeted approaches

28. Not all people who abuse drugs or are at risk are the same or are equally vulnerable. Strategies should therefore be carefully tailored to clearly defined target groups. Programmes should be age- and gender-specific, developmentally appropriate and culturally sensitive. Moreover, this means that prevention agents should be flexible enough to reach people where they are and engage them in a constructive dialogue about their choices and options with respect to drug abuse. This might mean bringing drug abuse prevention to the streets of the communities and wherever else necessary in order to convey effective prevention messages.

6. Sustaining the programmes in the long term

29. Substance abuse behaviours usually change slowly. Studies that have monitored the attitudes of young people towards drugs, the perception of risk and harm associated with specific drugs and patterns of abuse suggest that a change in the perception of risk and harm associated with a particular drug can take up to three years to translate into an increase or decrease in the abuse of that drug. Prevention programmes therefore need to be sustained over a long period of time to be effective.

30. While the interventions and principles described above already go a long way in giving an indication on how to develop and implement effective prevention programmes, much research still needs to be undertaken to identify risk and protective factors with more precision and to determine how to address them.

C. Practical guidance on prevention

31. UNDCP, with crucial inputs from many youth groups, community-based organizations and international organizations, is currently developing a series of practical handbooks and guides that give examples on how the principles described above might be put into practice in organizing different kinds of prevention interventions. Some of those handbooks and guides have already been published, while others are still in preparation (all are published by UNDCP unless mentioned otherwise):

(a) *A Participatory Handbook For Youth Drug Abuse Prevention Programmes: A Guide for Development and Improvement*, 2002 (available in all official languages of the United Nations);

(b) *Performance: Using Performance for Substance Abuse Prevention*, 2001 (available in all official languages of the United Nations);

(c) *Equal Partners: Organizing For Youth by Youth Events*, 2001 (available in all official languages of the United Nations);

(d) *Sport: Using Sport for Drug Abuse Prevention*, 2002 (available in all official languages of the United Nations);

(e) *Training Workshop On Needs Assessment and Programme Planning: A Booklet For Participants and Facilitators' Guidelines*, 2002 (pre-publication version available in English);

(f) *Primary Prevention of Substance Abuse: A Facilitator Guide* and *A Workbook for Project Operators*, WHO, 2000;

(g) *Lessons Learned in Drug Abuse Prevention: A Global Review*, 2002;

(h) *Drug and Alcohol Problems at Work: The Shift to Prevention*, ILO/UNDCP, 2003;

(i) "Good practices on assessing and planning for substance abuse prevention" (in preparation);

(j) "Good practices on using alternative activities for substance abuse prevention" (in preparation).

32. The publications that have already been published are also available on the web sites of the United Nations Office on Drugs and Crime (www.unodc.org/youthnet/youthnet_action.html and www.unodc.org/pdf/demand_reduction_lessons_learned.pdf).

IV. Treatment and rehabilitation

33. Drug dependence can be seen as a chronic, recurring disorder that can have serious associated problems, such as family disintegration, lack of job skills, criminality and psychiatric pathology. Drug abuse treatment can and should be expected to improve the health and alleviate the social problems of patients, which can be achieved in a cost-effective manner through proper organization and delivery of care. However, most people entering treatment have tried self-recovery before but were unsuccessful and most people who recover after treatment do so after more than one treatment episode.

34. The research evidence is clear that, for those with severe forms of drug dependence, the best available treatment services are ongoing, as with treatments for other chronic illnesses; able to address the multiple problems that are factors leading to relapse (i.e. medical and psychiatric symptoms and social instability); and well integrated into society so as to permit ready access and to forestall relapse.

35. Over the course of three decades, research has repeatedly demonstrated that treatment is effective in reducing drug abuse and dependence and that such reductions are also associated with meaningful reductions in crime, health-related problems and costs.

36. The paragraphs below provide a thematic summary of the effectiveness and main influential factors of contemporary drug abuse treatment (see also the publication *Contemporary Drug Abuse Treatment: A Review of the Evidence Base,* UNDCP, 2002).

A. Interventions

1. Detoxification-stabilization phase of treatment

37. This phase of treatment is designed for people who experience withdrawal symptoms following prolonged abuse of drugs. Detoxification may be defined as a

process of medical care and pharmacotherapy that seeks to help the patient achieve abstinence and physiologically normal levels of functioning with minimum physical and emotional discomfort.

38. Evidence suggests that detoxification from heroin and other opioids can be facilitated using dose-tapered opioid agonists and two non-opioid drugs, namely clonidine and lofexidine. The rapid opioid detoxification and ultrarapid opioid detoxification using drugs such as naloxone or naltrexone do not confer substantial advantages over existing methods, nor are they more successful in inducting or retaining abstinent patients during relapse prevention. Moreover, ultrarapid opioid detoxification has been associated with some medical risks.

39. Much debate exists regarding the effectiveness of either inpatient (hospital or residential setting) or outpatient (community-based setting) detoxification treatment. In general, inpatient detoxification is viewed as particularly appropriate for patients with acute medical and psychiatric problems and those who are alcohol-dependent. Patients with less acute problems and medical complications and who enjoy a stable, supportive home life may well be able to complete detoxification in the community, however.

2. Rehabilitation-relapse prevention phase of treatment

40. This phase of treatment is suitable for patients who are no longer suffering from acute physiological or emotional effects of recent substance abuse. Main goals include prevention of a return to substance abuse, assistance in developing control over drug craving and (re-)attainment of improved personal health and social functioning.

41. Strategies employed during this phase have included such diverse elements as medications for psychiatric disorders and for relief of drug craving; substitution pharmacotherapies to attract and rehabilitate patients; group and individual counselling and therapy sessions to guide and support behavioural changes; and peer help groups to provide continued abstinence support.

Patient- and treatment-related factors

42. A number of patient- and treatment-related factors have been found to influence treatment outcomes. Patient-related factors include severity of substance abuse, psychiatric symptoms, motivation, employment and family and social support. In turn, treatment-related factors include:

(a) *Setting.* For most treatment systems, it is recommended that patients with sufficient personal and social resources and who present with no serious medical complications be assessed for outpatient/day treatment. Given the typically high demand for residential care, it seems logical to prioritize that setting for those with acute and chronic problems who have social stressors and/or environments that are likely to interfere with treatment engagement and recovery;

(b) *Treatment completion and retention.* Available evidence indicates that patients who complete treatment will have superior post-departure outcomes than those who leave prematurely. This is also true for patients who stay for longer than specific threshold times, for example at least three months in residential programmes, 28 days in inpatient and shorter-stay residential programmes and one

year in outpatient methadone treatment. However, time spent in treatment does not directly mediate good outcome, as the extent or level of therapeutic progress attained has emerged as a stronger predictor of outcome than simply the length of stay;

(c) *Pharmacotherapies*. Several main forms of pharmacotherapy for opioid dependence have been developed and widely evaluated for their role in the rehabilitation-relapse prevention phase. As far as agonist medication (i.e. methadone, Levoalphacetylmethadol (LAAM) and buprenorphine is concerned, methadone has been evaluated in considerable depth in many countries. Numerous studies have reported sustained reductions in heroin abuse, HIV-risk behaviours and drug and property crimes among patients who entered methadone maintenance treatment. A clear finding is that the dose of methadone has a positive relationship with retention in treatment and a negative relationship with heroin abuse. LAAM is a longer acting form of methadone, capable of suppressing withdrawal symptoms for between 48 and 72 hours and permitting administration three times a week. Buprenorphine is a synthetic opioid with mixed agonist and antagonist properties. Research has shown it to be an effective maintenance agent with a better safety profile in cases of overdose than methadone and other agonists. Concerning antagonist medication (i.e. naltrexone), research data support the use of this opioid antagonist as part of relapse-prevention programmes as it is especially beneficial to those patients who are highly motivated to take their daily medication and when used in conjunction with various psychosocial therapies. When comparing this treatment with methadone, patients being prescribed the latter are retained in treatment significantly longer. However, there are no differences in levels of heroin abuse during either treatment. Despite extensive research and several attempts to develop antagonists for cocaine-dependence treatment, results have thus far been disappointing. Currently, there is no convincing evidence that any of the various types of cocaine-blocking agents are effective for even a significant minority of affected patients;

(d) *Counselling.* Access to regular substance abuse counselling can make an important contribution to patient participation and treatment outcome. For example, studies have shown that patients in methadone maintenance who also attend counselling sessions obtain greater reductions in drug use. Different types of counselling and behavioural treatments include:

(i) *General outpatient drug-free counselling*, which refers to abstinence-oriented counselling associated with reductions in drug use and crime involvement together with improvements in health and well-being. Studies comparing the relative effectiveness of psychotherapy and general counselling have however not reached conclusive results;

(ii) *Motivational interviewing*, which refers to brief therapeutic interventions designed to facilitate patients' internal commitment to change. Studies indicate that patients who receive motivational interventions report less illicit drug use, remain in treatment longer and relapse less quickly to drug abuse than patients in control groups;

(iii) *Cognitive/behavioural approaches,* which involve social and communication skills training, stress and mood management and assertion training. Of all the psychosocial interventions, this approach has received the

most frequent evaluation, obtaining encouraging results with, for example, cocaine users in terms of treatment completion and continuous weeks of abstinence;

(iv) *Community reinforcement and contingency contracting*, which refers to behavioural treatment integrating community-based incentives and contingency-managed counselling, has shown encouraging results in treating cocaine users as such treatment obtained better outcomes in terms of patient retention, abstinence and personal functioning than standard counselling approaches;

(v) *Counsellor and therapist effects*, which highlights that therapeutic involvement along with an increased number and quality of counselling sessions have a direct positive effect on retention. Moreover, studies suggest that counsellors who possess strong interpersonal skills, see their clients more frequently, refer clients to auxiliary services as needed and generally establish a practical and "therapeutic alliance" with their patients achieve better results;

(vi) *Participation in self-help groups*, where some studies have shown that participation in post-treatment self-help groups predicted better outcome among groups of cocaine- or alcohol-dependent individuals.

3. Reintegration phase of treatment

43. The ultimate aim of treatment and rehabilitation is the reintegration of the former drug abuser into society. Successful social reintegration requires sustained efforts, which include family and community support, job orientation, assistance at the workplace, reinstatement of health insurance and formal and informal educational services in order to destigmatize drug abuse.

B. Principles of treatment and rehabilitation

44. "Best practice" treatment includes mechanisms to ensure achievement of the ultimate goals of the treatment process, namely, the successful rehabilitation and social reintegration of the abuser. In most cases, specific treatment goals will be:

(a) To achieve abstinence or reduce the use and effects of substances;

(b) To improve the abuser's overall health and reduce the health consequences of drug abuse, in particular HIV/AIDS;

(c) To improve the abuser's psychological functioning;

(d) To improve the abuser's family life and social functioning;

(e) To develop the abuser's educational and/or vocational capabilities;

(f) To improve the abuser's job functioning and financial management;

(g) To reduce drug-related criminal behaviour.

45. In accordance with emerging scientific evidence that treatment works, UNDCP supports the development of drug abuse treatment and rehabilitation services that are based on the following key principles:

(a) Adapted to local circumstances and cultural traditions;

(b) Integrated in a community-based, diversified and coordinated system;

(c) Designed to reach and cater to the needs of different drug abuser population groups, in particular women, youth and those involved in the criminal justice system;

(d) Offer readily available services;

(e) Offer a wide range of components, such as counselling, behavioural therapies and medications (taking into account that detoxification is only the preparatory first stage of continued treatment and is unlikely to lead to long-term abstinence);

(f) Offer long-term care, as the treatment of drug abuse often involves multiple episodes;

(g) Attend to the individual's needs throughout the recovery process, not just his/her drug use/abuse;

(h) Integrate and link with other relevant services (pertaining to health, HIV/AIDS prevention and care, in particular, education, housing, vocational training, social support, etc.);

(i) Involve suitably qualified staff.

46. Treatment and rehabilitation services also need to respond to the advent of HIV/AIDS as associated with drug abuse, in particular with injecting drug use, as well as to facilitate access to appropriate health and social services, including those in which drug abstinence is not necessarily the primary goal, such as HIV/AIDS prevention services. A continuum of care through mutually reinforcing services therefore needs to be pursued. For example, HIV/AIDS prevention services can function as an "entry door" into drug treatment through motivation and referral. In turn, treatment and rehabilitation services can play a significant role in preventing HIV/AIDS transmission by sharing relevant knowledge and skills concerning HIV/AIDS.

C. Practical guidance on treatment and rehabilitation

47. In response to the priority set by the Declaration on the Guiding Principles on Drug Demand Reduction to develop evidence-based practice and to learn from experience, UNDCP is committed to providing guidance and assistance to Member States for the evaluation of drug abuse treatment services and programmes.

48. To that end and in collaboration with WHO and the European Monitoring Centre on Drugs and Drug Addiction, UNDCP has published guidelines and workbooks focusing on various components of treatment evaluation. Additionally, a handbook designed for drug counsellors in Africa has been produced in response to local needs. More information about these treatment-related materials is available at www.unodc.org/odccp/drug_demand_treatment_and_rehabilitation.html

V. HIV/AIDS prevention as linked to drug abuse

49. This section is based on the experience of various United Nations entities in their work to prevent and treat drug abuse and HIV infection, as well as on relevant policy principles guiding the work of the United Nations. It also draws on research findings to recommend evidence-based best practice, to provide general guidance and to indicate some programming principles for the prevention of HIV/AIDS as associated with drug abuse.

50. Sharing or use of contaminated needles is an efficient way of spreading HIV. Since injecting drug abusers are often linked in close-knit networks and commonly share injecting equipment, HIV can spread rapidly among members of the group. Injecting drug abuse is the main or a major mode for HIV transmission in many countries of Asia, Europe, Latin America and North America.

51. Numerous studies have found injecting drug users to be disproportionately likely to be involved in the sex industry or to engage in high-risk sexual activities. Drug injecting may also contribute to an increased incidence of HIV infection through HIV transmission to children of drug-injecting mothers and through sexual contacts between injecting and non-injecting drug users.

52. HIV risk among drug abusers does not arise only from injecting. Many types of psychoactive substances, whether injected or not, including alcohol, are risky in that they affect the individual's ability to make decisions about safe sexual behaviour. Studies have associated use of crack cocaine with elevated levels of high-risk sexual behaviours, for example, in the United States, where abusers of crack cocaine account for an increasing proportion of AIDS cases.

A. Interventions

53. Deciding on the implementation of intervention strategies to prevent HIV in injecting drug abusers is one of the most urgent questions facing policy makers. Studies have demonstrated that HIV transmission among injecting drug abusers can be prevented and that the epidemic has already been slowed and even reversed in some cases. HIV prevention activities that have shown impact on HIV prevalence and high-risk behaviour include AIDS education, access to condoms and clean injecting equipment, counselling and treatment for drug abuse.

1. Treatment for drug abuse

54. Drug abuse treatment is one approach that may have an impact on preventing HIV infection. Many large-scale studies have shown that patients participating in drug substitution treatment such as methadone maintenance, in therapeutic communities and in outpatient drug-free programmes decrease their drug consumption significantly. Several studies examining changes in HIV-risk behaviours for patients currently in treatment have noted that longer retention in treatment, as well as completion of treatment, was correlated with reduction in HIV-risk behaviours or an increase in protective behaviours. However, studies have found more effectiveness in changing illicit drug use than in changing high-risk sexual behaviours.

2. Outreach activities

55. Drug abuse treatment is not chosen by all drug abusers at risk from HIV infection or may not be attractive to drug abusers early in their injecting habits. In addition, recovery from drug addiction can be a long-term process and frequently requires multiple treatment episodes. Relapses to drug abuse and high-risk behaviour can occur during or after successful treatment episodes. Various outreach activities have therefore been designed to access, motivate and support drug abusers who are not in treatment to change their behaviour. Research findings indicate that outreach activities taking place outside the conventional health and social care environments reach out-of-treatment injecting drug users, increase drug treatment referrals and may reduce illicit drug use risk behaviours, sexual risk behaviours as well as HIV incidence.

3. Syringe and needle exchange programmes

56. Several reviews of the effectiveness of syringe and needle exchange programmes have shown reductions in needle risk behaviours and HIV transmission and no evidence of increase of injecting drug use or other public health dangers. Furthermore, such programmes have served as points of contact between drug abusers and service providers, including drug abuse treatment programmes. The benefits of such programmes increase considerably, however, if they go beyond syringe and needle exchange alone to include AIDS education, counselling and referral to a variety of treatment options.

B. Principles of HIV/AIDS prevention as linked to drug abuse

57. The ability to halt the HIV/AIDS epidemic requires a three-part strategy: (a) preventing drug abuse, especially among young people; (b) facilitating entry into drug abuse treatment; and (c) establishing effective outreach to engage drug abusers in HIV prevention strategies that protect them and their partners and families from exposure to HIV and encourage substance abuse treatment and medical care. More specifically, the principles described below should be considered when developing programmes and policies in response to HIV/AIDS as associated with drug abuse.

1. Human rights

58. Protection of human rights is critical for the success of HIV/AIDS prevention. People are more vulnerable to infection when their economic, health, social or cultural rights are not respected and it is then more difficult to respond effectively to the epidemic.

2. Early start

59. HIV prevention should start as early as possible. Once HIV has been introduced into a local community of injecting drug abusers, there is a possibility that the virus will spread extremely rapidly. On the other hand, experience has shown that injecting drug abusers can change their behaviour if they are appropriately supported.

3. Assessment of the situation

60. Interventions should be based on a regular assessment of the nature and magnitude of drug abuse as well as trends in and patterns of HIV infection. Interventions need to build on knowledge and expertise acquired from research, including empirical knowledge about the social milieu around which drug-taking revolves, as well as lessons learned from previous interventions.

4. Comprehensive approach

61. Comprehensive coverage of the entire targeted populations is essential for prevention measures to be effective in changing the course of the epidemic in a country. As many at-risk individuals as possible need to be reached. In addition, a comprehensive package of interventions for HIV prevention among drug abusers could include AIDS education, training in life skills, distribution of condoms, voluntary and confidential counselling and HIV testing, access to clean needles and syringes and to bleach materials and referral to a variety of treatment options.

5. Integration into broader social and health programmes

62. Drug demand reduction and HIV prevention programmes should be integrated into broader social welfare and health promotion policies and preventive education programmes. Specific interventions for drug demand reduction and HIV prevention should be sustained by a supportive environment in which healthy lifestyles are attractive and accessible, including initiatives aimed at poverty reduction and the provision of opportunities for education and employment.

6. Alternative to imprisonment and provision of services in the criminal justice system

63. Drug abuse problems cannot simply be solved by criminal justice initiatives. A punitive approach may drive those most in need of prevention and care services underground. Where appropriate, drug abuse treatment should be offered, either as an alternative or in addition to punishment. HIV prevention and drug abuse treatment programmes within criminal justice institutions are also important elements in preventing HIV transmission.

7. Available and flexible treatment

64. Treatment services need to be readily available and flexible. Treatment applicants can be lost if treatment is not immediately available or readily accessible. Treatment systems need to offer a range of treatment alternatives to respond to the different needs of drug abusers and should also should provide for ongoing assessments of patient needs, which may change during the course of treatment. Longer retention in treatment and completion of treatment are correlated with reduction in HIV-risk behaviours or an increase in protective behaviours. Drug abuse treatment programmes should provide assessment for HIV/AIDS and other infectious diseases and counselling to help patients change behaviours that place them or others at risk of infection. Attention should be paid to drug abusers' medical needs, including on-site primary medical care services and organized referrals to medical care institutions.

8. Participation of target groups

65. Developing effective responses to the problem of HIV among drug abusers is likely to be facilitated by considering the views of drug abusers and the communities they live in and ensuring their active participation in all phases of programme development and implementation. Programmes need to be meaningful to those they are designed to reach.

9. Focus on sexual risk behaviours

66. HIV prevention programmes should also focus on high-risk sexual behaviours among people who inject drugs or use other substances. Research findings indicate the increasing significance of sexual HIV transmission among injecting drug abusers as well as among crack-cocaine abusers. Drug abusers perceive sexual risk in the context of a range of other risks and dangers, such as risks associated with overdose or needle-sharing, which may be perceived to be more immediate and important. The sexual transmission of HIV among drug abusers may thus often be overlooked.

10. Outreach

67. Outreach work and peer education outside the normal service settings, working hours and other conventional work arrangements are needed to reach those groups not effectively contacted by existing services or by traditional health education. It is necessary to have a back-up of adequate resources to respond to the increase in client and casework load likely to result from outreach work.

11. Care and support

68. Care and support, involving community participation, must be provided to drug abusers living with HIV/AIDS and to their families, including access to affordable clinical and home-based care, effective HIV prevention interventions, essential legal and social services, psychosocial support and counselling services.

C. Practical guidance on HIV/AIDS prevention as linked to drug abuse

69. In order to provide those involved in the planning and implementation of drug abuse and HIV/AIDS prevention strategies and programmes with information on useful lessons and best practices in that regard, UNDCP and UNAIDS have produced a booklet entitled *Drug Abuse and HIV/AIDS: Lessons Learned*, which provides details of a range of practices being pursued in Central and Eastern Europe and the Central Asian States, where injecting drug use is significantly driving the HIV epidemic. The booklet is available at: www.unodc.org/odccp/report_2001-08-31_1.html UNAIDS also has various examples of best practices available on its web site: those related to injecting drug use can be found at: www.unaids.org/bestpractice/digest/table.html-inj and www.unaids.org/fact_sheets/ungass/word/FSdruguse_en.doc