

1. INTRODUCTION

Some 200 million people, or 5 per cent of the world's population aged 15-64, have used drugs at least once in the last 12 months. The main problem drugs at the global level continue to be the opiates (notably heroin) followed by cocaine. In Europe and Asia, opiates accounted for 62 per cent of all treatment demand in 2003 (UNODC, 2005).

Worldwide, more than 55 million people use opiates, cocaine and amphetamine-type stimulants, and an estimated 13.2 million people inject these drugs. Most (78 per cent) injecting drug users live in developing and transitional countries (Aceijas et al, 2004, as cited in UNODC, 2005).

Globally, it is estimated that 5-10 per cent of all HIV infections are attributable to injecting drug use, mostly via the use of contaminated injection equipment (UNODC, 2005).

While most HIV transmission among injectors worldwide is related to the sharing of injection equipment, in some areas, sexual behaviour is primarily responsible for HIV transmission among injecting drug users. Interventions aimed at reducing risky injecting practices may not be as effective at reducing risky sexual behaviour (Booth et al, 1994; Welp et al, 2002; as cited in UNODC, 2005).

There is also increasing evidence of the link between HIV epidemics among IDUs and other drug users and of the spread of HIV epidemics in the general population through sexual networks (Lowndes et al, 2003, as cited in UNODC, 2005).

The learned behaviour of associating drugs with sex makes it difficult to reduce high-risk sexual behaviour (Paul et al, 1993, as cited in UNODC, 2005).

Though no reliable data exists, it is estimated by policy planners and service providers that there are approximately four million drug users in the SAARC region. Chasing (inhaling the vaporised form) of heroin is popular in the region, though transition to injecting has occurred and is rapidly diffusing. It is again estimated that SAARC countries have about 400,000 IDUs. It needs to be stressed that at present, apart from India, no survey or size estimation of either drug use or injecting drug use has been carried out in the region. Of concern is the escalation in the abuse of pharmaceutical drugs, including synthetic opiates (like injectable buprenorphine), tranquillisers (diazepam), antihistamines and drug cocktails. The sharing of injecting equipment is common in India, Nepal and Bangladesh and many IDUs in the region also practise unsafe sexual behaviours.

Box 1: Treatment and rehabilitation process

People with drug abuse problems come from all walks of life and have different needs. Treatment services thus must offer a range of approaches and should be tailored to each patient.

The treatment and rehabilitation process should begin with the early detection of drug abuse. The process includes all stages leading to eventual reintegration into society. The following steps are regarded as essential:

- ♦ **Early detection** and access to services needs to be facilitated for high-risk individuals. This is best accomplished through primary health-care settings.
- ♦ **Outreach** programmes are necessary to reach the many drug users who are not in contact with any medical or drug abuse treatment institutions. Flexible, unconventional approaches developed outside formal health and social environments and aimed at accessing, motivating and supporting drug abusers can reach out-of-treatment drug users, increase drug treatment referrals and reduce illicit drug-use behaviour.
- ♦ **Detoxification** should be seen in the context of broader social and treatment interventions. Community-based (i.e. non-residential) detoxification can be a particularly cost-effective approach, provided that there is a basic medical and social support infrastructure. Inpatient detoxification is essential for a small minority who are likely to experience severe withdrawal and associated medical complications.

Opioid dependence, a complex health condition that often requires long-term treatment and care, is associated with a high risk of HIV infection when opioids are injected using contaminated injection equipment. Drug dependence treatment is an important strategy to improve well-being and social functioning of people with opioid dependence and to reduce its health and social consequences, including HIV infection. As no single treatment is effective for all individuals with opioid dependence, sufficiently diverse treatment options should be available. The treatment and rehabilitation process should begin with the early detection of drug abuse (Box 1).

1.1 Low Cost Community-based Care and Support (LCCS):

Low Cost Community-Based Care and Support, is one of the important approaches in addressing the adverse social, economic and health consequences of psychoactive substance use including vulnerabilities to STI/HIV, targeting population groups in resource-poor settings.

LCCS, thus, attempts to reach out to those drug users (including IDUs), who:

- ♦ are opioid and alcohol users and are at risk of transmission of STI/HIV through unsafe injecting as well as unsafe sexual practices, under the influence of psychoactive drugs.
- ♦ are far away from any institution-based addiction treatment (staying in remote areas).
- ♦ cannot afford to spare time to access the treatment (vulnerable women, daily wage earning drug users, etc.).

- ✦ cannot afford the cost of addiction treatment.
- ✦ due to several relapses, do not have confidence on institution-based addiction treatment.
- ✦ have undergone successful addiction treatment but continue to undergo repeated relapse episodes due to negative community influences.
- ✦ are HIV positive, are clinically indicated to start anti-retroviral therapy and have been advised to start anti retroviral therapy (ART).

LCCS is also recommended in a situation where there is no in-patient addiction treatment facility or where, if a facility exists, it is inadequate to cater to the demand of addiction treatment in a particular geographical area.

1.2 Advantages of community involvement

- ✦ The community's feeling of oneness is constructively utilised.
- ✦ Responsibility is shared, leading to 'doing with' rather than 'doing for'.
- ✦ The community, when sensitised to the problem, prevents further spread of HIV, by way of decriminalising drug use and addressing dual stigma associated with drug use and HIV/AIDS.
- ✦ The community is empowered to support clients in recovery.

1.3 What is Community-based Treatment Intervention?

A community-based response involving local agencies and organisations, including outreach

Box 1 Cont'd...

- ✦ **Psychosocial interventions** are a vital part of drug abuse treatment. Drug abuse affects other psychosocial, economic and behavioural dimensions. It is useful to have a multi-disciplinary team composed of medical, social and counselling providers.
- ✦ **Counselling** is a very important component of treatment. It is also the first step towards rehabilitation and eventual social reintegration. Involvement of the family and mobilisation of the community contribute significantly to long-term treatment and rehabilitation efforts.
- ✦ **Prescription of Substitutes** can be an important aspect of treatment for many patients. The prescription of methadone, buprenorphine or LAAM to people dependent on opiates can help them stabilise their lives and reduce illicit drug use.
- ✦ **Social reintegration** requires work with individuals, their families and communities. Marketable skills training and facilitating the re-entry of former abusers into the workforce are necessary components of rehabilitation programmes.
- ✦ **Integration of treatment and rehabilitation services** within existing health services or systems should take place wherever possible, without creating a separate drug treatment system.

('Access to treatment & rehabilitation', from www.unodc.org/unodc/en/treatment_toolkit.html (accessed on November 10, 2004))

Box 2: Community-based treatment in an Afghan refugee camp in Pakistan

A community-based drug treatment, rehabilitation and prevention programme was initiated by the United Nations International Drug Control Programme (UNDCP), in the Akora Kattak refugee camp outside Peshawar with an estimated adult population of 9,000 Afghan refugees. The programme provided home-based detoxification and coordinated aftercare and social reintegration activities through a network of local non-governmental organisations, other UN agencies, volunteers and community groups. During the year 2000, the programme made contact with 800 (male and female) drug users in the refugee camp. Over 300 drug users were provided with pre treatment motivational counselling, and 128 males and 102 females were provided with home detoxification. In addition, 150 recovering addicts were provided with work experience, job training or start-up funding for income-generating activities. Six self-help groups, three for male addicts and three for female addicts, were also established in the camp, as well as both male and female community volunteer groups.

The experiences from the programme suggest that a well-resourced community-based treatment programme with fully trained and supported staff can provide a viable and cost-effective home detoxification and treatment scheme for both male and female drug abusers in Afghan communities. Such a scheme, however, requires the full back-up and support of a wide range of community-based aftercare and social reintegration services and facilities, including

services, is a necessary component of a strategy that seeks to reach drug users who are not in contact with services. A community-based response aims at:

- ◆ encouraging behaviour changes directly in the community;
- ◆ actively involving local organisations, community members and target populations;
- ◆ establishing an integrated network of community-based services.

It is also important to mention the term 'community empowerment', which implies something more than just community participation.

Being 'community-based' in the context of drug treatment is often perceived as involving little more than placing a residential treatment centre in a community with a few limited aftercare facilities provided in the community. Many services are still based on an approach focused on an in-patient treatment centre.

The community-based approach that tries to establish an integrated model of drug abuse treatment by actively engaging the community, in planning and implementation of addiction treatment and ensure a community-based rehabilitation.

Thus, while both types of approaches are necessary, and ideally should be complementary, it is important to keep in mind what 'community-based' actually means. An example of a response that specifically targeted a community in need is given in Box 2.

As seen in Box 2, the key to the success of the programme was a radical change in the way staff understood drug abuse treatment services. The new concept relied heavily on the effective coordination of a wide range of non-specialist services, i.e., the professional delivery of addiction treatment by the treatment unit and the use of community resources.

Box 2 Cont'd...

community networking, to be successful and effective and to prevent relapse.

Drug Abuse Treatment & Rehabilitation, A Practical Planning and Implementation Guide, UNODC, 2003, Box 12, Chapter II, Page 14;

http://www.unodc.org/pdf/report_2003-07-17_1.pdf

1.4 Community approaches to addiction treatment – some examples:

In the area of addiction treatment, the community approach has been tried and successfully implemented.

Dr. Sell (1994)¹ analysed community approach programmes that dealt with drug addiction in Northern Myanmar, India and Sri Lanka. According to him, a community approach involves the following steps.

- ♦ identifying all drug dependent persons living in one specific locality through multiple entry points.
- ♦ initiating a process of rehabilitation before detoxification. The basic issue in this step is to spread optimism, de-dramatise withdrawal and de-mystify drugs. It is a process of empowerment, not indoctrination.
- ♦ bringing together the parents and/or relatives/friends of the users to form a support group for self-help and mutual aid. Community leaders may have to be involved in this process.
- ♦ mobilising ex-users or other volunteers for assistance in the planning of a detoxification camp and for later work with the users for their transformation into an ex-users' activist group.
- ♦ organising needed physical facilities inside of the locality which can accommodate the users, parents, and volunteers during the camp.
- ♦ involving all or almost all users of a locality. If pushers are active in the locality, ways will have to be found to expel those pushers.
- ♦ maintaining contact with the community by having some of the medical staff stay in the locality to maintain the momentum. Assisting some of the ex-users to find employment or housing or helping them in any meaningful manner.

¹ 'The community approach to drug abuse control'. Paper presented at the European Consultation on the Open Community Approach to Treatment/Care & Prevention of Drug Abuse. London 1-5 June, as cited in Development of a Manual for the Detoxification and Treatment of Aboriginal Solvent Abusers, A Literature Review by Melanie Lehmann, Aboriginal Drug and Alcohol Council (SA) Inc., 1998.

The community approach, therefore, covers treatment, rehabilitation and prevention. It ideally lends itself to a 'drug free zone' in the best of its meanings.

Kaplan, Morival and Bieleman (1993) after observing three camp models viz., opium de-addiction camps at Rajasthan, free treatment for alcoholics conducted by TTK Hospital in Tamil Nadu and the ad hoc camps conducted by the National Dangerous Drug Control Board of Sri Lanka, listed a few salient features of these camps.

- ◆ All use a comprehensive community approach involving prevention, treatment, rehabilitation and health promotion as well as activities that are integrated with social movements.
- ◆ All provide a highly structured and intensive therapy for a relatively short period. All restrict themselves to substance dependencies defining their client population fairly specifically.
- ◆ All initiate treatment with detoxification and expand the services with intensive rehabilitation and counselling.
- ◆ All employ multi-disciplinary teams involving physicians, psychologists, social workers and ex-addicts as well as multiple methods using medications or herbal remedies for symptomatic treatment instead of substitution drugs like methadone.