

**„Delivery systems for Substance Abuse Treatment“
USIP-UCLA-ISAM Meeting
Istanbul, september 4-8, 2005**

**Roots and present state of substance
abuse systems of care**

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Overview

- **Roots**
 - Religious background
 - Role of psychotropic substances
 - Locus of social control and responsibility
- **Present state and trends**
 - Main models of treatment systems
 - Attempts at integration
 - Public expectations

„Roots“ :

**Factors shaping
the societal response to
substance use problems
(extra-treatment factors)**

Religious background

- **Indigenous beliefs and cults**
 - Religious functions of substance use and ritualistic limitation of pleasure seeking
- **The great „World Religions“**
 - Rigoristic : aiming at ‚eradication of sin‘ (suppressing sinful pleasure, enforcing abstinence)
 - Pragmatic : aiming at ‚sin management‘ (optimising the integration of spiritual values and pleasure, minimising individual and social harm)
- **Secular civilisations**
 - Social role of religion mainly restricted to charity and caring for spiritual needs

Models of religious substance use and limitation of pleasure seeking

- **Hallucinogenic substances**
 - **Peyotism, Iboga, Cannabis, Opium, Amanita muscaria, Datura stramonium, Belladonna, Bufotenin**
(India, Africa, Europe, America, Asia)
- **Alcohol**
 - **Wine, palm wine (ancient Greece, Iran, Bali)**
- **Tobacco**
 - **Smoking rituals (American Indians, Africa, New Guinea)**
- **Substance is a gift from god / the gods**
- **Restricted to social use / regulated use / initiation rites**
- **Misuse (non-ritual use) is sanctioned**

Models of a rigoristic (fundamentalistic) approach

- **Full prohibition of any intoxicating substance use**
 - **Rigorous protestant value of sobriety (USA alcohol prohibition)**
 - **Rigorous islamic prohibition of alcohol and drugs**
 - **(UN conventions on illegal drugs)**
- **Consequences for treatment system**
 - **Abstinence-only approach**
 - **Enforced abstinence acceptable**
 - **No substitution treatment or harm reduction approaches**

Models of a pragmatic approach

- **Main focus : not the substance use per se, but adverse effects of use (protecting social wellbeing and health)**
 - **Rationing systems (Bratt system for alcohol availability in Sweden, Opium rationing in Laos)**
 - **Restrictive legislation (no driving under the influence, youth protection, public order...)**
 - **Other harm reduction measures (prevention of blood-borne infections)**
- **Consequences for the treatment system**
 - **Integration of substitution treatment /harm reduction**

Substances

- **Cultural image**
 - Homegrown, traditionally „encultured“ with high tolerance
 - Foreign / exotic : with low tolerance (especially if enforced by colonialism or if introduced by politically suspected minorities)
- **Advantages vs disadvantages**
 - Medically useful / harmful
 - Social cohesive / disruptive
- **Economical balance**
 - Gains / losses

Examples of medical use of psychotropic substances

- **Opium, opiates** : the most widely used universal medication in most regions (up to 20th century)
- **Cannabis** : used as a universal panacea in China, India, Caribbean, Europe (up to 20th century)
- **Hallucinogens** : used by native healers („psychedelic diagnostics“, healing rituals), 20th century in psychotherapy (USA, Europe)
- **Tobacco** : used as a universal medication in South Africa, North America, Asia, Europe
- **Cocaine** : energizer (Latin America), pain control
- **Other substances used as medications** : Khat, Kava, Alcohol, Datura stramonium

Examples of social cohesive substance use

- **Native American Church NAC : Peyote-ritual as a spiritual experience providing help in many problems of life, e.g. alcohol problems**
- **Rastafarians : ganja (Cannabis) smoking as a spiritual rite providing feelings of identity and cohesiveness**
- **Tobacco smoking / coffee drinking circles**
- **Traditional students associations : beer rituals**
- **Numerous forms of social drinking habits**
- **Youth subcultures in the 20th century**

Dysfunctional / disruptive use of ,culturally accepted‘ substances

- **Chronic use is considered to be dysfunctional**
- **Use outside socially accepted norms and rituals is considered to be dysfunctional**
- **Dysfunctional use is stigmatised / sanctioned even if use is culturally accepted /recommended**
- **Treatment focus increasingly on dysfunctional use**

Examples of economic gains / losses from substance use

- **Losses :**
 - Health costs from substance-related disease
 - Costs from lost productivity (Gin, Khat)
- **Gains :**
 - Gains from production and marketing
 - Using drugs as energizers (Cannabis, Coca, Iboga, Pituri, Tobacco, Caffeine...)
 - Medical use of drugs
- **Balance :**
 - *Who makes the gains, who pays the losses ?*

Locus of social control and responsibility

- **Definitions :**
 - Social control of *deviant behavior*
 - Social responsibility to *care for the deviant*
- **Models of social control and responsibility**
 - Religious authority
 - State authority
 - Community
 - Family / clan
 - Individual
 - Civil society (NGO)

Examples of social control and responsibility by centralistic religious authority

- **Traditional theocratic regimes**
 - Rule by religious leaders representing divine power
 - Rule by political leaders, monarchs etc. in the name of religion / with religious legitimacy
- **Present theocratic regimes**
 - Islamic Republics
 - Strong ecclesiastic influence on political decisions
- **Responsibility for the underprivileged and deviant**
 - Charity for the poor and the sick
 - Punishment and repention of the sinner

Examples of social control and responsibility by centralistic state authority

- **The model of Absolutism**
 - **European monarchs caring for hospital building and charity**
- **Socialistic / social democrat model**
 - **Communist regimes**
 - **Democratic socialist regimes**

Examples of social control and responsibility by the individual

- **Traditionally individualistic cultures**
 - **Some European countries : UK, France**
 - **Mainly protestant ethics of self-responsibility**
- **Neo-liberal position : freedom for individual life-styles, but the individual has to care for himself/herself**
- **Consequences for treatment system**
 - **Low societal solidarity, access and costs of treatment not guaranteed**
 - **Solidarity from family / NGO's**

Professional care models of delegated responsibility

- **Social / legal care model**
 - Deviant behavior is a psychosocial / educational / correctional problem
 - Offering individual support / family support / enforced re-education
- **Medical care model**
 - Deviant behavior is mainly a psychological / psychiatric problem
 - Offering psychotherapy / psychopharmacology / psychiatric rehabilitation / relapse prevention

**„Present state and trends“ :
Main models by end of 20th
century and ongoing
transitions**

Main models according to WHO

Approaches to Treatment of Substance Abuse, 1993

- **12 descriptors of treatment**
 - **Modality, goals, philosophy, phasing, time frame**
 - **Setting, provider, target**
 - **Availability, utilization, efficacy, cost**
- **No taxonomy /mapping of treatments can yet be given**
- **„Social ecology of treatment“**
 - **Political and economic context**
 - **Types of service integration**
 - **Methods to reach out to target population**

Political & economic context (1)

- **Community attitudes to substance use/abuse**
 - Low tolerance for public nuisance
 - Low tolerance for drunk / „drugged“ driving
- **Populations of concern to the community**
 - Discriminated minorities vs. integrated citizens
 - Role of blood borne infections
- **Financial and legal background**
 - Central planning vs. market mechanisms
 - Public vs. private funding of treatment, role of insurances
 - Legal status of substance use (Nigeria : treatment for alcohol problems only in the non-islamic south, severe penalties in the islamic north; Iran : change from punitive to care system and legislation)

Political & economic context (2)

- **Role of NGO's / voluntary organisations**
 - **Priority role in USA (AA, NA, TC movement), Latin America, European countries**
 - **Marginal role in CEEC and Asian countries**
- **Role of alcohol and drug production and industries**
 - **Revenues from production / export vs. Public health and Criminal Justice costs**
 - **Private gains vs. Public losses**
 - **Role of lobbying and corruption**

Types of service integration

- **Integration into health care system**
 - Canada, Brazil, Mexico, UK
- **Integration into mental health services**
 - Austria, Poland
- **Integration into social welfare**
 - Sweden
- **Integration into criminal justice system**
 - China, Singapore, Iran
- **Non-integration : separate systems**
 - USA, Norway

Methods to reach out to target populations

- **Main problems**
 - **Centralised vs. country-wide services**
 - **Structural elements : financial / bureaucratic barriers**
 - **Negative attitudes : fear of discrimination, desinformation**
- **Main strategies**
 - **Stepped-care model**
 - **Low-threshold model**
 - **Out-reach work**
 - **Compulsory treatment**

Treatment responses according to key informant surveys

(WHO 1993, 23 countries)

- *Countries*

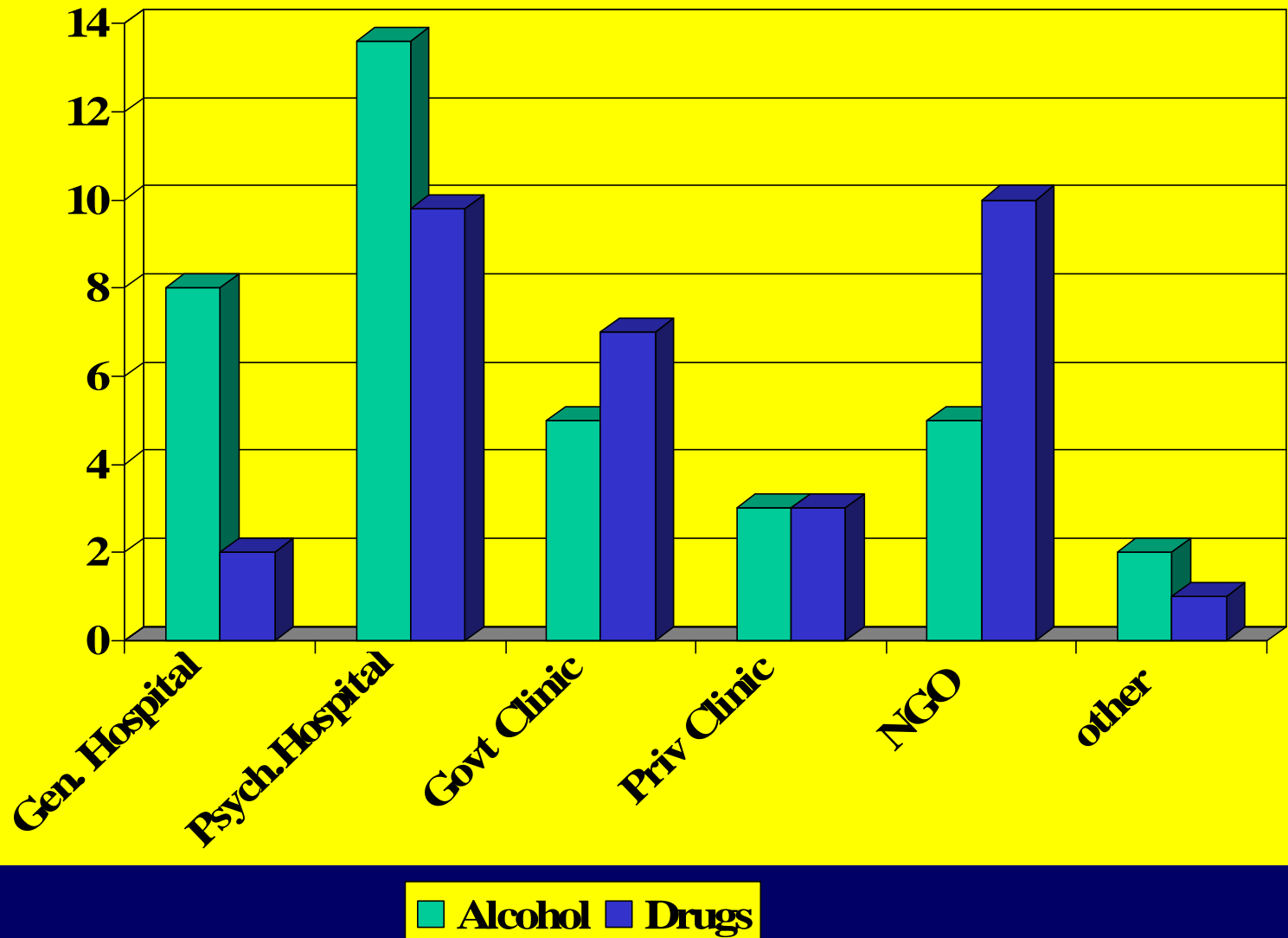
- *From all WHO regions, having high or low level of substance use problems, with or without national treatment services*
- *Bahamas, Canada, Chile, Colombia, Congo, Egypt, Finland, Ghana, Hungary, India, Italy, Mexico, Nigeria, Norway, Pakistan, Poland, Russia, South Africa, Spain, Sri Lanka, Switzerland, Thailand, Zimbabwe*

Treatment responses according to key informant surveys

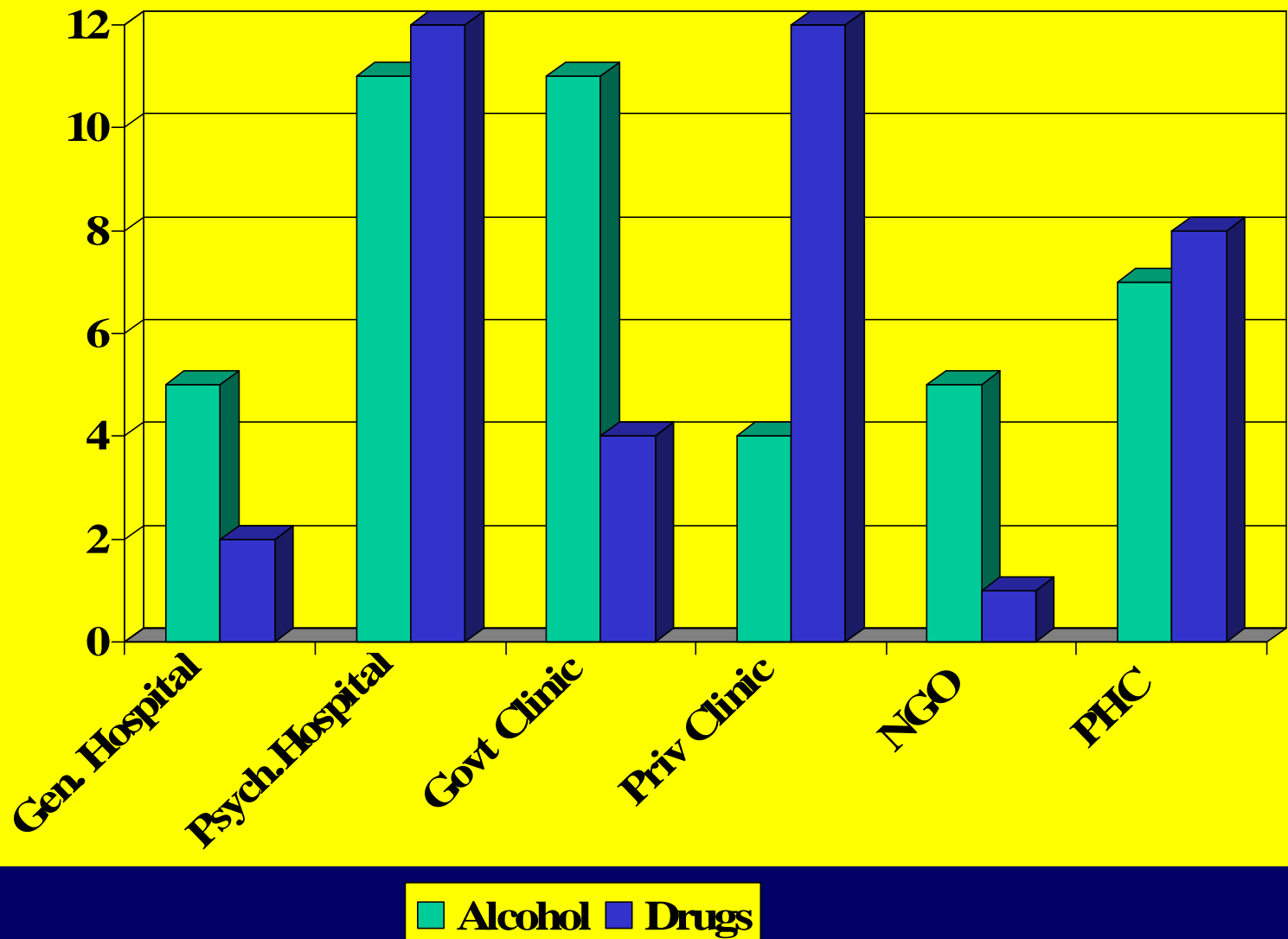
(WHO 1993, 23 countries)

- Location and capacity of services**
- Intensity and duration of treatment**
- Costs and effectiveness**
- Links between drug and alcohol services**
- Links with health care services**
- Treatment networks**

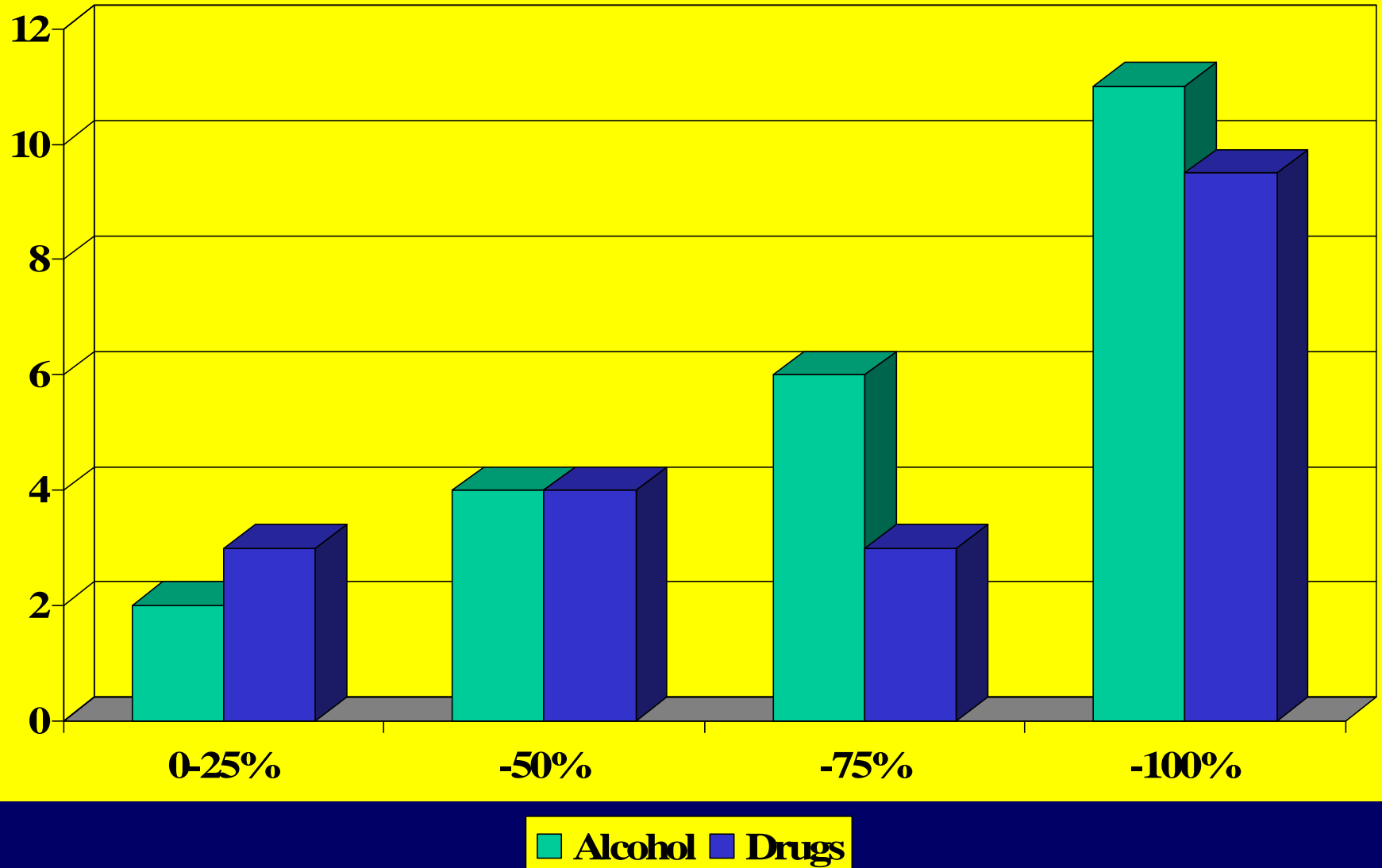
Location of residential services (WHO 1993, 23 countries)



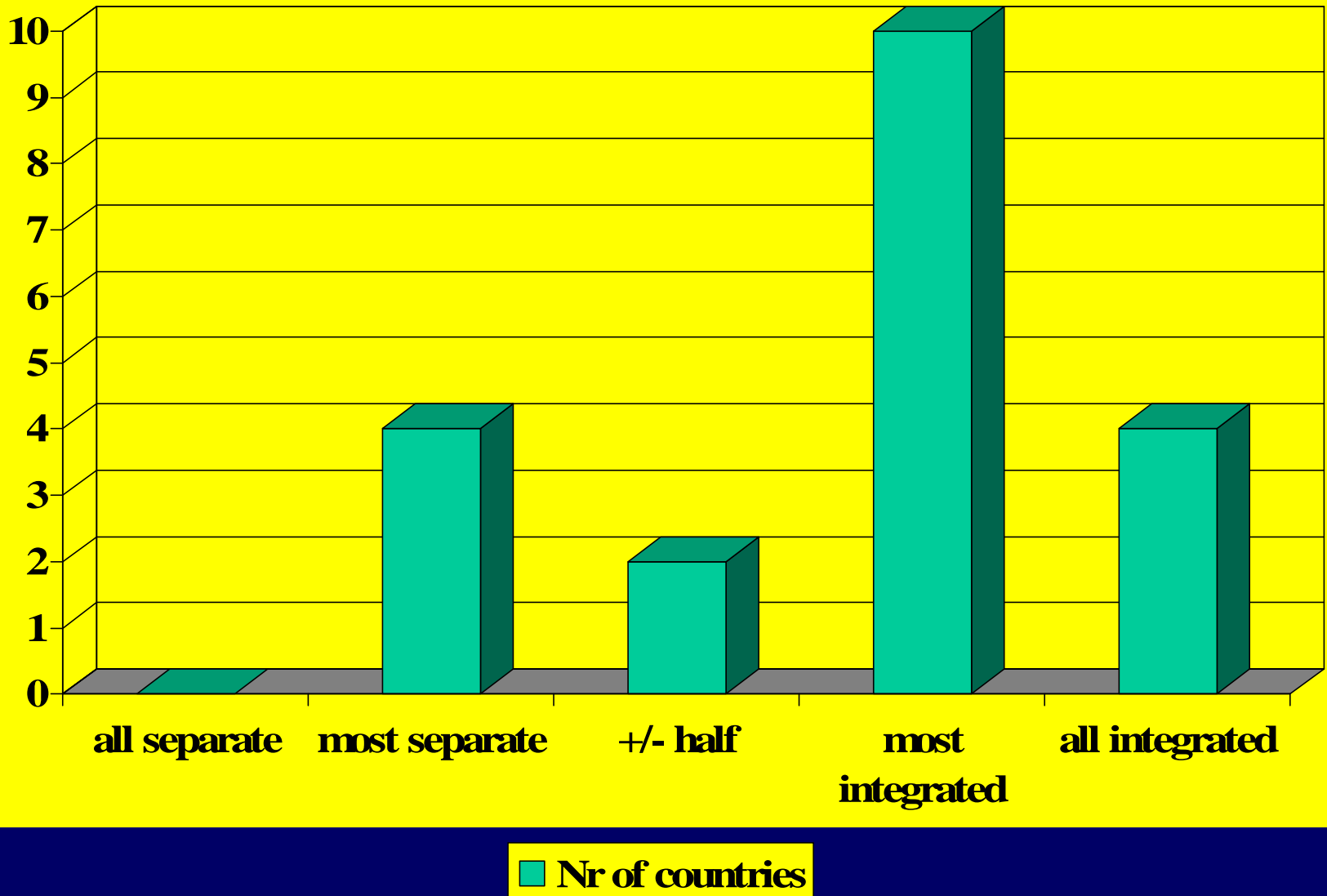
Location of non-residential services (WHO 1993, 23 countries)



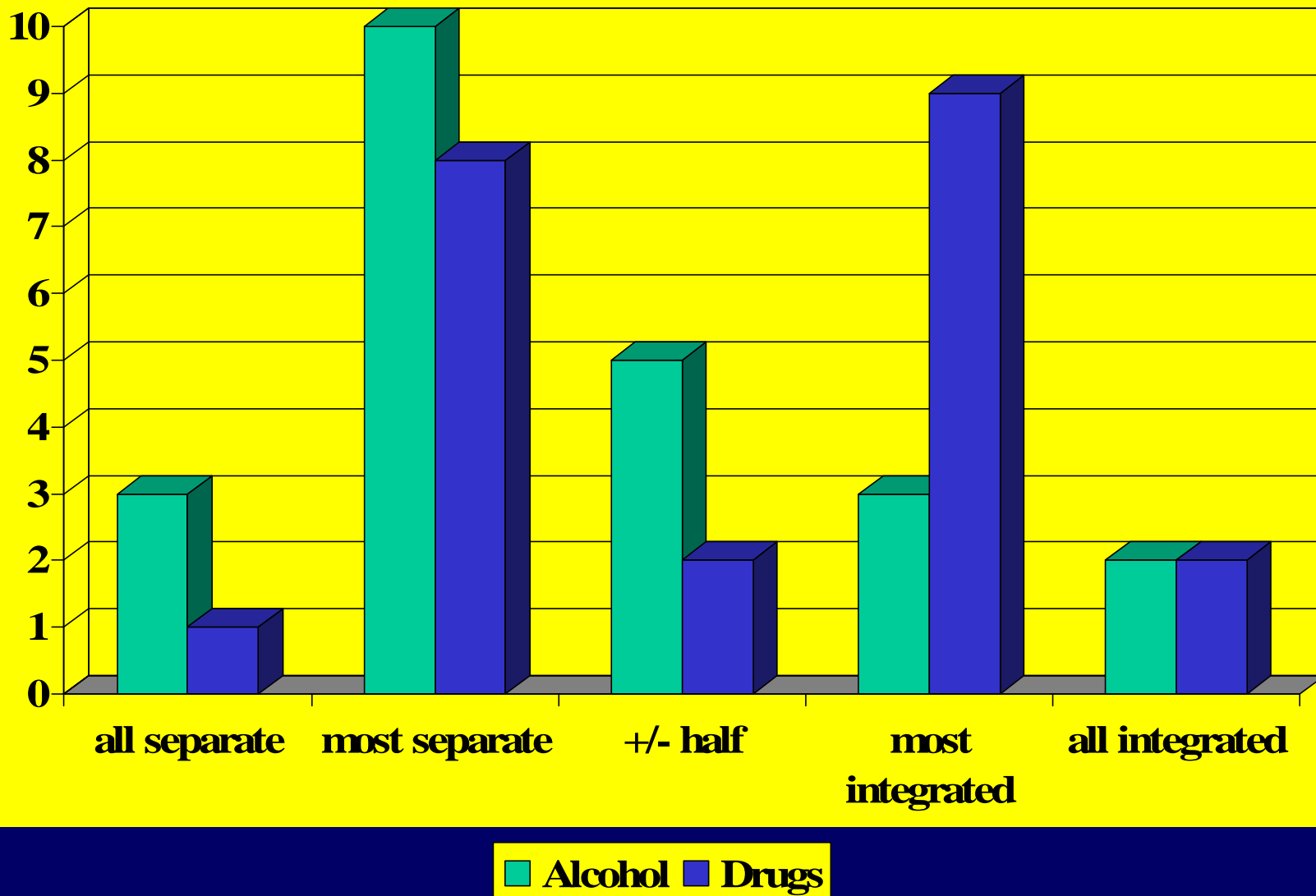
Proportion of non-residential services (WHO 1993, 23 countries)



Integration of drug and alcohol services (WHO 1993, 23 countries)



Integration with health care services (WHO 1993, 23 countries)



Alcoholism treatment systems in 16 countries

(„Cure, care or control“, Klingemann et al 1992)

- *Countries*

- *Sovjet Union, Hungary, Poland, Yugoslavia, Sweden, Finland, UK, New Zealand, Austria, Italy, France, USA, Canada, China, Nigeria, Switzerland*

- **Common directions**

- **From badness to illness to alcohol related problems**
- **Diversification and size of treatment systems**
- **From lower to all strata of society**
- **Integration into Public Health systems / insurance**
- **Preventive medicine and early interventions**

Drug treatment systems in 20 countries

(Klingemann & Hunt 1998)

- *Countries*
 - *Austria, Canada, China, Colombia, UK, Finland, France, Germany, Hungary, Italy, Japan, The Netherlands, Peru, Poland, Portugal, Spain, Sweden, Switzerland, Russia, USA*
- **Diversity of treatment systems and orientation**
 - **Abstinence-oriented (USA, Canada, Scandinavia)**
 - **Experimental (UK, Netherlands, Switzerland)**
 - **From crusade to pragmatism (Austria, Germany)**
 - **The mediterranean (Spain, Italy, Portugal, France)**
 - **Latin America (Colombia, Peru)**
 - **Transitions in CEEC and Russia**
 - **Strict control in East Asia (China, Japan)**

Integrated models of stepped care in substance abuse treatment

- **Principle**

- Low level / low threshold contacts first
- Proceed to higher / professionalised / specialised levels only if needed

- **Models**

- ASAM placement model
- From first-line to intensive care (Sobell & Sobell 1999)
- Dutch model : work in progress
- Evaluation results (Humphreys 2004)

Integrating self-help approaches

- **Self-help of persons with substance use problems**
 - Relying on AA, NA etc as first line of help
 - Relying in AA, NA etc for long-term aftercare and relapse prevention
- **Self-help of family members**
 - Relying on AlAnon etc for supporting family members in fostering motivation and compliance of clients/patients
 - Relying on AlAnon etc. for supporting family members to cope with their own problems

Integrating traditional healers

- **Practices**
 - Symbolic rituals, purification, confession, reconciliation
 - Ambiguous relationship with professional treatment systems
- **Examples**
 - Buddhist treatment centers: Thailand, Laos
 - Buddhist traditions Japan: Danshukai, Naikan
 - Chinese- taoist healing: Malaysia, Chinese populations
 - Hinduist ajurvedic healing: India, Nepal, Malaysia
 - Arab Islamic traditions: Egypt, Saudi Arabia
 - North American Indians traditions
 - Folk healing in Latin America
 - Alaska Inuit spirit movement

Integrating legal interventions

- **Treatment alternatives to imprisonment**
 - Drug courts (USA, Canada), Drug treatment and testing orders DTTO (UK)
 - Quasi-compulsory treatment as an option (most European countries)
- **Treatment alternatives during imprisonment**
 - Special units, special regimes
- **Linking correctional institutions to community-based services**
 - External services invited for programming and contact (Antennes toxicomanie in France)

Integrating medical and social services

- **Expanding early interventions (brief interventions) for harmful substance use**
 - in primary health care (hospitals, GP's)
 - in social services (community, workplace)
- **Establishing local/regional networks for systematic collaboration**
- **Providing joint training options**
- **Documenting and evaluating practical examples (Miller & Weisner 2002)**

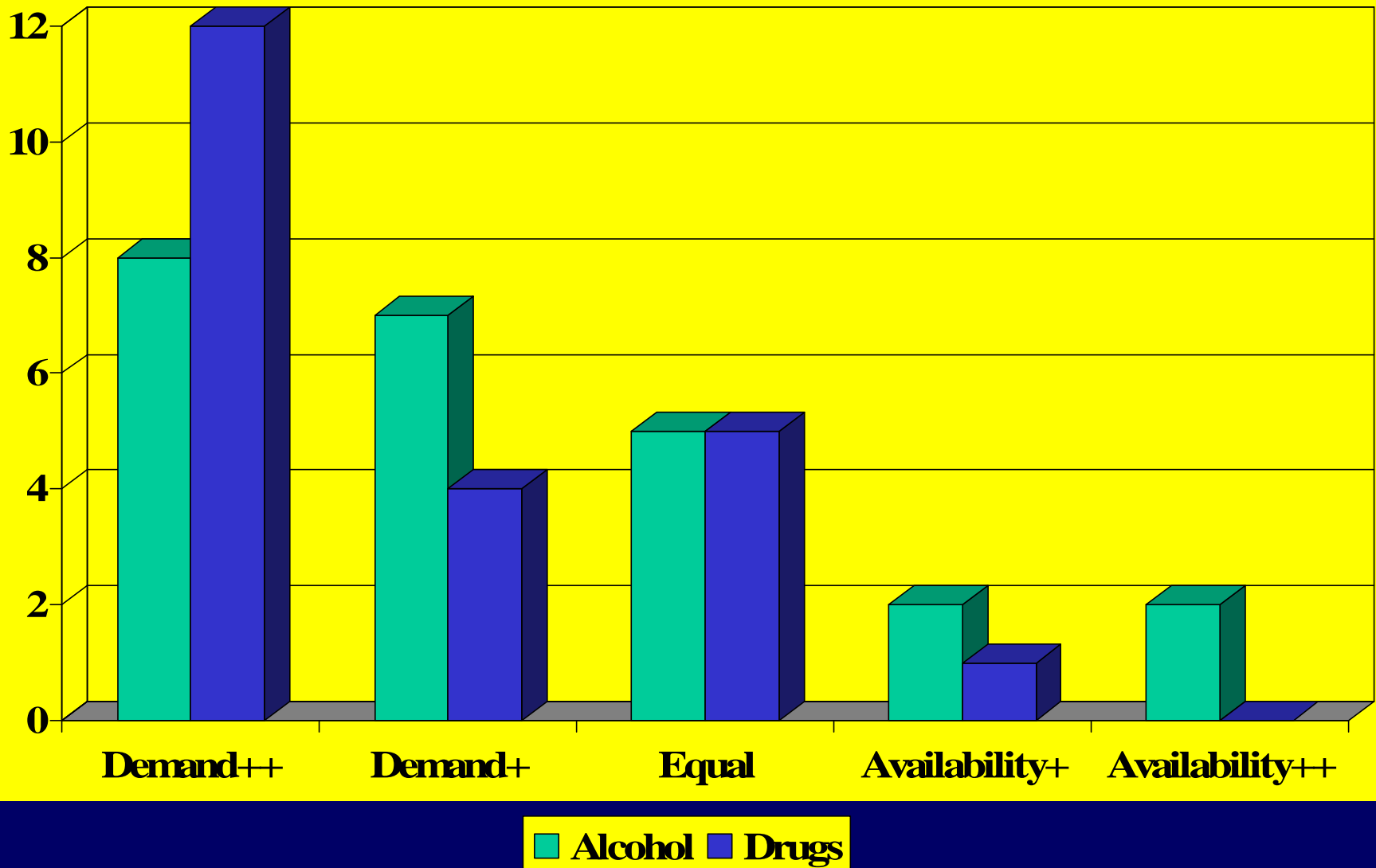
A process of transition

- Pragmatic approaches adopted increasingly in Australia, Western Europe, Canada**
- Pragmatic approaches developing in CEEC and in some NIS and Asian countries**
- Mainly rigorous approaches upheld in USA and Russia**
- Growing importance of community action and NGO's**
- Process complicated by financial constraints**

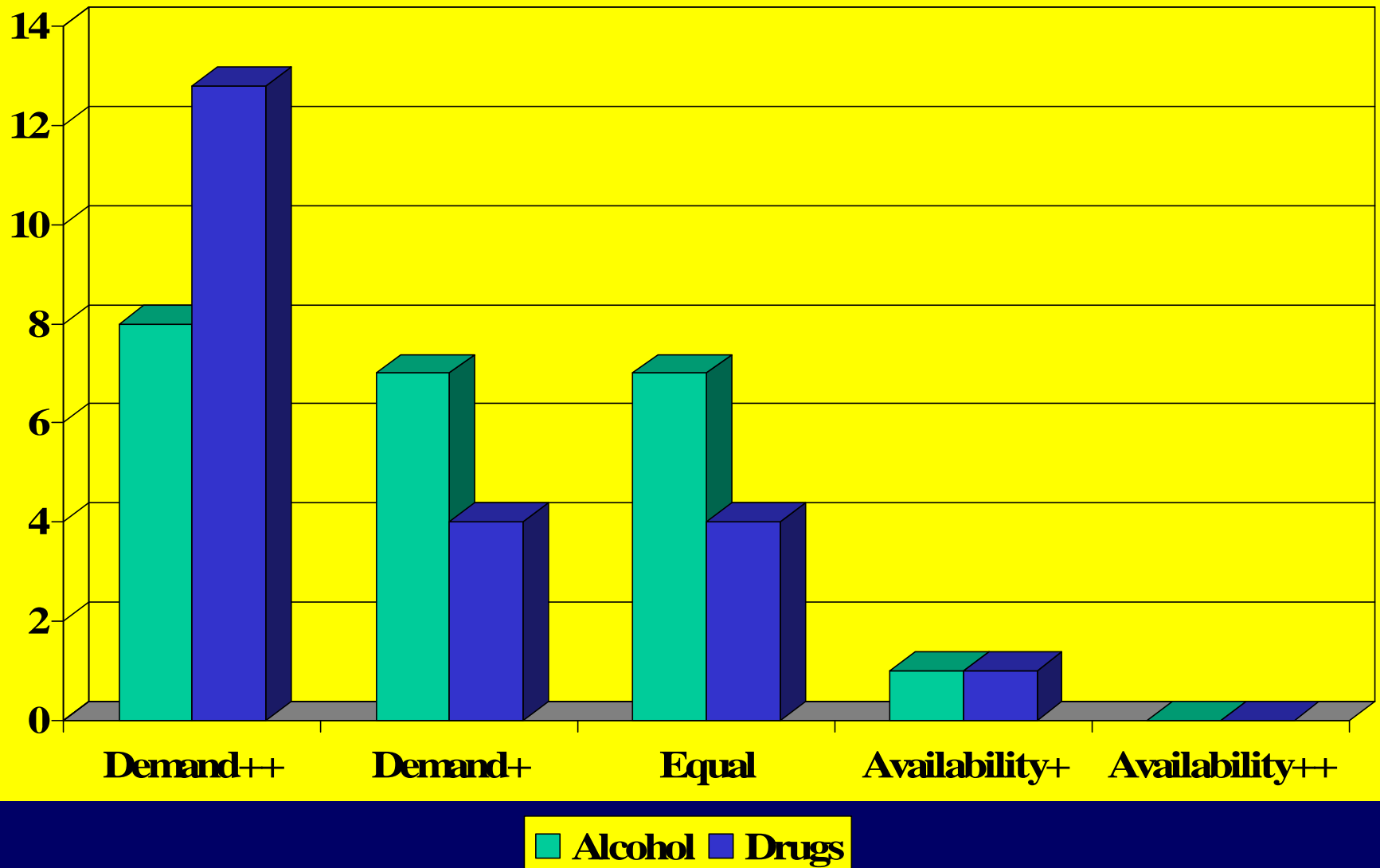
Responding to needs and public expectations

- **Coverage** : how are treatment systems covering the need for treatment ?
- **Quality** : how do services respond to standards and quality criteria ?

Demand / availability of residential services (WHO 1993, 23 countries)



Supply / availability of out-patient services (WHO 1993, 23 countries)



Treatment quality and standards

- **„State of the art“ criteria**
 - **Respecting evidence-based guidelines (e.g. NIDA 1999, UNODC 2002)**
 - **Principles of cost-effectiveness**
 - **Principles for good practice outside research evidence respecting local tradition and experience**
- **A look into reality**
 - **Substance abuse services in the USA**
 - **Substance abuse services in the EU**
 - **Substance abuse treatment in low resource countries**

What do we know about service quality (USA) ?

- **Findings from interviews with key staff in 175 US treatment agencies :**
 - **extremely high staff turnover (up to 53% per year)**
 - **15% of identified agencies were closed down or ceased to provide addiction services**
 - **29% reorganised under different management**
 - **much time wasted for administrative work, many working without computers, outdated infrastructure**
- (McLellan AT, Carise D, Kleber HD 2003)*

What do we know about service quality (EU) ?

- **Evaluation of the EU drug policy strategic target nr 3 („increase substantially the number of successfully treated addicts“) (2003):**
 - **increasing prevalence of problem drug use, but limited treatment for non-opiate drug problems**
 - **comparative evaluation rare and recent**
 - **guidelines for treatment services in a few countries only and restricted to substitution treatment**
 - **collaboration of services, continuity of care and case management not well established in most countries**

Strategies for intervention improvements

- National systems for knowledge transfer from research to practice**
- Valorisation and dissemination as integral part of research**
- Incentives for services regularly updating their knowledge (certification)**
- Incentives for effective and cost-effective work**
- Career-building opportunities**
- Reduction of administrative burden**

Which model to develop ?

What are relevant issues ?

- **Coverage**
 - Can persons in need of care be treated in sufficient numbers and sufficient quality ?
- **Conditions for adequate coverage**
 - Is the model efficient and cost-efficient ?
 - Is the model acceptable to the population and services at all levels ?
 - Is the model acceptable to those in need of care ?
- **The essential dilemma : more or better services ?**

A few strategic conclusions

- **There is no universally applicable model**
- **Applicability and cultural / professional acceptability of models are relevant for coverage and outcome**
- **Balancing optimal coverage and optimal quality is preferable over any perfectionism**
- **Integrated models make best use of available resources**
- **Improving integration needs bottom-up *and* top-down initiatives**