

DRUG ABUSE TREATMENT AND REHABILITATION IN THE CRIMINAL JUSTICE SYSTEM

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I. INTERNATIONAL REGULATORY FRAMEWORK

The 1961, 1971 and 1988 Conventions request Member States to provide, as an alternative or in addition to conviction or punishment, treatment, education, aftercare, rehabilitation, social reintegration to drug-abusing offenders, whether in prison or in the community.

The Demand Reduction Declaration, in addition to this, indicates that demand reduction/treatment programmes should:

- cover all areas of demand reduction
- embrace early intervention, counselling, treatment, rehabilitation, relapse prevention, aftercare and social reintegration as part of a continuum of care
- be effective, relevant, and accessible to those groups most at risk, taking into account gender, cultural and educational differences, early help and access to services should be offered to those in need
- integrate into broader policies and programmes and involve the community
- build on experience
- enhance close cooperation between criminal justice, health and social systems in the development of the appropriate capacities for assisting drug-abusing offenders

In addition, the United Nations Guidelines for the Prevention of Juvenile Delinquency adopted by the General Assembly at its 45th session state that comprehensive prevention plans against juvenile delinquency should be instituted, and high priority should be given to drug and alcohol prevention and treatment (resolution 45/112, annex, paragraphs 9 and 45), and the United Nations Rule for the Protection of Juveniles Deprived of their Liberty, adopted at the same session indicates that imprisonment should be the last resort for juveniles, and medical service should seek to detect and treat any substance abuse that may hinder reintegration in society (resolution 45/113, annex, paragraphs 1, 49 and 51).

II. EFFECTIVENESS OF TREATMENT AND REHABILITATION

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.

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.

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.

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A. Principles of Treatment and Rehabilitation

“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.

In accordance to scientific evidence the following key principles for the development of drug abuse treatment and rehabilitation systems have been developed:

- 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.

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.

B. Is Treatment Effective?

1. Interventions

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).

2. Detoxification-Stabilization Phase of Treatment

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.

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.

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.

3. Rehabilitation-relapse Prevention Phase of Treatment

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.

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

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 a 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

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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.

4. Reintegration Phase of Treatment

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 de-stigmatize drug abuse.

III. DRUG TREATMENT COURTS ("DRUG COURTS")

When drug abuse prevention fails, the public pays a high price – particularly if abusers commit serious offences under the influence of drugs (e.g., domestic violence) or to help pay for their habit (e.g., burglary, theft).

The UN 1988 Drugs Convention, UNGASS Guiding Principles on Demand Reduction and related Action Plan specifically target drug-abusing offenders and call on governments to take effective multidisciplinary remedial initiatives. Drug Courts can be a very effective initiative in an overall package of responses. Drug Courts began in the United States in 1989 as one way of stopping ongoing crime by addressing underlying drug abuse. Judges, prosecutors and treatment providers initiated the courts.

Successful Drug Courts rest on three pillars requiring a close partnership between the justice and treatment systems:

- appropriate treatment;
- court-based monitoring of programme progress through ongoing case management, regular court appearances, incentives to reward progress and sanctions to correct non-compliance;
- mandatory drug testing to reinforce monitoring and strengthen participant accountability.

A. UNDCP's Expert Working Group on Drug Treatment Courts – Success Factors and Best Practice

When UNDCP's Legal Advisory Programme began its Drug Court work in 1996, there were no Drug Courts outside the United States. Since then, UNDCP has built a practitioner network, which enabled initiatives like the December 1999 Expert Working Group. The report of that working group has since been used as a guide to establish Drug Courts outside the United States.

UNDCP's Expert Working Group reviewed collective Drug Court experience and impact, identified core factors underlying effectiveness and success, described what needed to change to achieve success and developed practical guidelines on how best to establish and implement these courts.

The group identified the following 12 success factors:

1. Effective judicial leadership of the multidisciplinary Drug Court programme team.
2. Strong interdisciplinary collaboration of judge and team members while each also maintains their respective professional independence.
3. Good knowledge and understanding of addiction and recovery by members of the court team who are not health care professionals.
4. Operational manual to ensure consistency of approach and ongoing programme efficiency.
5. Clear eligibility criteria and objective eligibility screening of potential participant offenders.
6. Detailed assessment of each potential participant offender.
7. Fully informed and documented consent of each participant offender (after receiving legal advice) prior to programme participation.
8. Speedy referral of participating offenders to treatment and rehabilitation.
9. Swift, certain and consistent sanctions for programme non-compliance but with rewards for programme compliance.
10. Ongoing programme evaluation and willingness to tailor programme structure to meet identified shortcomings.
11. Sufficient, sustained and dedicated programme funding.
12. Changes in underlying substantive and procedural law if necessary or appropriate.

The Expert Working Group then formulated 12 key principles for court-directed treatment and rehabilitation programmes in Drug Courts:

1. Integrated justice/health care system processing of common casework.
2. Non-adversarial approach to case problem-solving by the judge, prosecutor and defence.
3. Prompt and objective identification and programme placement of eligible offenders.
4. Access by participants to a broad continuum of treatment and rehabilitation services.
5. Objective monitoring of participants? Compliance through substance abuse testing.
6. Coordinated strategic response to programme compliance and non-compliance by all disciplines involved (police, prosecution, probation, treatment, social workers and court).
7. Ongoing direct judicial interaction with participants.
8. Programme performance monitoring and evaluation (of both process and impact).
9. Ongoing inter-disciplinary education of the entire Drug Court team.
10. Partnerships for programme effectiveness and local community support.
11. Ongoing case management including social re-integration support.
12. Adjustable programme content for groups with special needs (e.g., mental disorders).

B. Growing International Impact of Drug Treatment Courts

Drug Courts now exist or are planned in a growing number of jurisdictions [(e.g., Australia and Canada (1999); Ireland (2000); Bermuda, Brazil, Cayman Islands, Jamaica, and Scotland (2001); New Zealand, Mauritius, England, Wales, Northern Ireland (2002)].

UNDCP's Legal Advisory Programme has provided technical assistance to help plan, establish and operate courts in Jamaica, Mauritius and in other major demand jurisdictions, like Canada and Scotland.

Although treatment had long been part of the way courts in many countries dealt with drug offenders, the multidisciplinary, therapeutic and intensive way Drug Courts dealt with the offender throughout the programme was new and unique for all legal systems.

Drug Courts have evolved to suit different legal traditions (e.g. common law, civil law), cultures and localities. Underlying objectives, operating principles and core characteristics are usually similar, but priorities and means of achieving them often differ. Differences include target group, eligibility criteria, at what point in the justice process the case is diverted to treatment, etc.

To achieve the full benefits from Drug Courts, both common law tradition and civil law tradition States had to change the way they dealt with drug abusing offenders. For example:

- Common law adversarial system judges had to learn to directly interact with participants, rather than leave the conduct of the case to the prosecution and defence;
- Civil law inquisitorial system judges required legislation to enable them to oversee the programme before sentencing or to continue to supervise the case after sentencing;
- Judges, prosecutors, defence lawyers, police and treatment personnel in all legal systems had to learn the difficult process of effective multidisciplinary teamwork.

Drug Courts reflect a transformation of the way courts traditionally dealt with drug-abusing offender criminal casework. The traditional process was adversarial, emphasized the efficient but backward-looking adjudication of claims, rights and responsibilities and involved few participants and stakeholders. The transformed process practised in Drug Courts is collaborative, needs-based and emphasizes forward-looking, post-adjudication problem-solving and dispute avoidance, with a wide range of participants and stakeholders. It is aimed at efficient case processing and effective case outcomes to stop criminal recidivism and drug abuse.

Evaluations on the various Drug Court programmes show higher non-recidivism and retention in treatment rates than alternatives, whether traditional treatment or prison. They are stopping the revolving door back into prison.

UNDCP's Legal Advisory Programme works closely with professionals, practitioners and organizations in an informal Drug Court network.

APPENDIX

Some Useful Web Site Links

UNODC's Treatment and Rehabilitation Toolkit
www.unodc.org/odccp/treatmenttoolkit.html

National Association of Drug Court Professionals (United States)
www.NADCP.org

School of Public Affairs, American University – Justice Programs Office
<http://www.american.edu/academic.depts/spa/justice/drugcourts.html>

National Crime Prevention Centre (Canada)
<http://www.crime-prevention.org/english/main.html>

New South Wales Drug Court (Australia)
<http://www.lawlink.nsw.gov.au/drugcrt/drugcrt.nsf/pages/index>

'Treating Drug Users in Prison - a Critical Area for Health-Promotion and Crime-Reduction Policy'
<http://www.emcdda.org/infopoint/publications/focus.shtml>