ПРАКТИКА СОЦІАЛЬНОЇ РОБОТИ ТА СОЦІАЛЬНОЇ ОСВІТИ

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ІНТЕГРАЦІЯ ГРОМАДСЬКИХ ПРОГРАМ СОЦІАЛЬНОЇ РЕАБІЛІТАЦІЇ НАРКОЗАЛЕЖНИХ У СИСТЕМУ ДЕРЖАВНОГО РЕГУЛЮВАННЯ

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Стаття присвячена дослідженню кризи системи реабілітації наркозалежних в Україні та пошуку механізмів державного захисту ефективних громадських, зокрема християнських, резидентних програм. Для вирішення поставленої мети авторами проаналізовано сучасну ситуацію з наркозалежністю та ефективність державних закладів; систематизовано практику силового тиску правоохоронних органів на альтернативні реабілітаційні центри. Розкрито результати експертного опитування, що фіксує глибоку незадоволеність фахівців (93 %) та їхній запит на інтеграцію через ліцензування та медичний супровід (97 %). Запропоновано модель взаємодії, засновану на концепції проміжного правового статусу резидентних соціальних центрів і механізмі державно-громадського партнерства.
Ключові слова: *наркозалежність, реабілітація, християнські центри соціальної реабілітації, державно-громадське партнерство, медикалізація.*

INTEGRATION OF PUBLIC SOCIAL REHABILITATION PROGRAMS FOR DRUG ADDICTS INTO THE STATE REGULATION SYSTEM

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This article addresses the critical systemic failure within Ukraine's drug addiction rehabilitation sector, examining the tension between state medical institutions and non-state, often faith-based, residential programs. It identifies a dual crisis: the widely acknowledged ineffectiveness of the state medical model, contrasted with the legal vulnerability and frequent targeting by law enforcement of alternative community centers that have gained significant expert and social trust. The research employs a mixed-method approach, combining documentary analysis of law enforcement practices (2017–2025) with a quantitative expert survey (n=100) among professionals in narcology, public health, and social work. The survey data reveals a near-unanimous expert consensus on the insufficiency of the state system (93%) and a predominant view that law enforcement raids are excessively harsh (87%). Crucially, it identifies a strong expert mandate for systemic reform: a majority supports the integration of alternative models (63%), specific licensing frameworks (62%), and an overwhelming demand for mandatory medical supervision (97%). The analysis frames this conflict through the theoretical lenses of institutional legitimacy and competing paradigms – pitting a bio-psycho-social medical model against a punitive state response. Synthesizing these findings with international standards for treatment (WHO/UNODC), the study proposes a pragmatic model for integration, advocating an intermediate legal status for residential social rehabilitation centers operating under licensed medical supervision. The conclusion argues that a shift from suppression to regulated partnership is essential to ensure patient safety, system effectiveness, and humane care in the context of war-related trauma and rising addiction rates.
Keywords: *drug addiction, rehabilitation, Christian social rehabilitation centers, public-private partnership, medicalization.*

Problem statement in a general form and its connection to important scientific and practical tasks. According to the United Nations Office on Drugs and Crime, as of 2023, there were approximately 292 million drug-dependent individuals worldwide [1]. About 60 million of them were dependent on "hard" drugs, namely opioids. In the WHO European Region, these figures are 47 million and 4 million, respectively [2]; in Ukraine, it is 310,000 and 120,000,

respectively [3]. The greatest harm to society and drug users is caused by opioids, especially those used intravenously.

Drug addiction places a burden on society and destroys personal life, particularly social connections. The seminal study by Nutt D.J. et al. (2010) demonstrates the harm of drugs, alcohol, and tobacco to personal health and society [4]. The use of narcotic substances is associated with premature deaths (overdose, septic conditions from injection use), infection with blood-borne infections (HIV, hepatitis), and a higher incidence of sexually transmitted diseases (due to reduced behavioral self-control) [5].

Emergency care for drug-dependent individuals in an addiction inpatient setting involves the administration of medications from various groups to stabilize the condition and relieve symptoms. The period of overcoming opioid withdrawal is difficult and characterized by a series of symptoms resembling severe influenza. Opioid withdrawal symptoms typically begin 6–24 hours after the last use of short-acting drugs like heroin and last about 5–7 days, peaking in intensity at 48–72 hours. The main and most common physical symptoms are insomnia, headache, runny nose, tearing, yawning, loss of appetite, nausea, vomiting, sweating, goosebumps, alternating sensations of heat and chills, diarrhea, abdominal cramps, anxiety, agitation, restlessness, increased heart rate and blood pressure, intense craving for the drug, as well as muscle and joint pains. After the acute phase, sleep disturbances and mood changes may persist for weeks. Despite its severity, opioid withdrawal syndrome is usually not life-threatening for individuals without severe comorbidities [6]. To alleviate opioid cravings and for detoxification, other opioids with lower addiction risk or partial opioid receptor agonists, such as methadone or buprenorphine, are used. Medications to combat acute nausea and vomiting (e.g., metoclopramide), drugs against spasms and seizures (clonidine, baclofen, etc.), antidepressants and sleep aids (trazodone, etc.), non-steroidal anti-inflammatory and analgesic agents (ibuprofen, paracetamol) are employed [7]. This list is provided to demonstrate the intensity of the required pharmacotherapy.

The period of overcoming drug withdrawal is characterized by a strong craving for the drug. For effective overcoming of this phase and preventing immediate relapse caused by an overwhelming desire, creating a controlled environment that limits access to psychoactive substances is critically important. Thus, at the initial stage of treatment, the need for special conditions ensuring physical and social isolation from external temptations often arises.

After "detox," the dependent individual requires a long period of rehabilitation, during which they need psychotherapeutic treatment and social support. Psychotherapeutic treatment includes cognitive-behavioral therapy, individual psychotherapy, group therapy (including the 12-step program), art therapy, and meditative techniques (including prayers) [8]. Social support includes step-by-step social support (Case Management), long-term attendance at support groups (including participation in Narcotics Anonymous programs), active assistance in employment, and psychological help for co-dependents [9].

The diagnosis of drug addiction is lifelong. Even long-term success in non-use of narcotic substances is considered temporary remission [10]. The high relapse rate explains the long-standing existence of "harm reduction" programs, which include support for safe use of "hard drugs" (outreach needle exchange programs) and methadone programs [11]. The implementation of these programs is primarily entrusted to specialized medical-social public organizations.

In Ukraine, besides the state medical narcological system, alternative models of long-term rehabilitation based on the principles of residency (isolation), complete immersion in a therapeutic environment, and intensive group support have historically developed and spread. These include both non-religious therapeutic communities and centers based on religious (mostly Christian) programs. The medical and residential models of drug addiction rehabilitation face serious challenges: the state system shows low rates of long-term remission, and residential centers (especially religious ones) often operate in a legal vacuum, leading to

risks of participants' rights violations (illegal deprivation of liberty, lack of medical support) and their systematic confrontation with law enforcement agencies.

Treatment and rehabilitation are considered effective if after "detox" the drug-dependent individual does not use drugs for one year. The average effectiveness of treatment and rehabilitation in narcological institutions is close to 5–30% [12]. Christian rehabilitation centers show treatment and rehabilitation effectiveness up to 70%, which is explained by the replacement of drug addiction with religious dependence [13].

It is important to consider that direct comparison of these indicators is methodologically limited. State institutions work with all cases, while residential centers may screen participants. Data on the high results of Christian centers remain unconfirmed by independent modern research with clear patient selection criteria and outcome assessment. Thus, the cited figures indicate the potential effectiveness of different models but are not a basis for unequivocal conclusions about the superiority of one of them.

This methodological gap in outcome measurement is a reflection of a larger, systemic problem: Ukraine lacks a unified state system for monitoring and evaluating the effectiveness of all types of rehabilitation assistance. The absence of reliable comparative data does not allow for evidence-based determination of priorities in policy and funding. That is why the search for mechanisms to integrate different models into the legal framework is also necessary to ensure transparency, quality control, and the collection of objective data, which in the future will become a true guide for building an effective assistance system.

This determines the relevance of searching for legal, organizational, and financial mechanisms to integrate effective practices of residential rehabilitation (including religious) into the legal framework and the system of social service provision, which would allow for control, safety, and quality of assistance while preserving its effectiveness.

Analysis of recent research and publications. The previously mentioned study by Nutt D.J. et al. (2010) [4] is a fundamental work that first assessed the harm of various psychoactive substances using a unified scientific methodology. The authors evaluated 20 substances across 16 criteria, nine related to harm to the consumer's health and seven to harm to others and society. The results showed that the greatest overall harm is caused by alcohol, which scored 72 points, surpassing even heroin (55 points) and crack cocaine (54 points). At the same time, the greatest harm directly to consumer health is caused by crack, heroin, and methamphetamine. This study demonstrated a significant discrepancy between scientific data on substance harm and existing legislative classifications based on political decisions from the 1960s.

After this study, the methodology for assessing the harm of narcotic substances through the Multi-Criteria Decision Analysis (MCDA) continued to develop in subsequent research worldwide, adapting it to regional characteristics. In 2015, a European study was published, combining the opinions of 40 experts from 21 European Union countries [14]. It confirmed the conclusions of the classic British work, again rating alcohol as the most harmful substance with an overall score of 72, while heroin and crack cocaine took second and third place with scores of 55 and 50, respectively. The remaining substances, including cannabis and ecstasy, received significantly lower harm ratings, emphasizing the need to reorient policy from prioritizing these substances to combating alcohol and tobacco. In 2019, Australian researchers conducted their own assessment, involving 25 local experts and including 22 substances in the analysis, adapted to the national context [15]. This work showed that the greatest harm to users is caused by fentanyl, heroin, and crystal methamphetamine; however, in the overall harm assessment (to the user and others), alcohol again emerged as the leader, receiving 77 points, followed by tobacco, methamphetamine, cannabis, and heroin. A feature of the study was the analysis considering the prevalence of use of each substance in Australia, and even by this parameter, alcohol remained in first place. The next important update of the method occurred in Germany in 2020, where synthetic cannabinoids and non-opioid analgesics such as gabapentin and pregabalin were

included in the assessment for the first time [16]. Alcohol, methamphetamine, heroin, cocaine, cannabinoids, and cathinones known as "salt" were in the top part of the danger rating.

The most recent to date is a study from New Zealand, published in 2023, which not only assessed overall harm but also for the first time separately analyzed risks for adolescents aged 12–17 [17]. The researchers concluded that for the general population, the greatest harm was caused by alcohol, methamphetamine, and synthetic cannabinoids, which were the most dangerous primarily for youth.

In Ukraine, a similar national ranking study using the MCDA methodology has not been conducted. The latest national report of the Public Health Center of Ukraine for 2024 data showed that due to the lack of national population studies, it is difficult to estimate the exact prevalence of use among adults. Instead, there are data for specific groups: among consumers in nightclubs, the most common are ecstasy, psilocybin mushrooms, amphetamine, and cocaine, while among those who inject drugs, opioids predominate. A serious problem is the misuse of medicines, particularly benzodiazepines, pregabalin, and Z-drugs. In 2024, nearly 67,000 people received medical help for drug use disorders, and over 105,000 for alcohol use. The report also notes a significant increase in the number of drug-related offenses, including driving under the influence.

Pathophysiologically, the "replacement" of drug addiction with religious practice is associated with the activation of the mesolimbic dopaminergic reward system (ventral tegmental area – nucleus accumbens) and modulation of the prefrontal cortex, which reduces impulsivity and stress. Prayer and meditative practices cause the release of dopamine and endogenous opioids, providing a subjective sense of pleasure and calm without exogenous psychoactive substances [18].

Since 2017, Ukrainian law enforcement agencies (Security Service of Ukraine, police, and prosecutor's office) began conducting systematic forceful actions in Christian drug rehabilitation centers, with searches, seizure of money, and "liberation" of drug-dependent individuals. Organizers of rehabilitation centers received suspicions under Article 146 of the Criminal Code of Ukraine "Illegal Deprivation of Liberty or Abduction of a Person." This essentially destroyed the system of Christian rehabilitation in Ukraine, which had been built up over the previous two decades: rehabilitation centers closed, and their organizers moved to other European countries. Drug-dependent individuals lost opportunities to receive rehabilitation assistance within a model that could potentially be more effective than narcological rehabilitation.

Since the beginning of the full-scale war, indicators of drug addiction in Ukraine have been rising, and long-term effective rehabilitation of drug-dependent individuals remains relevant. The number of people with chemical dependencies is increasing among individuals with PTSD resulting from hostilities [19].

The practice of pressure on rehabilitation centers continues [20]. Instead of developing institutionally regulated mechanisms for interaction between Christian rehabilitation programs and the healthcare and social protection systems, the Ukrainian state again offers a forceful scenario, which officially is a response to illegal deprivation of liberty of drug-dependent individuals during their social isolation, but in fact helps law enforcement agencies increase performance indicators in crime fighting reports.

Analysis of media reports and the National Police of Ukraine allows us to identify the following dates and places of forceful actions in rehabilitation centers for drug-dependent individuals:

2017 – searches by the Security Service of Ukraine of an Orthodox rehabilitation center in the village of Kosachivka, Chernihiv region, with the "liberation of over 200 people" [21]; "liberation" of rehabilitation participants in Kyiv and the region [22]; searches at a rehabilitation center in Sumy [23]; "liberation of nearly 90 people" in Dnipropetrovsk region [24]; searches at the "Volna+" rehabilitation center in the village of Harazdzhia, Volyn region [25];

2018 – searches at "Volna" rehabilitation centers in Poltava [26];

2019 – searches at a rehabilitation center in Zaporizhzhia with the "liberation" of 80 people [27];

2020 – searches of rehabilitation centers in Ivano-Frankivsk region [28];

2023 – searches in rehabilitation centers in Kyiv city and region [29]; in Ternopil region [30];

2024 – searches at rehabilitation centers in Khmelnytskyi and Ternopil regions [31];

2025 – searches of rehabilitation centers in Odesa with the "liberation" of 10 people [32].

Common features of all forceful actions were "mask show" (militarized policing), searches, seizure of money, "liberation" of rehabilitation participants from the rehabilitation process. In none of the reports about such events was it stated to which medical institution patients with drug addiction were transferred for further treatment. As a result of each such forceful act, rehabilitation centers ceased operations.

The results of our analysis of official reports and media messages allow us to assert that it was the conduct of systematic forceful raids that led to the collapse of the Christian rehabilitation infrastructure. This, in turn, deprived a significant number of drug-dependent individuals of the opportunity to receive assistance within this model, which, given the data on its potentially high effectiveness, can be seen as a significant loss for the assistance system as a whole.

This conclusion, of course, does not deny the official legal basis for the raids. However, it indicates that the state's response, aimed at eliminating violations by individual centers, took a form that de facto liquidated the entire alternative model, without offering mechanisms for its reform or guarantees of providing adequate substitute assistance to the freed patients, information about whose fate, as a rule, is lost.

Ukrainian researchers of the problem mostly replicate clichés from police reports. Thus, Ivakhnenko O.A. (2024) reports [33] that despite the existence of legislative and sub-legislative acts regarding licensing and accreditation of rehabilitation institutions, the legal status of centers remains unclear, complicating control over their activities and creating risks for the emergence of "pseudo-rehabilitation" institutions that may illegally detain people or violate their rights. However, the work lacks a detailed analysis of the practical aspects of the functioning of residential rehabilitation programs, highlighting the necessity of social isolation to restrict the freedom to leave for another dose of drugs. The isolation regime is legal in a medical institution with a corresponding license. Similar actions in public rehabilitation centers may receive criminal-legal assessment as illegal deprivation of liberty.

It is known that drug-dependent individuals consent to their rehabilitation and always try to refuse rehabilitation under the influence of withdrawal [34]. Social isolation of drug-dependent individuals in the initial stages of rehabilitation contributes to a reduction in the criminal violent offenses characteristic of drug addicts. Staying in a rehabilitation center involves temporary restriction of contacts with the external environment, which is an element of the therapeutic process. It refers to a structured, controlled environment where therapeutic interventions aimed at stabilizing the condition of individuals with addiction are applied. Social isolation allows avoiding relapses of drug use. The researcher's conclusions indicate limited consideration of empirical data on the organization of the rehabilitation process.

Shlapko T.V. and Danich S.A. (2023) report [35] that in Ukraine, the legal regulation of the activities of rehabilitation centers for drug-dependent individuals has significant gaps, allowing centers to operate without proper control and standards. However, rehabilitation centers have no opportunity to work legally: they are unable to meet the licensing conditions for medical institutions of a narcological profile. At the same time, the effectiveness of their work is higher than such institutions. A way out of this legal deadlock could be the regulation of the status of residential social centers, which would not require them to obtain a medical license but would mandate the presence of a contract with a licensed doctor or medical institution to provide necessary support. Shlapko T.V. and Danich S.A. also acknowledge that the lack of clear

requirements for personnel, material-technical equipment, and inspection procedures creates conditions for violations of the rights of dependent individuals and limits the effectiveness of state policy in the field of combating drug addiction.

A comparative analysis of Ukrainian and European legal regulation of rehabilitation services shows that in Ukraine, an effective state system for ensuring the right of drug-dependent individuals to rehabilitation has not yet been formed. The absence of a separate law and international standards complicates access to services and increases the risk of human rights violations [36].

The **aim** of the research was to study the methods of interaction of the Ukrainian state with Christian drug rehabilitation organizations, existing and possible alternatives.

Presentation of the main research material. The research was conducted using systematic analysis, bibliosemantic, comparative, and sociological methods. Systematic analysis was conducted according to the algorithm of Yevhen Holubkov [37].

Within the bibliosemantic method, a search for literary sources in Google, Google Scholar, and PubMed was performed using keywords: militarized policing, drug rehabilitation center raid, law enforcement and faith-based rehab, criminalization of addiction treatment, Ukraine drug policy. To test the research hypothesis (namely, that organizing state interaction with Christian rehabilitation centers for drug-dependent individuals is possible without forceful pressure) and to study the world's best practices for supporting social programs for drug-dependent individuals, the comparative method was used.

Within the sociological method, through anonymous surveying, the opinions of 100 specialists working in the fields of narcology, public health, and social protection of vulnerable population groups were studied. Surveying via a Google Form began in 2023 and ended when the number of respondents reached 100 in 2025. The sample size of respondents was determined by: 1) ease of calculating results, where 1 respondent corresponds to 1% of those surveyed; 2) sufficient statistical reliability of sample sociological studies according to the Student's criterion (since the standard critical value Z=1.96 for a 95% confidence interval under a normal sample distribution is sufficient for expert assessments of pilot studies) [38].

The research was conducted within the scientific topics: 1) of the Kharkiv Regional Institute of Public Health Services "Support of Public Initiatives to Counter the Spread of Chemical Dependencies" (2023–2028); and 2) of the scientific topic of the Department of Public Health and Health Care Management of the Kharkiv National Medical University "Medical and Social Aspects of the Quality of Life of Student Youth under Conditions of Use of Narcotic Substances, Alcohol, Tobacco Smoking" (2024–2026), state registration number 0124U002696.

The questionnaire included: 1) a passport part with questions about gender, age, profession, place of work, presence of an academic degree, confirmation of filling out this questionnaire only once, absence of conflict of interest; 2) questions regarding the assessment of the importance of effective rehabilitation of drug-dependent individuals; 3) questions regarding the assessment of state forceful actions; 4) selection of the best strategies for organizing state interaction with centers of Christian (religious) rehabilitation of drug-dependent individuals.

The group of specialists who took the survey was represented by scientists (23%), scientists and social work practitioners simultaneously (38%), doctors (mostly narcologists) and nurses (19%), and representatives of medical-social public organizations. Specialists who had worked in the field of narcology, social work, and public health for at least 5 years were invited to the survey. 16 respondents had academic degrees of Doctors and Candidates of Sciences (PhD). Among the respondents, there were 66 women and 34 men. The average age of respondents was 38.4 years. If a respondent declared a conflict of interest, the result of their survey was not considered. 2 out of 3 cases of declared conflict of interest were related to the religious position of the respondents.

Among the respondents, 93% consider the modern system of rehabilitation of drug-dependent individuals in Ukraine insufficiently effective, 76% believe that such a rehabilitation

system can be significantly improved; 63% believe that Christian rehabilitation can be the basis for such improvement.

Excessively harsh actions by law enforcement are considered by 87% of respondents. The other 13% believe that some rehabilitation centers exceed their authority regarding restricting the freedom of drug-dependent individuals, and that the actions of law enforcement are justified.

The need for licensing is stated by 62% of respondents. 48% believe that licensing conditions for Christian rehabilitation centers should differ significantly from licensing conditions for medical centers. 38% believe that instead of a license for a certain period, rehabilitation centers should receive long-term work permits from local self-government bodies. A mandatory condition for the work of such centers, according to 97% of respondents, should be the participation of a doctor in the work of the rehabilitation center. 33% of respondents believe that a doctor should be on 24-hour duty at the rehabilitation center, 44% believe that one visit per week is sufficient.

The survey results of specialists clearly record a deep systemic dissatisfaction with the state model of rehabilitation (93%), which leads to an active search for alternatives. In this context, support specifically for the religious model at the level of 63% is indicative: it indicates the perception of the traditional system as so ineffective that even an alternative that does not fit into classical evidence-based frameworks is considered by specialists as viable and needed.

Criticism of forceful methods by more than 87% of respondents has a dual nature. First, it completely coincides with the consensus of international evidence-based literature on drug policy and human rights. Second, the extremely high indicator of criticism points to a deep institutional conflict in Ukraine between the professional community of healthcare/social work specialists and law enforcement agencies. Unlike stable democracies, where such contradictions are usually regulated in the legal field, in Ukraine this conflict takes on an acutely polarized character.

The crisis of trust is also manifested in the gap between formal requirements (licensing, medical standards) and informal practices that arose as a response to state inaction. The low legitimacy of the official system leads to alternative models (e.g., Christian centers) operating in a legal vacuum, relying on internal, often religious norms and the authority of organizers, not on state regulation. The desire of specialists to license and medicalize these centers (62% and 97%, respectively) is an attempt not just to improve quality, but to transform an informal yet effective practice into a legitimate part of the national healthcare system, overcoming this split between "law on paper" and "law in life."

Thus, the expert field demands not the liquidation of alternatives, but their medicalization and legal legalization, as confirmed by the almost complete agreement regarding mandatory doctor participation (97%). This indicates a desire for a new model that combines the social effectiveness of residential centers with safety guarantees and quality standards based on evidence-based medicine.

Support for licensing (62%) and almost unanimous demand for doctor participation (97%) demonstrate the specialists' desire for systemic integration. These results are fully consistent with international quality standards based on evidence-based medicine and requiring medical support and regulation to ensure safety [39]. Importantly, this demand for regulation is not support for repression. On the contrary, it forms a clear alternative scenario to the criticized forceful methods: specialists advocate not for "storming" centers, but for creating legal conditions for their work that guarantee the quality of assistance through mechanisms of licensing and medical control, not criminal prosecution.

Research conclusions and prospects for further scientific research. The conducted research allows us to conclude that a deep systemic crisis has formed in Ukraine in the field of rehabilitation of drug-dependent individuals, manifested in the complete loss of trust of specialists in the state medical model (93%), acute conflict with law enforcement (87%), and a

desire for alternatives, even religious ones (63%). The state's response in the form of forceful raids proved counterproductive, as it liquidated a viable alternative infrastructure without offering a replacement. A key conclusion is the clearly expressed demand by experts not for repression, but for constructive integration of alternative centers into the legal field through their medicalization and special regulation (support of 62% for licensing and 97% for doctor participation), which fully corresponds to international quality standards.

Prospects for further research should be directed at working out a practical mechanism for such integration. The most important task is the development of a specific model of an intermediate legal status ("residential-type social service") for non-state rehabilitation centers. This model should provide not for the impossible for them obtaining of a medical license, but a mandatory contract with a licensed medical institution for support, as well as mechanisms for licensing or accreditation through social policy bodies with clear standards of safety and service quality.

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