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Drug Abuse Treatment and Rehabilitation

A Practical Planning and Implementation Guide

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Drug Abuse Treatment and Rehabilitation:

a Practical Planning and Implementation Guide

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Chapter I

Introduction

Welcome to the United Nations International Drug Control Programme (UNDCP) practical guide for the planning and implementation of drug abuse treatment and rehabilitation services. *Drug Abuse Treatment and Rehabilitation: a Practical Planning and Implementation Guide* is designed to be a practical resource for Governments, policy planners, service commissioners and treatment providers. The material presented is intended to be of value in a wide range of national and cultural contexts. A key audience for this resource is communities in which there is currently little or no provision for the treatment of substance abuse problems. The *Guide* should also be of interest and value for communities where treatment services are well developed but need further integration.

Developing a practical guide in this area is a challenge, primarily because its target audience is so diverse and at different stages in developing and delivering treatment services. There is also considerable international variation in strategic and practical terms in the way in which States tackle drug abuse and related problems. Nevertheless, there is an international trend towards convergence on key ideas that underpin successful treatment and rehabilitation. The *Guide* is therefore founded on core principles that are important when considering, planning and delivering clinically and economically effective services.

The *Guide* has been developed on the basis of international experiences in the planning, operation and evaluation of services in different countries. It aims at providing a broad up-to-date framework to guide planners and implementers through a number of key steps required for the initiation and the further development of treatment and rehabilitation services. It is hoped that the material will be of particular value to countries that are interested in developing or enhancing the capacity of their treatment services.

A. Cultural settings

The *Guide* is designed to be applicable to a wide range of cultural settings where there is substantial variation in perspectives on addiction and some major economic, cultural, religious and political dimensions that affect the ways in which different societies tackle drug abuse. Such variation adds to the rich and diverse nature of the responses to drug abuse problems. There is a critical need for key cultural issues to be respected. The *Guide* is based on the principle that treatment programmes that have been shown to be effective in one cultural setting should be capable of adaptation for use in other cultural contexts.

B. Resource constraints

The resources available in different communities vary widely and the *Guide* recognizes that some countries face major resource constraints in the development of services. However, drug abuse problems now cause a substantial burden to almost all societies and, in all settings, it is vital to invest time and energy in responding to those problems. Such an investment is of particular importance in resource-poor settings where hidden costs and burdens related to drug abuse problems (for example, costs to the health system, loss of productivity at work and criminal justice costs) cause substantial demands on resources that might be directed elsewhere if comprehensive prevention and appropriate intervention strategies were in place.

C. Principles underpinning the *Guide*

The *Guide* takes a positive philosophical stance to tackling drug abuse and related problems. Such a stance is based on the emergence in many countries of robust research evidence indicating that well-organized treatment and trained and supportive treatment personnel can have a rapid and lasting impact on people affected by drug abuse. That provides a clear rationale for national and international policy makers to strive to ensure that resources are made available to tackle the serious problem of drugs and drug abuse in a constructive fashion.

Investing in treatment has been shown to reflect sound judgement in human and economic terms. As the com-

panion publication to the present *Guide, Investing in Drug Abuse Treatment: a Discussion Paper for Policy Makers* [1], further elaborates, it is possible to identify a range of effective treatment approaches as well as important active ingredients of effective treatments. It will then be important to adapt those elements within the context of different sociocultural and economic circumstances [2].

The preparation of the material in the *Guide* was based on the following 11 guiding considerations:

- People with drug-related problems often have multiple treatment needs across a range of personal, social and economic areas;
- Drug abuse problems can be treated effectively if people can access treatment and rehabilitation services that are appropriate to their needs and of sufficient quality, intensity and duration;
- The financial support that underpins treatment and rehabilitation should be directed to those services that have an impact of proven efficacy;
- No one single treatment approach is effective for everyone. People may need different types of treatment, which are integrated and coordinated effectively, at different times and stages in seeking help;
- People should be able to access or be referred to the treatment that best meets their needs. Treatment services should take into account specific needs related to gender, age, health and risk behaviours;
- The prevention of blood-borne infections, including the human immunodeficiency virus (HIV) and hepatitis B and C, is a key component of a comprehensive treatment approach;
- Treatment services should, as far as possible, build on, link with and integrate with existing health and social agencies and provide a continuum of care. They should also include community-based support services;
- The coordination of care is an essential task of any effective and efficient treatment system;
- Effective planning for treatments should involve a partnership between Government and regional and local governmental and non-governmental agencies and providers, service users [3] and the community;
- Treatment and rehabilitation services should play a key role in reducing the social stigma and discrimination against drug abusers and supporting their reintegration into society as healthy and productive members of the community;
- Research activities should be geared towards filling key gaps in knowledge about the effectiveness of treatment approaches and treating specific groups. Staff training should follow suit.

D. How the *Guide* was constructed

The *Guide* has been developed through the partnership of an international team of experts from Australia, Thailand and the United Kingdom of Great Britain and Northern Ireland, engaged by UNDCP, and United Nations treatment and demand reduction experts. The emphasis throughout has been on consulting with a wide range of audiences about the material. In doing so, the goal has been that no one professional or country approach should predominate. Rather, a multidisciplinary perspective has been taken so that the material contains contributions from the perspectives of general medicine, psychiatry, psychology, social welfare and justice. The international team of experts drafted the initial version of the core sections of the *Guide* between October 2000 and January 2001. A meeting of the core team with international experts from Colombia, Nigeria, Pakistan and the United States of America was held in Vienna from 26 to 28 February 2001 to review the draft material and further consider relevant issues. Practical examples of how different communities have tackled treatment and rehabilitation issues were provided by sources from a broad range of countries in close liaison with UNDCP field offices. Where possible, the material in the *Guide* is supported by key citations from the resource literature, with an emphasis on materials that can be accessed using the World Wide Web.

Pilot testing and/or review of the *Guide* was then conducted in a range of countries in Central America and South America (Bolivia, Costa Rica, El Salvador, Guatemala, Guyana, Honduras, Mexico, Nicaragua and Panama); East Africa (Ethiopia, Kenya, Mauritius, Seychelles and Uganda); the Middle East (Egypt and Jordan); and South Asia (Pakistan) and South-East Asia (Lao People's Democratic Republic and Myanmar). A draft version of the *Guide* has also been peer-reviewed by senior treatment and drug demand experts based in Canada, the Netherlands, Switzerland, the United Kingdom and the United States.

E. Purpose and structure of the *Guide*

The *Guide* promotes a systematic approach to thinking about drug abuse problems and abusers in need of treatment, as well as to planning and implementing services. It advocates a logical, step-by-step sequence that links policy to needs assessment and treatment planning and implementation to monitoring and evaluation.

In addition to the present introduction, the *Guide* includes the following chapters:

Chapter II: Developing a strategic framework for treatment;
Chapter III: Assessing treatment needs;
Chapter IV: Effective treatment and rehabilitation services;
Chapter V: Developing and implementing treatment services;
Chapter VI: Effective integration of treatment services;
Chapter VII: Monitoring treatment activity and outcome.

Chapter II describes the core components of a strategic plan or policy on drug abuse treatment and rehabilitation and how such a plan or policy can be developed and implemented. The material deals with how treatment fits into the broader policy concerns and legal framework in a country and how best to judge the progress of the policy against its goals and objectives.

Chapter III describes how best to conceptualize the issue of "need for treatment" and how to look at the population in a country in terms of the sorts of problems that they might have and the different groups that may be important to consider. Practical suggestions are then offered to conduct a needs-assessment exercise that can be used on a routine basis.

Chapter IV considers the range of treatment and rehabilitative services that have been shown by research studies to be effective. The material should be of practical benefit when considering exactly which types of treatment to develop to tackle specific problems. Chapter V should be read in conjunction with the companion publication *Contemporary Drug Abuse Treatment: A Review of the Evidence Base* [4].

Chapter V offers practical guidance on developing single treatment services or more elaborate treatment and rehabilitation systems. Those responses to assessed needs incorporate evidence-based treatment services from chapter IV. Practical step-by-step suggestions for how to take the planning process forward are dealt with in that central part of the *Guide*.

Chapter VI continues the planning and developmental work of chapter V. The focus is on ensuring that single services and several types of services work in an integrated and efficient manner and on how best to ensure that teams work effectively.

Chapter VII links with all the preceding chapters of the *Guide*. It looks at the issue of evaluating or monitoring the delivery of treatment and assessing its effectiveness. Practical suggestions are offered on how best to gather basic or more complex information about how a treatment service works and how well it is meeting its stated objectives.

The following six chapters of the *Guide* can be read in sequence or independently. For countries that are considering developing their treatment capacity, it is suggested that chapters II to VII of the *Guide* be followed in sequence. Countries with developed systems may be inclined to focus on chapters VI and VII, but may nonetheless find chapters III and V of interest when organizing a new assessment of need in a particular community or for dealing with a newly emerging drug abuse problem and how best to respond to it.

The following self-assessment questionnaire may be helpful in deciding how best to use the *Guide*.

F. How to use the *Guide*

UNDCP recognizes that many readers will approach the *Guide* with a specific interest or strategic need. In order to help the reader to navigate through the material, several questions about the context and situation for each reader are set out below in a self-assessment questionnaire. Completing it may help the reader to use the material in the *Guide* as a practical tool.

Self-assessment questionnaire

Q1. Does your country have a national policy or strategic plan that covers drug abuse treatment and rehabilitation?

No *Begin at chapter II then go to Q2.*

Yes *Does that include performance indicators and targets to monitor progress?*

Yes - *Go to Q2.*

No - *Begin at chapter II then go to Q2.*

Q2. Do you need to work out how to assess which drug problems require treatment and what sort of treatment may be needed to tackle known drug problems in a particular community or population group?

Yes *See chapter III then go to Q3.*

No *Go to Q3.*

Q3. Do you need to review the range of services that have an international research evidence base for their effectiveness in treating drug abuse?

Yes *See chapter IV then go to Q4.*

No *Go to Q4.*

Q4. Is there a need to develop a new treatment and rehabilitation centre or improve existing services in one or more parts of the country?

Yes *See chapter V then go to Q5.*

No *Go to Q5.*

Q5. Is there a desire to review the operation of existing services or enhance the links and effective integration and coordination between services?

Yes *See chapters VI and VII.*

No *Go to Q6.*

Q6. Is there a need to improve the arrangements for monitoring the operation and performance of treatment and rehabilitation services in one or more areas?

Yes *See chapter VII.*

Chapter II

Developing a strategic framework for treatment

In chapter II of the *Guide*, the following question is asked: "How should a strategic framework for treatment be conceptualized, and what are the key issues that need to be addressed when developing and implementing a treatment policy and plan?"

The benefits of reading and using Chapter II of the *Guide* are as follows:

- Placing the development of treatment services into broader strategic and legal frameworks for drug control and demand reduction;
- Recognition of the importance of setting measurable objectives and policy planning priorities;
- Understanding the key elements and guiding principles of a treatment policy;
- Understanding the need for multisectoral partnerships for the development and the effective delivery of treatment services.

The material in Chapter II deals with the elements of a strategic framework and how those fit into a wider national plan on drugs. It is designed to assist in the task of developing a treatment strategy. The target audience for Chapter II is policy makers and senior professionals and their advisers from national and local bodies, including government departments (health, justice and social welfare) and regional and state agencies. Other important stakeholders that need to be committed in the development of the framework include individual treatment providers, services users and community groups and advocacy organizations that will also have a role to play in the development of the strategy.

Chapter II of the *Guide* should be read with reference to the partner document *Investing in Drug Abuse Treatment: A Discussion Paper for Policy Makers.* That concise document considers the expectations that societies have in treating drug abuse problems and the nature of return on investment that is likely to be seen from providing treatment services in terms of improved health for individuals and reduced social problems for families and communities. It specifically considers the impact of various forms of treatment in the light of non-treatment alternatives—such as no treatment at all and criminal justice interventions—and argues the case for treatment being included in the mix of policy options that form part of the national framework.

Chapter II is divided into three sections. Section A introduces the rationale for a strategic framework and addresses treatment definitions and principles underlying policy and the key features that are usually contained in a strategic plan. Section B addresses the legal and regulatory background to the strategy and legal issues concerning treatment provisions, professional conduct, treatment quality and operational issues, fiscal and contracting issues, and treatment in the criminal justice system. Section C looks at developing and implementing the strategy and considers the importance of involving different partners; ensuring policy commitment; conducting sound assessment and planning; building on research evidence; developing an incremental and step-by-step approach; fostering collaboration and integration; building on community-based responses; ensuring service diversification, availability and accessibility; and monitoring performance.

A. Strategic definitions and principles

Today, almost all countries need to consider how best to respond to the abuse of one or more psychoactive substances that are causing problems for individuals, families and communities. Those drugs include cannabis, opioids (such as heroin), cocaine, amphetamine-type stimulants, sedatives/tranquillizers, hallucinogens, solvents/inhalants and alcohol. The response of a country to drug abuse is best organized and guided by a public policy and a strategic framework. While it is possible to develop a single treatment programme or an entire treatment system without such a framework, there are substantial benefits in establishing one. The value of the strategic framework lies in the way in which it communicates, in a clear and concise document, the nature of the problem, the actions that the country is taking to tackle it and what sort of results are expected.

The development of contemporary treatment responses to drug abuse at the local, regional or national level is

best guided by a public policy and a planning process to develop the strategic framework. Such a framework for treatment should fit within the context of the drug master plan of the country concerned or the national drug policy framework, and should become an important element of the demand reduction strategies embedded within those documents.

1. Defining treatment

Before working towards a strategic policy of treatment, a clear conceptualization and definition of treatment itself is needed.

Treatment can be defined in general terms as the provision of one or more structured interventions designed to manage health and other problems as a consequence of drug abuse and to improve or maximize personal and social functioning. According to the World Health Organization (WHO) Expert Committee on Drug Dependence, the term "treatment" refers to "the process that begins when psychoactive substance abusers come into contact with a health provider or any other community service, and may continue through a succession of specific interventions until the highest attainable level of health and well-being is reached [5]."

The United Nations Office on Drugs and Crime of the Secretariat (formerly called the Office for Drug Control and Crime Prevention of the Secretariat) publication *Demand Reduction: A Glossary of Terms* adds: "Essentially, by providing persons, who are experiencing problems caused by their use of psychoactive substances, with a range of treatment services and opportunities which maximize their physical, mental and social abilities, these persons can be assisted to attain the ultimate goal of freedom from drug dependence and to achieve full social reintegration. Treatment services and opportunities can include detoxification, substitution/maintenance therapy and/or psychosocial therapies and counselling. Additionally, treatment aims at reducing the dependence on psychoactive substances, as well as reducing the negative health and social consequences caused by, or associated with, the use of such substances [6]."

The nature of treatment interventions, including medical, psychosocial, traditional healing and other rehabilitative services, can take a different form across different countries. Those interventions are not static and are subject to various political, cultural, religious and economic factors that influence how they are organized and delivered and how they evolve over time.

2. International consensus on treatment strategy development

There is now a consensus among the States Members of the United Nations to invest and develop a range of prevention and treatment activities. The Declaration on the Guiding Principles of Drug Demand Reduction states that "Demand reduction programmes should cover all areas of prevention, from discouraging initial use to reducing the negative health and social consequences of drug abuse. They should embrace information, education, public awareness, early intervention, counselling, treatment, rehabilitation, relapse prevention, aftercare and social reintegration. Early help and access to services should be offered to those in need." The Declaration also set out specific principles that should underpin strategy development. Those principles are summarized in box 1.

Box 1
Declaration on the Guiding Principles of Drug Demand Reduction[a]

"8. … in accordance with the principles of the Charter of the United Nations and international law, in particular, respect for the sovereignty and territorial integrity of States; human rights and fundamental freedoms and the principles of the Universal Declaration of Human Rights; and the principle of shared responsibility:

(a) There shall be a balanced approach between demand reduction and supply reduction, each reinforcing the other, in an integrated approach to solving the drug problem;

(b) Demand reduction policies shall:

- *(i)* Aim at preventing the use of drugs and at reducing the adverse consequences of drug abuse;
- *(ii)* Provide for and encourage active and coordinated participation of individuals at the community level, both generally and in situations of particular risk, by virtue of, for example, their geographical location, economic conditions or relatively large addict populations;
- *(iii)* Be sensitive to both culture and gender;
- *(iv)* Contribute to developing and sustaining supportive environments."

"10. Demand prevention programmes should cover all areas of prevention, from discouraging initial use to reducing the negative health and social consequences of drug abuse. They should embrace information, education, public awareness, early intervention, counselling, treatment, rehabilitation, relapse prevention, aftercare and social reintegration. Early help and access to services should be offered to those in need."

[a]General Assembly resolution S-20/3, annex.

Most countries have a national drug master plan or a broader national policy framework designed to organize and guide how the country is tackling the problem. Because drug abuse problems can affect many sections of the population and lead to health, social and legal problems, those plans are often integrated within existing law enforcement, justice, education, health, labour, agriculture, economic and social policy.

Successful drug abuse treatment strategies must be placed in that broader policy framework where drug supply and demand reduction are of central importance. Treatment and prevention responses are critical dimensions that support the successful implementation of a balanced demand reduction response. While prevention policy is not within the remit of the present study, it must be developed at the same rate as treatment policy if an overall balanced approach is to be achieved. Overall, strategic planning is a critical task in which one or more agencies determine the nature and extent of the needs of a population and establish a framework to make the best use of resources to address those needs.

3. Key features of a strategic framework for treatment

There is a growing expectation in many communities that a range of treatment services should be accessible, regardless of age, race, gender, sexual preference, social and economic class and location. The key to successful responses to drug abuse is partnership and active cooperation between central and local governments, non-governmental agencies, service providers and the community. Drug abusers are often a stigmatized population and the community partners may need to take an advocacy role along with opinion leaders to promote understanding of drug abuse problems and how they can be effectively treated. Support for treatment services in the community is clearly advantageous. It can foster a positive climate of drug abuse prevention and can help to ensure that the interventions receive the necessary resources for the operation and development of the services.

A treatment framework presents a description of important principles that underlie the approaches to treatment in the country and set out the goals, objectives and activities for the national treatment system. Resources, agencies and organizations involved in delivering outputs based on the framework are identified, allowing the activities to be monitored through achievement indicators.

In some countries, plans of that nature have evolved to become detailed and elaborate policy and action statements. However, a strategic framework document does not have to be long and detailed. It does, however, need to reflect the cultural and economic context of the nation and its identified priorities in tackling the problem. It is important to state the overall principles and goals clearly in the framework document. It is also important to set out specific activities that will be undertaken, together with an agreed set of indicators that are to be used to judge how well the strategy is meeting its objectives. Importantly, strategic frameworks for treatment are best viewed as living documents that have a fixed lifespan and are subject to regular review and updates as required.

Although they vary, strategic plans on drug abuse share some common features. In particular, most plans:

- Estimate and describe the populations affected by drug abuse and the nature and extent of the problems to be treated;
- Summarize the beliefs, values, goals and objectives of the national, regional, community and service provider agencies that are to be involved in tackling the problem;
- Identify a governing body or individual who will have responsibility for governance of the policy;
- Describe the general roles of each of the national, regional and local (governmental and non-governmental) agencies involved and how they will contribute to the various stages of the planning and implementation of the policy;
- Specify the mechanisms for community involvement and representation;
- Specify the legislative framework and provisions that will allow treatment to take place;
- Detail specific types of treatments that are to be developed or otherwise enhanced, and the activities that need to be undertaken to do that;
- Specify the levels of financial and human resources that will be made available;
- Identify realistic outcomes that can be expected from treatment and the methods to assess the attainment of those outcomes;
- Specify how the strategy will be monitored and reviewed and its operation and impact communicated and considered within the nation.

As examples of national drug abuse policies, the key elements of the national drug strategic framework of Australia are described in box 2 and the national treatment service network of the Government of Spain is described in box 3.

Box 2

National drug strategic framework of Australia, 1998/99 to 2002/03

The Government of Australia has developed a national drug strategic framework for 1998/99 to 2002/03.

Access to treatment, building partnerships, links with other strategies and professional education and training are four of the eight priority areas identified in the strategic framework.

Under the heading "access to treatment", the strategic framework sets out the following areas for future development of treatment services:

- Improving the range of services available, for example, by developing a range of effective alternative pharmacotherapies for the treatment of opioid dependence to better tailor treatment to individual needs;
- Improving the effectiveness and quality of services, for example, by ensuring that service provision is evidence-based and provided by experienced and appropriately qualified staff;
- Improving access to services and ensuring community acceptance of services, including the development of services for specific population groups (young people, indigenous people, women with children, people who live in rural and remote areas, people from culturally and linguistically diverse backgrounds) and improving the delivery of culturally responsive services from mainstream treatment facilities;
- Increasing the involvement of mainstream service providers, such as general practitioners and hospitals, in early intervention and relapse prevention;
- Building stronger links between drug treatment services and mental health services, to improve service provision in both sectors and in mainstream health services for the management of clients with coexisting mental health and drug problems;
- Improving access to treatment for people in the criminal justice and juvenile justice systems, including expanding the use of diversion programmes to enable those apprehended for minor drug-related offences to be diverted to a range of appropriate drug treatment services.

For further details, go to **http://www.health.gov.au/pubhlth/publicat/document/ndsf.pdf**

Box 3

Services offered by the Spanish treatment and rehabilitation network

At present Spain has a consolidated and diversified network of programmes and resources offered to drug abusers, including a variety of actions to meet the different needs of the consumers and their families.

The network depends on the communities and autonomous cities, the local entities and the non-governmental organizations that deal with drug addiction.

The majority of people receive care in outpatient treatment services, with methadone prescription and/or dispensation services being the second type of resource most frequently used.

In that sense, the substantial increase in the latter type of programme (that of methadone maintenance), and in general all those directed towards reducing the harm associated with drug consumption (vaccination programmes, syringe dispensation and exchange programmes, sanitary kits etc.) in the last few years must be emphasized.

The objective of other programmes is that of incorporating into society the people who are affected by drug addiction and are under treatment. The programmes include academic and professional training and integration into the labour force (work in handicraft workshops, specific employment programmes, promotion of self-help cooperatives etc.), as well as residential support (by means of half-way houses or foster families etc.).

In relation to the promotion of work incorporation programmes, and in accordance with a collaboration agreement between the Ministry of the Interior and the Ministry of Labour and Social Matters, five thousand places have been made available to promote the integration of drug addicts into the labour force via the National Training and Professional Integration Programme.

In addition, a global intervention programme for drug addicts with legal or penal problems include the following strategies: alternatives to custodial sentences; programmes in police stations and courts; and intervention programmes in penitentiary institutions, especially treatment with methadone.

Source: Plan Nacional Sobre Drogas of Spain. For further information, go to http://www.mir.es/pnd/presenta/html/user.htm

B. Legal and regulatory background

International drug control treaties provide the legal foundation for action related to drug control. The Single Convention on Narcotic Drugs of 1961 [7], the Convention on Psychotropic Substances of 1971 [8] and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988 [9] include provisions requesting the States Members of the United Nations to give special attention to, and take all practicable measures for, the early identification, treatment, aftercare, rehabilitation and social reintegration of individuals with drug abuse problems. The Member States are also requested to promote the training of personnel in the treatment, aftercare, rehabilitation and social reintegration of drug abusers [10].

Responding to drug abuse problems is a complex area of social intervention that will often include a wide range of agencies, including social services, criminal justice agencies such as the police, probation and prison authorities, as well as other health and social agencies.

A range of legal issues and provisions affect the organization and delivery of treatment for drug abuse and dependence. There is a marked variation between countries in the nature and scope of those legal controls. In many cases, legal provisions affecting substance abuse treatment are not found in one single law or legislation, but are included in different regulations such as drug laws, consumer rights provisions or regulations concerning medical practice. In all cases, there needs to be a high degree of consistency between the strategic framework for treatment and relevant national legislation and regulations. Drug control legislation will frequently precede the development of treatment strategies. In such cases, it will be necessary to analyse existing laws for consistency with the envisaged policies and strategies for national treatment and modify them if necessary. The remainder of the present section highlights legal issues in nine areas.

1. Designation of treatment authority

A key aspect frequently covered by legislation regulating substance abuse treatment and rehabilitation is the designation of responsible agencies. Given the personal health,

Box 4
Legal Provisions on drug treatment in Slovenia

The Slovene Law on the Prevention of the Use of Illicit Drugs and Dealing with Consumers of Illicit Drugs (1999) defines, inter alia, measures for the treatment of drug abuse and dependence. The law determines that the treatment of consumers of illicit drugs should be carried out through hospital-based and outpatient-clinic treatment programmes approved by the Health Council.

The minister responsible for health is to appoint a body for the coordination of the centres for the prevention and treatment of addiction to illicit drugs. That body develops the addiction treatment policy, verifies the implementation of the policy, and coordinates professional cooperation between the centres for the prevention and treatment of addiction to illicit drugs. In accordance with the act regulating medical activities, treatment includes maintenance with methadone and with other substitutes approved by the Health Council.

Outpatient centres for the prevention and treatment of addiction to illicit drugs is organized at the primary care level as part of the public health service network. Services provided in outpatient centres include the methadone maintenance programme.

In addition, the Government of Slovenia is to establish a public health institution in charge of the implementation of hospital-based and specialist outpatient-clinic treatment—the Centre for the Treatment of Illicit Drug Addicts. Hospital treatment is deemed to include hospital detoxification, psychosocial treatment, extended treatment and health rehabilitation.

According to the Law, resident communities are deemed to be therapeutic communities that carry out professional therapeutic and rehabilitation programmes, communal groups with a programme that is mainly based on mutual help, and special-care homes with a programme that is mainly based on life and work in groups.

The Law also addresses the need for the involvement of non-governmental organizations and the coordination of their activities with the national programme.

It is foreseen that the funds for co-financing the implementation of prevention and treatment programmes and for monitoring consumption will be provided from the national budget. The activities of non-governmental organizations are to be co-financed from the national budget and other funds. Participants in a programme are to contribute part of the payments.

social, familial, economic and criminal problems that are associated with substance abuse, it is common for several central and local government departments to take an active role in tackling the issue. Drug abuse strategies are often drafted as statements of core policy with a broad partnership and designation of authority within government, albeit with a lead department assigned with overall responsibility for policy analysis and direction. Historical precedent and the organization of the health-care and social welfare system in the country typically determine the balance of responsibility between departments. Whatever balance is established, the result should be to ensure effective coordination of treatment services. An example of how designation of treatment authority and the overall coordination of services have been established in Slovenia is shown in box 4.

2. Professional standards and conduct

Personnel working in treatment services who have a formal professional qualification should work in the context of a professional code of conduct and usually a regulatory and supporting professional body. There may also be an overarching association of professionals working in a particular discipline in the substance abuse area—such as counselling. Professional standards may include:

- A commitment to ensuring that no professional will discriminate against clients on the basis of their gender, race, religion, sexual orientation or disability;
- Adherence to the governing regulations and standards pertaining to the conduct of their work and the provision of information to clients in relation to their treatment;
- Specific adherence to the promotion of the rights of clients, including the right to confidentiality, with respect to the preparation, storage and communication of records and clinical information;
- Ensuring that the professional has the required level of competence to carry out a specific duty and that routine supervision and continuous education and training are provided as required;
- A demonstrated commitment to the values and goals of an organization, as evidenced by participation in quality assurance and strategies for monitoring performance and outcome on a routine basis.

The elements of a professional code of conduct may include: the safety of professionals; roles and limitations of professionals; rules of disclosure; and measures and sanctions in case of misconduct. The professional body usually has some statutory powers to investigate and/or suspend an individual from duty. Most professionals working with substance abusers are required to have professional insurance or indemnity coverage.

3. Rights and duties of treatment programme participants

Many countries have enacted general legislation on individual rights to health and social care with no special reference to drug abuse. Under those general provisions, drug abusers have the same rights to receive treatment as persons with other chronic health disor-

Box 5
Practical application of legislation on consumer rights to drug abuse prevention and treatment

The United States Substance Abuse and Mental Health Services Administration has produced guidelines on the rights of clients in drug abuse prevention and treatment services. It is a practical application of United States legislation on consumer rights and considers key issues that have arisen in implementing a Consumer Bill of Rights and Responsibilities in the contexts of mental health and chemical dependency prevention and treatment. A range of issues have been addressed along with practical operational guidance and examples of how those rights and responsibilities may be put into practice. The following issues are covered in connection with guidance:

Information disclosure	Providers and plans
Emergency services	Treatment decisions
Respect and non-discrimination	Confidentiality of health information
Complaints and appeals	Consumer responsibilities
Access to services	Ombudsman programmes
Health literacy	Glossary of terms

For further details, go to **http://www.samhsa.gov/mc/content/cbr/index.htm**

Box 6
Supported initiative of the Inter-American Drug Abuse Control Commission: standards of care in drug abuse treatment

The supported initiative undertaken by CICAD since 1997 is designed to help Governments develop a consensus within the national health-care community around the desirability of establishing standards of care, and then to implement practices and guidelines. A long-term objective, recommended by the CICAD Expert Group on Demand Reduction (March 1998, and again in August 2001), is to develop systems of accreditation for treatment providers.

For further information, go to **http://www.cicad.oas.org/en/demandreduction/Projects/Standards.htm**

ders. Those rights may be expressed in different ways in a variety of policies and statements, including: the individual dignity of the person; the provision of non-discriminatory services; access to treatment services that are appropriate to individual needs; and advocacy and counsel arrangements that relate to criminal justice proceedings. Users of services are also bound by a statement of their duties in relation to treatment services, usually concerning their behaviour and appropriate conduct and participation in the therapeutic programme.

In many countries, service users benefit from rights and charters that provide for the right to complain about inadequate treatment and the right for a client to see and obtain a copy of all clinical records kept on them. Confidentiality regulations are also well established in many treatment systems. They usually restrict treatment providers by establishing an absolute minimum legal requirement for releasing to, or seeking from, a third party personal and treatment-related information about an individual without informed written consent. Detailed consideration of those issues and some practical guidelines on the rights of clients are highlighted in box 5.

4. Service standards and accreditation

There is a growing interest in the development of accreditation systems for substance abuse treatment services. Accreditation relates to a system of assurance that a service provider meets a set of performance standards and the existing legal regulations relating to the organization, management and delivery of treatment.

One of the most developed accreditation systems is that of the United States. The Centre for Substance Abuse Treatment oversees the United States accreditation system for substance abuse and provides technical assistance to enable service providers to meet the accreditation standards [11]. Box 6 describes the initiative of the Inter-American Drug Abuse Control Commission (CICAD) to support the development of standards of care in the western hemisphere.

5. Quality and operational issues

Many countries operate quality control and clinical and other service standards that are supported by national and international law. Those standards may cover environmental issues and matters such as building safety, the privacy of clients in residential care, adequate accommodation (heating, lighting, food etc.) and related facilities. National clinical governance regulations may also require certain organizational policies and practices by law, including:

- Management bodies and committees of a certain size and composition;
- Client record keeping and data security issues;
- Procedures for risk assessment and professional disclosures without consent (for example, in situations where clients are judged to be a risk to themselves and/or to others);
- Legal registration, with a government agency, of the agency providing treatment;
- Procedures for the storage and disposal of controlled medications;
- Obligations relating to staff under the employment law.

Examples of initiatives relating to standards of care are given in boxes 7 and 8.

Box 7

Development of minimum standards of care for drug abuse and dependence treatment programmes in Nicaragua

The Government of Nicaragua is in the process of developing minimum standards of care for drug abuse and dependence treatment centres or programmes, under the coordination of the Executive Secretary of the National Council against Drugs and the Ministry of Health. As part of that process, a workshop aimed at developing consensus and facilitating the drafting of the standards was organized in Managua in January 2002, within the framework of a UNDCP-supported regional project. A total of 31 participants from different government sectors in charge of related matters (health, family, drug control and criminal justice), as well as from State and non-governmental treatment service providers, contributed to the workshop. That level of participation was essential to develop standards of care that responded to the Nicaraguan reality.

The overall goal of the planned minimum standards of care was to improve the quality of care at public and private centres or through programmes offered to people with problems caused by drug consumption. The identified immediate objectives of the standards were as follows:

- To serve as reference and guidance for the work of treatment institutions;
- To establish nationally uniform criteria for the evaluation of the quality of care at public and private institutions;
- To identify the factors that are associated with non-compliance with the newly established national standards of care.

The workshop was based on a participatory methodology that included working groups, brainstorming sessions, discussions and presentations of participants. The main outcome of the workshop was a consensus document containing a total of 87 standards of care grouped in the following categories:

- Access, availability and admission criteria;
- Client assessment;
- Nature, services and organization of treatment;
- Treatment discharge, follow-up and case referral;
- Service coverage and rapid intervention;
- Client rights;
- Physical infrastructure of treatment centres;
- Staffing.

The group agreed on an action plan for the design and implementation of a system to monitor compliance with the agreed minimum standards of care. The action plan set specific target dates and established committees in charge of carrying out the actions agreed upon. A coordinating committee led by the Department of Mental Health of the Ministry of Health was to develop the final document for pilot testing. The monitoring system was expected to be in place by the end of 2002.

Box 8

Minimum standards of services in India

In accordance with its mandate for coordinating the alcohol and drug demand reduction strategy of the Government of India, the Ministry of Social Justice and Empowerment, for the last 15 years, has been implementing a wide range of community-based programmes, through the voluntary sector, for the prevention of alcoholism and drug abuse and the treatment and rehabilitation of addicts.

The community-based organizations associated with the programmes have been engaged in a wide variety of innovative, needs-based, localized interventions, adapted to the needs of the community in general and the target groups in particular.

Training programmes, meant for the service providers, on the principles and practices of care and protection in substance abuse rehabilitation have, over the years, set certain minimum standards of services among the rehabilitation professionals.

However, considering the size of the country, the wide variety of sociocultural settings and the varying degrees of capacity among the implementing agencies, the need has long been felt to identify the best practices in the delivery of services and to codify them into a set of guidelines that could be uniformly applied to all the implementing agencies as minimum standards.

The *Manual on Minimum Standards of Services for the Programmes under the Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse* is a result of that effort. With "whole person recovery" as the avowed objective, the *Manual* defines the essential components involved in alcohol and drug demand reduction programmes under the Scheme, the minimum infrastructural requirements for each component, the nature and quality of services, the activities involved in delivery of different services, the inputs and the anticipated outputs for each activity, the mandatory records to be maintained etc. It has also laid down the framework of networking and linkages between the services and institutions to ensure holistic interventions and optimum utilization of resources. Besides standardizing the experiences into practices, it would also ensure an objective performance-based evaluation of the programmes.

The Manual has defined a code of ethics for the service providers, based on recognition of the rights and duties of the clients. That is intended to ensure a positive, empathetic and caring environment within the institutions.

The Manual, if implemented sincerely by the partners, the Government and non-governmental organizations, is expected to usher in a new era of quality-based services through voluntary organizations in the social sector. It would also pave the way for continuous review and refinement in standards through new experiences and increasing maturity in the implementation of programmes.

Source: Foreword to Asha Das, Manual on Minimum Standards of Services for the Programmes under the Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse (New Delhi, Ministry of Social Justice and Empowerment of India, 2001).

6. Regulation of pharmacotherapies

A specific legal requirement concerns the provision of medical drug abuse treatments that involve use of a therapeutic drug to treat drug dependence. The most commonly prescribed substitute medication is methadone for opioid dependence. International drug control conventions require that controlled substances that are supplied or dispensed to individuals be done so via medical prescription only. That prescription can only be made by an authorized (or licensed) medical practitioner. There may also be legal controls on various aspects of pharmacotherapies including:

- Authorized institutions and/or personnel who can provide different treatment modalities;
- The formulation of the medication allowed (commonly only oral form);
- Conditions for dispensation of controlled drugs (for example, whether the client is able to self-medicate without supervision);
- Specified maximum dose levels for treatment induction and subsequent maintenance phases;
- Eligibility criteria for substitution treatment (for example, minimum age, previous treatment attempt or minimum length of time dependent);
- A requirement for regular biological testing of clients for illegal drugs.

7. Fiscal and contractual issues

There is enormous variation internationally in the human and financial resources available to support treatment efforts and the legal provisions that govern their deployment. No matter how modest those resources, an effective strategy should describe the level of investment that can be expected and how it is allocated to support treatment services. That may involve, for example, national health systems funded through individual taxation and insurance, mixed economies of public and privately operated treatment services, or exclusively privately funded services.

Treatment providers may have legally binding contractual arrangements with funding or sponsoring bodies that provide financial resources for the delivery of treatment. Those arrangements may refer to:

- The provision of a specified volume of service in a defined period;
- The duration of any agreement for service and exit clauses and contractual infringement aspects;
- Specified penalties for failure to provide care of a sufficient volume or quality;
- Obligations on the part of the funding body or payer concerning the timing of payments for treatment and other financial arrangements.

There may be reciprocal arrangements in operation between two or more countries that allow individuals to be treated in another country. Such arrangements operate in the European Union for example.

8. Informal and formal pressures to enter treatment

The motivation to seek treatment may involve various forms of pressure, both informal and formal (legally based). Concerns about damage to family relations and their financial situation may be in the mind of some who decide to enter treatment. Others may be concerned about the loss of employment and agree to enter treatment under a formal referral by their personnel or medical department.

Direct coercion into treatment can take place in the form of legally mandated treatment, although many jurisdictions require the informed, written consent of the person concerned. The written consent also provides an important act of responsibility-taking by that person, which can be built upon during the programme, while providing some measure of accountability to help break through any later obstacles to progress.

Such a measure can be a cost-effective and rehabilitative alternative to incarceration for drug abuse offenders. In order for it to be effective, an adequate strengthening of the treatment system, intensive coordination and teamwork between justice and treatment agencies, and ongoing evaluation must support legal provisions. Importantly, legal provisions must be carefully drafted, as they imply restrictions on the basic rights to freedom and security of the individual.

9. Treatment in the criminal justice system

Individuals with substance abuse and dependence have a relatively high likelihood of contact with the criminal justice system. Referral initiated by the criminal justice authorities, community treatments and prison-based rehabilitation programmes can form part of the overall treatment system. The high prevalence of substance abusers in the prison system has led to special health services, as well as drug dependence treatment and rehabilitation programmes being established within penal institutions.

In many countries, legislation provides for the diversion of drug-dependent persons from the criminal justice system into treatment and rehabilitation programmes. In some approaches, the police can allow a detainee access to a specialist drug abuse referral worker who can undertake a needs assessment and recommend a specific treatment programme. The court may take that contact and assessment into account and may itself offer a convicted individual the chance to enter a community treatment service as an alternative to a custodial sentence. That alternative to punishment is governed by strict requirements to attend and comply with a treatment regime. In the event of non-compliance, the person may be terminated from the diversion programme, and the case returned for traditional criminal justice processing.

Some jurisdictions offer substantial incentives to remain in treatment and succeed. For example, in Bermuda, if a participant is drug-free and has not reoffended by the end of the first 12 months of a drug treatment court programme, the original offence charged may be cancelled. If those conditions still hold after two years, the person's entire criminal record may be expunged.

In some countries, the prevailing political and legislative situation means that offending drug abusers are likely to receive a custodial sentence without referral to treatment. In those situations, arguments for the value of developing a treatment referral option in the criminal justice system will need to be couched in terms of the likely cost-effectiveness of such a policy.

UNDCP has established an online legal library that provides details of those and other related legal issues (see box 9).

Box 9
UNDCP online legal library

The UNDCP online legal library makes available the full text of laws and regulations promulgated by States to give effect to the three main international drug control treaties. Under the treaties, States have an obligation to communicate their drug control legislation to the United Nations. Most States communicate such legislation to UNDCP on a voluntary basis. Initially, only legislation adopted since 1990 has been included online.

The updating of the legal library holdings relies on the communication by States of their updated legislation. Therefore, UNDCP cannot guarantee that the user will always find the latest legislative status of every country.

States having adopted legislation that has been incorporated into the database, and that contains specific provisions on drug treatment, include Austria, Cyprus, France, Germany, Greece, Italy, Kenya, Nicaragua, Poland, Portugal, South Africa, Spain, Sweden, Thailand and the United Kingdom.

For further information, go to
http://www.undcp.org/legislation.html.

C. Developing and implementing an effective treatment strategy

In the present final section of chapter II, attention is directed to 11 areas that should be considered as part of the development and implementation of a treatment strategy. Those areas are as follows:

- Involving partner agencies;
- Involving service users and the community;
- Ensuring policy commitment;
- Conducting sound assessment and planning;
- Allocating resources in accordance to needs;
- Building on research evidence;
- Developing an incremental and step-by-step approach;
- Fostering collaboration, coordination and integration;
- Building on community-based responses;
- Ensuring service availability and accessibility;
- Monitoring performance.

1. Involving partner agencies

In a number of countries, drug abuse treatment is predominantly provided within the health sector, while, in other countries, it tends to be provided by social welfare agencies or predominantly in the criminal justice system. While the balance of the contributions of the health, social and criminal justice sectors may vary over time, ideally all sectors should be involved.

In addition to helping people to stop using drugs, treatment services also focus on attaining immediate health benefits through reducing harmful drug-taking and associated behaviour that poses a health risk. Specialist treatment programmes also need to collaborate with other service providers to resolve the range of health, behavioural, social and economic problems confronting individuals and families affected by drug abuse.

It is important to be aware of the wide array of agencies that can be involved in modern treatment systems. There are public sector or government-funded agencies as well as private sector, non-governmental and other

community-based, including religious, organizations. In addition, other forms of traditional healing and social support can play a role in the overall organization and delivery of comprehensive treatment systems. Primary health and social care and community-based interventions are critical components if the treatment system is to be accessible and a broad public health and population-based approach to treatment planning and service provision is to be used.

2. Involving service users and the community

There is increasing recognition that treatment service users are part of the community and that the process of service development needs to be accountable to and shaped by the wide range of community interests. Service users play an important role in helping to shape an approach that ensures appropriate accountability and responsibility of all those involved in providing services. The involvement of service users in strategy development aims at promoting the following:

- Individual behaviour change;
- Improvement of the responsiveness of health services to user needs;
- Improvement of the utilization of health services;
- Community-oriented interventions;
- Supportive public opinion and health policy.

In the planning process, an effort should be made to contact and involve those groups that are likely to be affected by the development of the strategic framework or system of treatment. That can lead to local support and advocacy for treatment. The reduction of any local resistance to the development of a drug abuse treatment service in a local area should be a key objective.

When planning developments in treatment, it is important to consult with a broad range of individuals and groups in the community, including:

- Local community organizations;
- Clients of existing services;
- Client advocacy and representative groups;

Box 10

Developing the national drug strategy of Ireland: the power of public consultation

The Government of Ireland developed a drug strategy during 2000 for the period 2001-2008. Part of the process of development was to engage in a wide consultation process with the public.

A review of the existing strategy included the extensive consultative process, research focused on international examples of best practice and an examination of various relevant evaluation reports and other literature. All statutory authorities and key community stakeholders and professional groups were invited through national newspaper advertisements to submit views on existing gaps and to recommend new approaches or, if necessary, new arrangements through which to deliver a new drug strategy.

Eight regional consultation forums were conducted throughout the country. At the forums, the Minister responsible for the drug strategy presented an overview of the current strategy, followed by presentations from the sectors of health and education, and from non-governmental organizations and the police. An open forum discussion with questions and answers was held. That was followed by workshops on the key areas of risk reduction, treatment and rehabilitation, supply reduction, education approaches and other issues, including emerging drug problems and gaps in the current strategy. Subsequently, 34 groups representing government departments, agencies, service providers and other interested parties were invited to meet the Minister and members of the Review Group to discuss their respective contributions to overcoming the drug problem and to explore how they might address issues emerging from the forums.

Written evidence and oral presentations from key stakeholders were also given. The topic was then debated in both the Senate and the Parliament and, finally, a detailed action plan and a timeline for implementation was published.

The overall aim of the drug strategy of the Government of Ireland is to provide an effective, integrated response to the problems posed by drug abuse. Three basic principles underpin the strategy:

- The response to the drug problem must take into account the different levels of drug abuse being experienced around the country;
- All programmes and services that respond to the drug problem should be delivered in a coherent and integrated manner;
- Communities experiencing the highest levels of drug abuse should be encouraged to participate in the design and delivery of the response to the problem in their areas.

For further information, go to **http://www.gov.ie/tourism-sport/pressroom/archive/ndstrategy01-08.pdf**

- Drug abusers who are not in treatment;
- Parent groups and other concerned community and
- Representative bodies of professional groups;
- Social welfare and community agencies;
- Clinical staff;
- Existing drug abuse programme managers and administrators;
- Health-care providers and organizations;
- Official policy makers and strategic planners;
- Government agencies in the areas of health, social welfare and justice;
- Technical advisers (as required).

The value of extensive consultation to support and give direction to the strategy is highlighted in the national drug strategy of Ireland, described in box 10.

3. Ensuring policy commitment

At the political level, it may be necessary to seek support for interventions that might otherwise be seen as inappropriate. In some countries, for example, there are political and community objections to some forms of pharmacotherapy programmes to alleviate drug dependence. Public policies influence both the adverse consequences of drug abuse as well as the likelihood of developing effective treatment responses. At the same time, there is a widespread expectation that the investment of national resources into treatment will have a beneficial impact on reducing harms and inequalities. Governments have a natural inclination to require arrangements to be put in place to monitor performance and outcome and to demonstrate a "return on investment". In a wider context, a commitment by the Government to a regular review of the legal framework concerning substance abuse and treatment provision is also advantageous, and, in some countries, specialist professional advisory bodies are employed to inform that process.

4. Conducting sound assessment and planning

Effective treatment responses are based on sound assessment. The present *Guide* provides the technical means for assessing and developing needs-based interventions associated with substance abuse. Needs-based assessments allow the matching of resources, both human and technological, to the problems as they manifest themselves in the community. They also ensure that services are located where there is the greatest need. Further guidance on how to assess the nature and extent of the need for treatment in a particular locality or country is provided in chapter III of the *Guide*.

5. Rationalizing resource allocation in accordance with needs

In some countries, valuable experience has been gained in revising and refocusing the current strategy for the treatment of drug abuse. That process involves an analysis of existing needs and resources and a reallocation of resources in accordance with a set of predefined need indicators. The example shown in box 11 reflects such a process, where the selected indicators for the prioritization of health services in the respective catchment areas were the prevalence of drug abuse, the human development index, investment by other sectors and the potential for treatment expansion.

6. Building on research evidence

International research has provided a well-established evidence base for the effectiveness of some types of treatment, and that has done much to make the case for treatment provision to Governments and service funders. However, the evidence is far from complete, and some countries have to rely almost exclusively on treatment outcome and other research that has been conducted in other countries. It may be difficult to judge whether the findings from other countries can be fully applied to a particular cultural context, since there are often marked differences in the types of people who take part in outcome studies and in the structure and operation of the services studied. That may have led to an increasing commitment by Governments to build on the research evidence, and often a desire to employ and adapt international studies and experience, as a means of providing a sure footing for the national strategy.

7. Developing an incremental step-by-step approach

A systematic approach should be followed to ensure the best utilization of available resources for the development of drug treatment services. The type of services to be developed will obviously be determined by the amount of available local and national resources. While, in all cases, a combination of primary care and specialized services will be required, in many situations such services will need to be developed using a "building-blocks" approach. Where there is a major resource constraint, services will need to rely on the adequate training of personnel within community and primary care frameworks. However, as soon as resources become available, there is a possibility to add specialist services.

Box 11

Renewed national treatment and rehabilitation programme of Chile

Over the last 10 years, the public health sector in Chile, which covers 70 per cent of the population, has implemented a range of measures to deal with alcohol and drug problems. The main aspects of the action undertaken are as follows:

- Increasing human resources in the health services with the greatest need;
- Facilitating the stabilization of therapeutic communities;
- Training professionals in the addiction and rehabilitation field;
- Increasing the early detection of alcohol and drug abuse problems among primary health-care patients;
- Facilitating the reactivation of, and coordination with, self-help groups, especially multifamily groups.

A 2001 in-depth evaluation of treatment plans has resulted in a decisive course of action involving the collaboration of the Ministry of Health and the Consejo Nacional para el Control de Estupefacientes (CONACE) in a new strategy with the following key elements:

- Institutional alliance. The Ministry of Health and CONACE, together with the 28 health services (each responsible for the health needs of from 50,000 to 1 million people) and the National Health Fund, have established an alliance under which each party takes responsibility, as appropriate, for particular aspects such as financing, the establishment of norms, technical support and supervision, in order to ensure more extensive and qualified care of abusers;
- Adequate use of available information. Strategic decisions are based on objective information (for instance, last-month prevalence and addiction rates) provided by household surveys carried out by CONACE, which permit an estimate of potential treatment demand;
- Investment according to a needs hierarchy. Health services are ranked according to the characteristics of their catchment areas, and more resources go to those with a higher prevalence of consumption, a lower human development index, a higher potential for expanding treatment and a lower level of investment;
- Designing diversified services. Six treatment plans have been created and clinical protocols to support and guide the implementation of each plan are being drawn up. The plans are as follows:
    - First-response intervention plan, implemented by the primary health-care units:
    - Basic outpatient plan;
    - Intensive outpatient plan;
    - Residential treatment plan;
    - Withdrawal syndrome treatment plan (detoxification);
    - Dual diagnosis treatment plan;
- Financial transfers to treatment centres. Transfers are carried out regularly according to a previously estimated and agreed upon workload for each centre. Funds are received from CONACE through the mediation of the National Health Fund;
- Records. Treatment centres keep a standard system of records to allow monitoring of the services provided to patients, on a local and a national basis;
- Evaluation. Two studies have been conducted: a comparative study of treatment centres and their capacities and results; and a cost evaluation of the different treatment plans;
- Capacity-building. Programmes have been established for professionals and technicians working in rehabilitation, including staff training to ensure the required level of quality of care. Capacity-building also involves initiating a supervisory mechanism to solve difficulties.

The first 10-month evaluation demonstrates satisfactory levels of functioning in most of the nearly 200 operating treatment centres. Approximately 4,000 people have been or are in treatment. Coordination has been a significant burden to management, but client and staff satisfaction are on the rise. The next step, currently in a preliminary phase, will be an outcome evaluation based on information provided by regular data collection at each treatment centre, and on the results of the three- and six-month follow-up periods after discontinuation of treatment.

For further information, go to **http://www.conace.cl**

8. Fostering collaboration, coordination and integration

Treatment responses focus on multiple levels, including individuals, families, the immediate community context and the wider social environment. Core underlying principles of an effective intervention response include the need to encourage engagement at the level of the individual, families, services, communities, environments and policies. Treatment provision should also be seen in the context of a broad, collaborative approach aimed at the prevention of problems and linking schools-based and public education and communication initiatives with community-based advice, information and treatment provision.

No single treatment is appropriate for all individuals. Effective substance abuse responses depend on an integrated response at all levels including the community. Agencies involved in treatment programmes should not only work together but also integrate with related programmes. Integration may include the following dimensions:

- The integration of different types of demand reduction programmes, of which treatment and rehabilitation are a component, with each other;
- The integration of issues relating to illicit drug abuse with the abuse of other substances and with other general health issues, in particular HIV and acquired immunodeficiency syndrome (AIDS);
- The integration of demand reduction and supply reduction programmes as part of a comprehensive strategy;
- The integration of programmes related to drug abuse with those dealing with major social and humanitarian issues such as poverty, housing refugees, employment or rural development.

9. Building on community-based responses

Strategies for community-based treatment intervention are an effective means of delivering interventions. Many people affected by the adverse consequences of substance abuse may have limited contact with existing organizations. Innovative methods are needed in order to reach populations most affected by substance abuse. A community-based response involving local agencies and organizations, including outreach services, is a necessary component of a strategy that seeks to reach drug abusers who are not in contact with services. A community-based response aims at:

- Encouraging behaviour changes directly in the community;
- Actively involving local organizations, 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. If communities can establish a sense of ownership of facilities and services, the latter are much more likely to be successful and sustainable.

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,

Box 12
Community-based treatment in an Afghan refugee camp in Pakistan

A community-based drug treatment, rehabilitation and prevention programme was initiated by 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 organizations, other United Nations agencies, volunteers and community groups. During 2000, the programme made contact with 800 (male and female) drug abusers in the refugee camp. Over 300 drug abusers 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 community networking, to be successful and effective and to prevent relapse.

rather than on a community-based approach that tries to establish an integrated model of drug abuse treatment. Thus, while obviously both types of approaches are necessary, and ideally should be complementary, it is necessary 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 12.

As seen in box 12, 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. The only infrastructure developed in the previous example, the Community Drug Treatment Programme Centre, was designed as a base for outreach activities including detoxification and family counselling, volunteer training etc. Community drug treatment meant precisely that-treatment in the community.

10. Ensuring service diversification, availability and accessibility

Key determinants of effective service delivery include diversification, availability and accessibility. Services need to be effective in making and retaining contact with target populations. They need to be able to provide a variety of services in order to be responsive to the health and service needs of the target populations. The key ingredients include:

- Being user-friendly;
- Geographical accessibility;
- Economic affordability;
- Community-based response;
- Provision of an adequate, coordinated mix of agency-based and non-agency-based services;
- Encouraging client participation and involvement;
- Providing secondary prevention as well as treatment;
- Services that are flexible and open to improvement and change.

11. Monitoring performance

Achieving major goals for any strategy is usually a result of partnership and combined efforts between different organizations. In order to monitor progress, a performance management framework is used by many countries for each of the elements in a strategy. Two examples of performance management frameworks are provided in boxes 13 and 14.

Each goal of a strategy should have a core objective and a set of indicators and targets in the short, medium and longer term. Those indicators should, as far as is feasible, meet certain criteria. In particular, they should:

- Be specific and easily interpretable;
- Be measurable;
- Be time-bound;
- Be sensitive to change and thus capable of reflecting progress in tackling drug abuse;
- Be feasible and affordable, in terms of a viable, economic and sustainable measurement and reporting system;
- Be informed by international performance indicator systems and United Nations global reporting systems (see chapter VII, section B, subsection 1);
- Provide valuable information for strategy evaluation and local planning.

Box 13
The performance management framework in the United States

The Office of National Drug Control Policy in the United States has developed a performance management framework based on the following structure:

Strategy	*Goals*	*Objectives*	*Targets*	*Measures*
The strategy is to reduce drug use (demand), drug availability (supply) and consequences thereof.	The goals define the major directives or directions of the strategy.	The objectives define major lines of action to achieve the desired goals.	The targets define desired end states with which to compare actual performance.	The measures represent means (variables and events) for tracking progress towards targets

The United States approach is to develop a clear diagram called "logic model" that describes how various stakeholders, including the central and local Government and various non-governmental organizations, contribute to achieving the strategy.

Box 14

Development of performance indicators in Wales

The Welsh National Assembly has set out the strategic plan for Wales, "Tackling Substance Misuse in Wales: a Partnership Approach", based on the setting and monitoring of performance indicators as a means of highlighting goals and monitoring progress. Four central strands underpin the national strategy: children, young people and adults; families and communities; treatment; and availability.

The key performance indicators for the treatment strand and additional and supporting indicators are described below.

The key performance indicators for the treatment strand are designed to increase the number of participant substance misusers in substance misuse treatment programmes by 40 per cent in 2002; by 70 per cent by 2005; and by 100 per cent by 2008. Those targets are increases on the estimated baseline of people in treatment before 2002. The additional supporting indicators are designed to reduce the health and social damage that substance misusers inflict on themselves.

Other indicators are designed to:

- Increase the number of problem substance misusers in contact with substance misuse services;
- Increase access to appropriate services for people with dual diagnosis of substance misuse and mental health problems;
- Reduce the time spent by substance misusers waiting for an assessment of their needs;
- Reduce waiting time between assessment of need and availability of treatment;
- Reduce the proportion of drug misusers who inject and the proportion of those sharing injecting equipment over the previous three months;
- Reduce the number of deaths relating to substance misuse.

Key points

The key points covered in chapter II of the *Guide* are as follows:

- A strategic framework is a critical element of an integrated and successful treatment response;
- There is a need to see treatment within the context of broader demand reduction policies, which are encompassed in the national drug control master plan or the national policy framework;
- The framework should emphasize the importance of broad community involvement and consultation with a full range of stakeholders;
- The framework clarifies roles of policy makers, planners and providers of services and reflects key guiding principles of an effective treatment response;
- The key elements of a strategic framework are:

  (i) Description of the population affected by drug abuse;
  (ii) National statement setting out values, principles and goals and objectives;
  (iii) Identification of priority areas with clear goals and measurable objectives;
  (iv) Specification of the governing body of the strategy, as well as of the governmental and non-governmental agencies involved and their shared responsibilities and role expectations;
  (v) Mechanisms for community involvement and representation;
  (vi) The legislative framework;
  (vii) Specification of the types of treatments to be developed and action to be taken to that end;
  (viii) Financial and human resources available;
  (ix) Realistic outcomes and methods of assessing their attainment;
  (x) Monitoring, review and communication arrangements to support the strategy;

- The guiding principles of an effective treatment strategy are:

  (i) Involving all partner agencies in strategy development;
  (ii) Involving service users and the community;
  (iii) Ensuring policy commitment by Governments and official agencies;
  (iv) Conducting sound assessment and planning;
  (v) Building on research evidence;
  (vi) Rationalizing resource allocation in accordance with needs;
  (vii) Developing an incremental and step-by-step approach;
  (viii) Fostering collaboration and integration of different programmes;
  (ix) Building on community-based responses;
  (x) Ensuring service diversification, availability and accessibility;
  (xi) Planning for monitoring performance.

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Legislation and regulatory issues

Porter, L., Argandona, M., and Currant, W. J., *Drug and Alcohol Dependence Policies, Legislation and Programmes for Treatment and Rehabilitation* (World Health Organization, Geneva, 1999).

Standards of care

WHO Programme on Substance Abuse, *Assessing the Standards of Care in Substance Abuse Treatment* (World Health Organization, Geneva, 1993).

Internet resources

National treatment policies and strategies

National Drug Strategy, Australia
http://www.nationaldrugstrategy.gov.au
National Illicit Drug Strategy, Australia
http://www.health.gov.au/pubhlth/strateg/drugs/illicit/index.htm
New South Wales Office of Drug Policy, Government Plan of Action, Australia
http://www.druginfo.nsw.gov.au/pdf/plan.pdf
National Anti-drugs Council, Brazil
http://www.senad.gov.br/ingles/botoes.htm
Drug Strategy, Canada
http://www.hc-sc.gc.ca/hppb/cds-sca/cds/pdf/englishstrategy.pdf
http://www.hc-sc.gc.ca/hppb/cds-sca/cds/pdf/profile.pdf
(Profile substance abuse treatment and rehabilitation in Canada)
National Narcotics Control Council (CONACE), Chile
http://www.conace.cl
National Strategy, Spain
http://www.mir.es/pnd/presenta/html/national.htm
Consensus Statement on Drug Treatment, Finland
http://www.aka.fi/users/132/1623.cfm
Three-Year Plan to Fight against Drug Use and to Prevent Dependence, France
http://www.drogues.gouv.fr/uk/index.html
Treatment and Rehabilitation in Hong Kong
http://www.info.gov.hk/ne/text/treat/index.htm
National Drug Strategy, Ireland
http://www.gov.ie/tourism-sport/pressroom/archive/ndstrategy01-08.pdf
Progress Report on the Drug Policy in the Netherlands (1999-2001)
http://www.minvws.nl/documents/gvm/Rapport/drugs-progress-eng.pdf
National Drug Strategy, Portugal
http://www.ipdt.pt/biblio/LDroga/enlcd_eng/estrategia_eng.pdf
National Action Plan, Portugal
http://www.ipdt.pt/biblio/LDroga/horizon2004_eng/horizon2004_eng.pdf
Drug Policy, Switzerland
http://www.bag.admin.ch/sucht/politik/drogen/e/drugpol.pdf
Drug Policy, Thailand
http://www.oncb.go.th/e1-frame02.htm
Home Office, Drugs Prevention, United Kingdom
http://www.homeoffice.gov.uk/atoz/drugs.htm

Government Strategy on Drug Abuse Treatment, United Kingdom
http://www.archive.official-documents.co.uk/document/cm39/3945/3945.htm
http://www.archive.official-documents.co.uk/document/cm39/3945/aim-3.htm
(Aim (iii): Treatment-To Enable People With Drug Problems to Overcome them and Live Healthy and Crime-free Lives)
Office of National Drug Control Policy (ONDCP), United States
http://www.whitehousedrugpolicy.gov/policy/policy.html
http://www.whitehousedrugpolicy.gov/publications/policy/ndcs01/chap3_2.html
(National Drug Control Strategy 2001, Treating Addicted Individuals)
Changing the Conversation, A National Plan to Improve Substance Abuse Treatment, United States
http://www.natxplan.org
Drug Strategies of European Countries, EMCDDA
http://www.emcdda.org/policy_law/national/strategies/strategies.shtml

Legislation and regulatory issues

Approval and Monitoring of Narcotic Treatment Programs: A Guide on the Roles of Federal and State Agencies, United States
http://www.treatment.org/taps/tap12/TAP12toc.html
http://www.treatment.org/taps/tap12/TAP12exhibita.html
(Major federal legislation on addiction treatment in the United States)
http://www.treatment.org/taps/tap12/tap12appe.html
(United States regulations on confidentiality of alcohol and drug abuse patient records)
http://www.treatment.org/taps/tap12/tap12appc.html
(United States regulations on drugs used for treatment of narcotic addicts)
(http://www.treatment.org/taps/tap12/tap12appf.html)
(Definitions used in United States treatment regulations)
Consumer Bill of Rights and Responsibilities: Implications for Mental Illness and Chemical Dependency Programmes and Practices, Substance Abuse and Mental Health Services Administration (SAMHSA), United States
http://www.samhsa.gov/mc/content/cbr/index.htm
Credentialing Bodies, Certification Requirements for Drug Counsellors, United States
http://www.nattc.org/getCertified.html
Opioid Treatment Programs Accreditation Project: Program Information, United States
http://www.samhsa.gov/centers/csat/content/opat/otpaccr.html
Standards of Care in Drug Abuse Treatment, Inter-American Drug Abuse Control Commission (CICAD)
http://www.cicad.oas.org/en/demandreduction/Projects/Standards.htm
UNDCP Online Legal Library
http://www.undcp.org/legislation.html
UNDCP Expert Working Group report on best practice in planning, establishing and running drug treatment courts
http://undcp.org/legal_advisory_expert_working_groups.html
UNDCP model drug court legislation
http://undcp.org/legal_advisory_model_legislation.html

Chapter III

Assessing treatment needs

In chapter II of the *Guide*, the rationale, structure and development of national responses to drug abuse and the place of treatment services within the strategy are described. In chapter III, the nature and extent of the need for treatment in a particular locality or country are examined. The matters covered include the following: the nature and content of a needs assessment; identification of the major problems to be dealt with and the main services likely to be needed by different populations affected by drug abuse; and determining the key steps that should be followed to conduct a needs assessment.

Detailed methodological guidance on specific techniques used to carry out assessments is not included in the *Guide*. The reader is referred to more specific resources on that subject, such as the guidelines and workbooks on treatment evaluation developed by UNDCP, WHO and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (see box 41).

The benefits of reading and using chapter III of the *Guide* are as follows:

- Clarification of the rationale for conducting a needs assessment and what can be expected from it;
- Understanding of the linked steps that can be followed when undertaking and using the results of a needs assessment;
- Conceptualization of the overall target population of drug abusers in terms of subgroups that are likely to have specific treatment needs;
- Understanding of major problems and the main services needed for each subgroup of drug abusers and each priority group.

The target audience for chapter III is policy makers, technical advisers and treatment service providers at national and local levels. The material in chapter III is designed to assist those partners and their advisers in considering how best to assess the needs for treatment of the drug-abusing population as a basis for the development of a national strategy or a local treatment initiative.

The treatment needs of populations with substance abuse problems vary both within and between countries, mainly because of the differences between prevalent drug problems, target populations, existing service systems and resources available for the service systems. Undertaking a needs assessment, however modest and rapid, should be an essential element in all planned treatment systems. A needs assessment approach is just as valuable in the development of new services as it is for the audit and review of an existing treatment system.

Chapter III is divided into three sections. Section A introduces the concepts and rationale for conducting a needs assessment and summarizes its overall structure. In section B, a ten-step sequence that can be followed to implement the exercise is introduced and several important points for conducting a needs assessment are discussed. Section C presents different subgroups in the population of drug abusers that need to be taken into account when conducting a needs assessment.

A. Nature of a needs assessment

A needs assessment, similar to a rapid situation assessment, is a research methodology using a combination of several quantitative and qualitative data collection techniques in order to assess the nature and extent of certain health and social problems such as drug abuse and the current ability of a community to respond to those problems. It may not be immediately obvious to all why a needs assessment should be carried out.

1. Concept of need

"Need" may be defined as what an individual might benefit from by accessing the treatment system. That concept can also be applied to the total population in terms of an aggregate level of benefit. The concept of need may or may not correspond to what an individual wants from treatment. A needs assessment is therefore a systematic exploration of the current status of a single individual or a group with drug abuse problems and of the changes that they and others consider necessary to

improve their health and social status. In this part of the *Guide*, the assessment of group needs (at local, regional or national level) rather than individual needs assessment is discussed.

It is important to have a clear conceptualization of the need for treatment and of the epidemiological aspects of drug abuse. An example of such a framework has been used in the United Kingdom for considering major disease conditions and how they should be best treated (see box 15).

Box 15
Structure of the epidemiologically-based framework for needs assessment in the United Kingdom

The Department of Health and National Institute of Clinical Excellence of the United Kingdom has funded wide-ranging reviews of the framework for needs assessment for major disease conditions, including drug and alcohol abuse, together with several other conditions, including cancers, diabetes, renal disease, obesity, hypertension and peripheral vascular disease. Each framework document uses a standard structure and presents the best available epidemiological and treatment-service-related information. The structure is as follows:

- Statement of the problem;
- Subcategories;
- Prevalence and incidence;
- Services available and their costs;
- Effectiveness and cost-effectiveness of services;
- Quantified models of care and recommendations;
- Outcome measures, audit methods and targets;
- Information and research requirements.

For further information, go to
http://hcna.radcliffe-online.com/main.html

2. Rationale for conducting a needs assessment

There may be obvious and visible signs of drug abuse in a particular community and a strong political and professional commitment to tackling the problem. On the other hand, many aspects of drug abuse may be hidden from view or information about the problem may be available from many disparate sources. A needs assessment therefore can provide considerable insight into the problem and can represent a concise exercise in marshalling information to serve as a basis for future planning. The needs assessment exercise does, however, require boundaries. It should set out priorities and the type of learning that is to be acquired, the resources and methods that are needed (or allocated) and the anticipated benefits from undertaking the project.

3. Components of a needs assessment

The components of a needs assessment may include:

- Contextual assessment: describing those structural, social and cultural factors that may influence the overall drug use and abuse situation;
- Drug use assessment: arriving at a comprehensive description of the drug use situation and associated problems using various tools, including reviews of the literature, interviews, focus group discussions (see annex IX), questionnaires and reviews of treatment service data;
- Resource assessment: identifying existing resources, such as funds, organizations and human resources;
- Intervention and policy assessment: assessing the nature, appropriateness and adequacy of existing specific interventions and policies.

As described in chapter II, many government agencies and treatment planning bodies undertake formal and informal needs assessment as part of their public consultation process. The results of a needs assessment can be used to inform the treatment strategy planning process, and that can include helping to make specific decisions about:

- The appropriate strategies that respond to the needs of various target populations (that is, which services to develop where);
- The allocation of financial and human resources;
- The mechanisms that are used to finance service delivery and the controls over those systems;
- How best to establish monitoring and evaluation arrangements to assess the outcomes of interventions.

Appraisal of the level of care needed by the target populations and commissioning of strategic service responses should be flexible and adaptable to changing circumstances in each locality, including:

- Variations and new trends in drug use and consumption patterns;
- The geographical distribution and concentration of drug abuse;

- Variations in demand for services;
- The changing relationship between drug use and other conditions (notably HIV infection and blood-borne viral hepatitis);
- Changing policy in response to drug strategy;
- Changes in the organization of health services;
- Results of the monitoring of the evidence base for current and new treatment services.

B. Designing and conducting a needs assessment

A needs assessment for drug abuse treatment has three basic elements: assessment of the nature and extent of drug abuse; appraisal of existing service responses (if any) and the gaps in provision; and identification of the necessary services and resources required to implement them.

1. Aims of a needs assessment

Those involved with the planning of treatment services should aim at determining:

- The type and likely size of the subpopulations that are abusing different drugs and that have treatment needs (see section C, subsection 1, below);
- The risks and harm conditions that require a specific intervention (see section C, subsection 2, below);
- The best options, methods and providers available for their delivery;
- The likely service capacity that is required for each intervention modality;
- How to choose between different providers of services (see section C, subsection 3, below);
- How best to monitor the provision of services and control expenditure on contracts (see chapter VII).

Detailed guidance in each of the steps involved is provided in the *Evaluation of Psychoactive Substance Use Disorder Treatment, Workbook 3—Needs Assessment,* developed jointly by WHO, UNDCP and EMCDDA [12]. Guidance can also be found in *Drug Abuse Rapid Situation Assessments and Responses,* describing the method developed by UNDCP [13] and in the method of rapid assessment and response developed by WHO [14]. Those resources are highly recommended to anyone wishing to undertake a needs assessment.

An audit of existing sources of information and the use of available data should be the starting point for the assessment of treatment needs. Many countries are investing in drug information systems that report on patterns of and trends in the drug abuse situation. It is therefore important to capitalize on the available information before embarking on any new data collection exercise.

2. Ten-step process for conducting a needs assessment

A ten-step process may be helpful in organizing the needs assessment. It should be noted that some steps can be done concurrently and that the starting point and sequencing may vary according to the scale and emphasis of the assessment exercise. Detailed guidance on practical aspects is provided in the above-mentioned publication *Evaluation of Psychoactive Substance Use Disorder Treatment, Workbook 3—Needs Assessment.* The ten steps involved are indicated below.

Step 1. Allocate resources and establish an agreed plan and methods for the needs assessment.

Step 2. Estimate the number of people in need of treatment in the target population and identify and profile subgroups and priority groups.

Step 3. Prepare a resource map of the treatment services provided in the locality, together with the services that are provided by facilities that are located in other areas.

Step 4. Conduct an audit of the demand profile of treatment services (capacity; number of episodes; and estimated number in need).

Step 5. Hold personal interviews with key informants across different stakeholder and professional groups to discuss strengths and weaknesses of current services and the areas of unmet need.

Step 6. Hold focus groups or other types of open discussions with key stakeholders to explore what they want from services.

Step 7. Compile a report containing an analysis of gaps in the current and desired profile of service provision, including the gap between financial and human resources and services needed or required.

Step 8. Offer recommendations for increasing treatment coverage, purchasing efficiency and service effectiveness based on available evidence.

Step 9. Undertake an assessment of reactions to recommendations from strategists, commissioners, service providers and service users.

Step 10. Develop an implementation plan based on the identification of activities, resources and timetables (see chapter V of the *Guide*).

The following points should also be noted in conducting a needs assessment:

- The communication of the key messages and results from the needs assessment should be considered very carefully. The format and content of reports will vary according to the target audience. Concise summaries will be required for policy makers, and reports on the technical detail of the needs assessment will be made available for their advisers as required. Community groups will want a digestible summary of the findings of the needs assessment and its implications;

- A needs assessment should be repeated on a periodic basis in order to respond to changing needs and circumstances.

An interesting example of a national needs assessment exercise that was conducted in Pakistan is summarized in box 16.

Box 16
National assessment of drug abuse in Pakistan, 2000

The Pakistan National Assessment Study, conducted by the Anti Narcotics Force Pakistan with the technical and financial support of UNDCP in 2000, consisted of a set of studies that provided a comprehensive picture of problem drug use in Pakistan. The objectives of the National Assessment Study included gaining an overview of the patterns of and trends in drug abuse and of perceived problems associated with the consumption of illicit drugs, as well as reviewing treatment provision in Pakistan. A brief description of each of the studies conducted as part of the National Assessment Study is given below.

A national contour mapping exercise using key informants to produce an overview of patterns and trends of drug use in the country was conducted in 36 urban and rural sampling sites. Those sites were selected to allow a broadly representative national picture of drug abuse in the country. Key informants in those sites were selected on the grounds that they had an informed understanding of drug abuse patterns and trends in their area. In total, 283 key informants representing medical professionals, non-governmental organizations, teachers, community leaders, religious leaders, the police and former drug users were interviewed for the study to elicit their perceptions of the current patterns and changing trends of drug use in their locality.

Interviews of addicts, including regular heroin and injecting drug users, were conducted in the four provincial capitals of the country—Karachi, Lahore, Peshawar and Quetta. In those cities, a total of 1,049 drug abusers were recruited and interviewed in almost equal proportions in street settings, treatment facilities and prisons. Through those interviews, information was elicited on the social and demographic profile of the drug abusers; their history of drug use; current patterns of drug abuse; injecting risk behaviour; treatment history; and incarceration for drug-related or other offences. Lifetime treatment contacts, mean age at first treatment contact and the time lag between regular drug abuse and first treatment contact were also explored in the study.

The third main study as part of the National Assessment Study involved an update of the national treatment register. In that exercise, the field workers visited 18 major urban centres in the country, updated the previous information on treatment services, and audited the type of treatment facilities and nature of services provided by each in the urban centres. They also collected information on the profile of the clientele served, the average occupancy rates within the treatment facilities and other related services provided by them.

The findings of the National Assessment Study indicated that a majority of the drug users in the study areas were in need of treatment, although many of them had not been able to access treatment mainly for financial reasons. The Government, non-governmental organizations and private services provided treatment and rehabilitation for people with drug problems. Non-governmental organizations appeared to be providing the broadest range of services and comprehensive care, while the government services were mostly focusing on the provision of detoxification. The study results suggested the need to expand the provision of community-based rehabilitation and aftercare services to supplement the inpatient detoxification currently provided predominantly in the government treatment facilities. There was also a need for affordable treatment services that responded to the needs of different population groups.

C. Estimating the size of the population in need

Clearly, it is important to understand the extent of treatment need within a community and the characteristics of those who are likely to be a priority for service provision. In many cases, precise estimates are not practical for the purpose of service development. Valuable information can be provided by techniques such as rapid situation assessment (see annex IX), focus groups and targeted community studies, which can provide insight into the type and extent of unmet treatment needs. Those methods have the benefit of being low-cost and relatively simple to implement, and that they do not require a large investment in time and other resources. Generating a more robust estimate of prevalence is desirable but technically demanding, and it requires a significant resource investment. A range of epidemiological methods including survey techniques, indirect statistical estimation methods and the use of data from ongoing surveillance activities can all be used to that end. For guidance on those issues, the reader is referred to the EMCDDA study *Estimating the Prevalence of Problem Drug Use in Europe* [15], and the UNDCP Toolkit Module 3: Indirect Methods for Prevalence Estimation.

1. Population subgroups

The heterogeneous population of drug abusers across the world can be divided into different subgroups for effective needs assessment and strategic planning purposes. At the highest level, the population may be grouped in terms of gender and age. The following general factors are important when considering the characterization of subgroups:

- Age, gender and culture;
- Socio-economic status;
- Education level;
- Pregnancy;
- Familial pattern;
- Type of drugs used, including quantity and frequency of administration;
- Acute intoxication (overdose liability);
- Extent of impairment and complications;
- Route of drug administration (oral, inhalation and intramuscular and intravenous injection);
- Nature of living situation and social and environmental supports and stressors;
- Available resources and other personal strengths.

Complex cases will usually (but not always) be characterized by drug-related impairment, dependence, regular injecting, high tolerance levels and concurrent problems across physical, psychological, personal and social functioning domains.

2. People with specific treatment needs

In addition to categorizing subgroups, there are eight priority groups with specific treatment needs that require consideration. Special attention should be given to responding to the needs of each of the following groups when planning treatment services:

- Young people and children;
- Women;
- Seniors;
- People who have drug problems and other psychiatric problems;
- People who are homeless;
- People from racial and ethnic minority populations;
- People who are HIV positive;
- People in the criminal justice system.

Each of the eight above-mentioned priority groups and their specific needs are described in annex I.

3. Subpopulation and service matching

People with drug abuse problems have different characteristics, problems and treatment needs. Consequently, treatment services must offer a range of approaches that should as far as possible be adapted to individual need. Although a wide range of services should be available for all drug users, a significant proportion of the resources should be allocated to specific target groups.

Putting aside the complexities of the number and combinations of different drugs that may be used, six non-independent (overlapping) population subgroups can be identified for the purposes of needs assessment. The characteristics of those subgroups have specific implications for the assessment of care needs and the planning and provision of treatment services. The subgroups are as follows:

- Non-dependent drug abusers;
- Injecting drug abusers;
- Dependent drug abusers;
- Acutely intoxicated drug abusers;
- Drug abusers in withdrawal;
- Drug abusers in recovery.

Each of the six above-mentioned subgroups is described in annex II. People in the six subgroups are not all the same, and each group must be characterized on the basis

of the severity of the problems to be dealt with (and the extent of any complications). It is also important to note that the above subcategories are not mutually exclusive. Indeed it is likely that a person will occupy more than one category at any particular point in time (for example, the injecting dependent heroin or cocaine user). The multiple occupations of different categories may also vary over time. In addition to those groups, a further category can be labelled "at risk". Of particular concern are segments of the younger population thought to be at risk, and prevention initiatives and general educational programmes are required.

It should also be stressed that the subgroups are not meant to convey a hierarchy of problem severity per se. Appropriate interventions should be based on a comprehensive assessment of need, a functional analysis concerning drug involvement and a programme of brief counselling and support. Such a process may then trigger the identification of other health and social care needs. It should also be stressed that some of the subgroups may be present in small numbers in a particular locality or country and that the mix of groups and problems will vary both within and across countries.

Box 17 summarizes the major problems experienced by each of the groups and the main types of services required to meet their needs.

As services for drug abuse are comprehensive and costly, a treatment setting may not be able to provide all services to all subgroups. In a community with many treatment settings providing services for drug abuse, some of them may be assigned responsibility for particular subgroups within the community. For example, while a drug treatment centre may be responsible for dependent drug abusers and those in recovery, a general hospital may be principally responsible for acutely intoxicated drug abusers and those suffering from overdose complications.

Box 17

Subgroups of drug abusers: major problems and main services needed

The Office of National Drug Control Policy in the United States has developed a performance management framework based on the following structure:

Subgroups of drug abusers	*Major problems*	*Main services needed*[a]
Non-dependent drug abuser	Negative consequences and risks of becoming dependent	Appropriate early interventions
Injecting drug abuser	Drug abuse, at risk for blood-borne infection and other medical complications	Drug abuse treatment programmes, HIV/AIDS education and counselling, needle and syringe exchange programme and medical care
Dependent drug abuser	Drug abuse disorders, health and other negative consequences	Drug abuse treatment programmes
Acutely intoxicated drug abuser	Acute behavioural disorders and overdose	Short-term medical and psychiatric intensive care
Drug abuser in withdrawal	Withdrawal symptoms	Short-term detoxification programme
Drug abuser in recovery	At risk of relapse to drug use	Rehabilitation and relapse prevention programme

[a]A variety of services are included in drug abuse treatment programmes, for example, intensive community and residential treatment, aftercare support and social and legal assistance.

Key points

The key points covered in chapter III of the *Guide* are as follows:

- There are two essential aspects of a needs assessment: the assessment of the size and characteristics of the population in need of treatment; and the assessment of the number, capacity, coverage, types, strengths and weaknesses of existing treatment resources;
- The nature and extent of substance abuse problems are often hidden from view and needs assessments can achieve valuable insights into the problem and *guide* future planning;
- An audit of existing sources of information and the use of available data should be the starting point for the assessment of treatment needs. Additional data collection can be undertaken, depending on existing data gaps and available resources;
- A needs assessment can be implemented using a ten-step process. Some of the 10 steps for a needs assessment can be done concurrently and the starting point and sequencing may vary according to the scale and emphasis of the assessment exercise;
- The needs assessment should investigate the needs of different population groups. Particular attention should be paid to the identification of the needs of groups of drug abusers frequently underserved by the treatment system, such as young people and children, women, seniors, people with psychiatric problems, people who are HIV positive, people who are homeless, offenders and minorities;
- Drug abusers may be classified into six subgroups, including non-dependent drug abusers, injecting drug abusers, dependent drug abusers, acutely intoxicated drug abusers, drug abusers in withdrawal and drug abusers in recovery;
- The above-mentioned groupings have important implications for treatment services and the skills needed to meet the different needs in the population;
- Needs assessment reports need to ensure that key messages are available for different audiences in the format required;
- Needs assessments should be repeated on a periodic basis.

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http://www.who.int/substance_abuse/PDFfiles/needsassessment.pdf

Internet resources

The epidemiologically based needs assessment framework in the United Kingdom
http://hcna.radcliffe-online.com/main.html

Rapid Assessment and Response, WHO
http://www.who.int/substance_abuse/pubs_prevention_assessment.htm

Chapter IV

Effective treatment and rehabilitation services

Chapter III of the *Guide* outlined the rationale and methods for conducting a treatment needs assessment. Assuming that there are identified gaps in service provision, the next question concerns what sort of treatment services should be made available. Chapter IV of the *Guide* asks the question: "What are the effective approaches for treating people with drug abuse problems?"

The benefits to be gained from reading chapter IV of the *Guide* are as follows:

- Clarity about treatments that are effective and supported by the research evidence;
- Clarity about the purpose of each approach in terms of the people it is designed to treat and the main goals and objectives of treatment;
- Understanding of the range of treatment services available.

Chapter IV of the *Guide* should be read in conjunction with the companion documents *Investing in Drug Abuse Treatment: A Discussion Paper for Policy Makers and Contemporary Drug Abuse Treatment: A Review of the Evidence Base.* Those documents present a summary international review of research studies that document the clinical, social and economic effectiveness of specific forms of treatment. Chapter IV of the *Guide* places that evidence in the context of the services that should be considered when planning a treatment response.

Policy makers and treatment planners are naturally interested in knowing which treatments for drug abuse are effective in dealing with the problem. Since there is no one single treatment that is effective for everyone, policy makers are also interested in knowing what range of treatments should be made available as part of a system of care and rehabilitation.

Clearly, providing effective treatment services requires investment of financial and human resources, and many countries may be unable to allocate sufficient investment to develop a fully comprehensive system. However, several scenarios can be envisaged, ranging from a basic to a comprehensive response. UNDCP advocates a building-blocks approach in which the basic elements of a comprehensive treatment system—the evidence-based treatments—can be added together over time, depending on the nature and extent of the problem, the level of fiscal resources available and the cultural and political context. In that regard, it is important to note that community-based day treatment is usually less costly than hospital inpatient and residential care and may be the best option in contexts where resources are at a minimum.

Chapter IV is divided into two sections. Section A summarizes the elements of a comprehensive treatment system that are supported by research evidence. Section B briefly highlights how to access information on research into treatment effectiveness.

A. Elements of a comprehensive treatment system

Globally, various terms and labels are used to describe treatments and referral and support services for drug abuse. The present *Guide* uses "open access" services and "structured treatments" as organizing terms. It is recognized that many countries will use alternative terms to describe their treatment modalities. Whatever terms or names are used to describe treatments, it is important that they are used consistently across the country. Furthermore, it will be beneficial if those involved in the treatment system share a common understanding about the overall purpose and operation of each treatment modality.

1. Open access services

Open access services are important elements of an integrated treatment response. Those services do not provide formal treatment as such, but act as important points of first contact for people who have drug-related problems and for those concerned about the drug use of another (for example, parents, siblings, spouses and friends). Open access services are sometimes called

"street agencies", reflecting their community location. They are often managed by non-governmental organizations, involving peer interventions, and can provide the following services:

- "Drop-in" (that is, non-appointment-based) service for accessing information and advice (health care, legal issues, housing, employment, training etc.), as well as basic survival services;
- Community outreach and advice; blood-borne virus prevention services, including education, counselling and syringe and needle exchange; and overdose prevention education;
- Appointment-based general counselling service;
- Telephone helplines for anonymous, confidential advice;
- Onward referral information and advocacy;
- Self-help groups;
- Family support groups;
- General community aftercare and support services.

An important member of the range of open access services is self-help groups for individuals and family members (for example, Narcotics Anonymous and Cocaine Anonymous). They are based on the original principles of Alcoholics Anonymous and are run by and for people who are recovering from drug dependence and who attend a group-based discussion and support session on a routine basis. Those and other community resources are also an important source of aftercare and support following structured treatment.

In some countries with high levels of drug injecting, policies to reduce the health and social consequences of drug use have led to the development of syringe exchange services that have become a central plank of prevention activities aimed at reducing blood-borne viral infection and other injection-related physical harms (abscesses etc.). Those initiatives promote improved hygiene during intravenous drug use and encourage the use of new syringes and the safe disposal of used injection equipment.

It is hard to overemphasize the importance of open access services. Some drug abusers may be reluctant to resort to specialized drug dependence services, and open access resources can be a critical place of first contact for them. It is common for someone with a drug abuse problem to resort to an open access service with a general problem—for example, a health problem, relationship difficulty or financial concerns—and their specific drug abuse difficulties may be disclosed in the course of their contact with the open access service. Specialized open access services, in particular those providing information and specific services to prevent overdose and the acquisition and transmission of blood-borne infection, are also of great importance as part of a community strategy to minimize the adverse consequences of drug abuse and as entry points to the treatment system.

2. Structured treatments

Succinct categorizations of treatments for substance abuse are surprisingly difficult to develop. In the present section, a summary of the main types of structured treatment are offered. Structured treatment characterizes services that are based on a formal assessment, the development, monitoring and review of individual plans for client care and a programme of medical treatment and/or counselling services. Some therapeutic programmes, in particular those delivered in a residential setting, are highly structured and involve an intensive schedule of individual and group-based educational, therapeutic and training sessions to promote rehabilitation. A schematic description of a care process is shown in box 18.

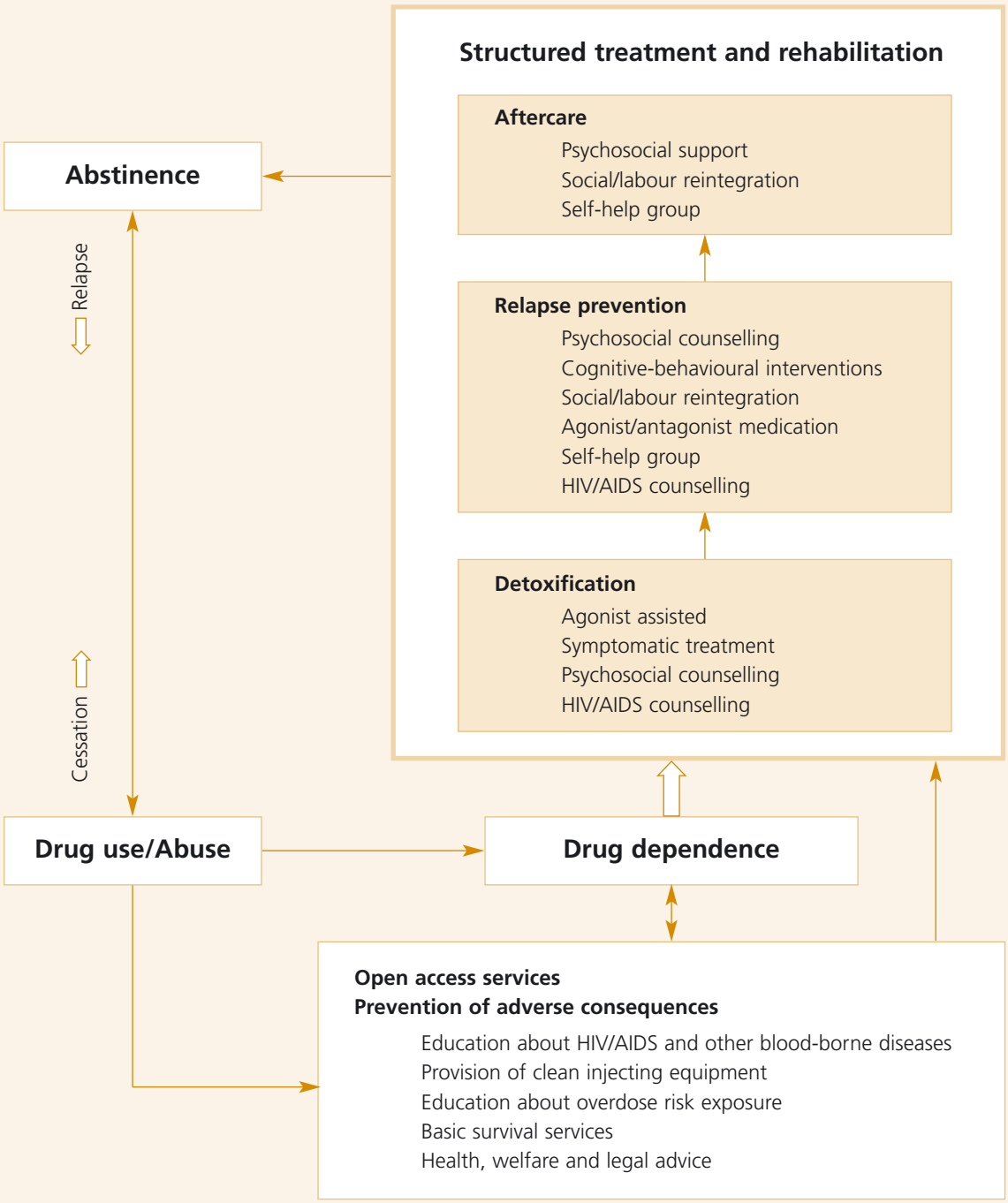
(a) Detoxification: stabilization phase of treatment

Medical detoxification is the initial and acute stage of drug treatment. Such programmes provide medically supervised detoxification to people with a drug dependence. People who are heavy, consistent abusers of certain drugs (opioids and sedative and hypnotic drugs) and are likely to experience withdrawal complications require medically supervised withdrawal (detoxification). A withdrawal syndrome that can develop after stopping the use of a drug will vary according to the type of drug the person was using. Common general features can include craving for the substance, anxiety, restlessness, irritability, insomnia and impaired attention.

Dependent users of psychostimulants, in particular amphetamines and cocaine, may also require medical supervision during the acute withdrawal phase following cessation of use. While there may be no direct physical withdrawal effects (and no prescribing of an agonist to minimize discomfort), the individual may have severe psychological problems (including induced psychosis) and sleep disturbance that may be managed by prescribing suitable medication.

The main goal of detoxification programmes is to achieve withdrawal in as safe and as comfortable a manner as possible. Various medications have been shown to be effective in opioid detoxification, including true analogues or agonists such as methadone, partial agonists

Box 18
Drug treatment and care process



such as buprenorphine and other non-opioid drugs that are called α_2-adrenergic agonists (lofexidine or clonidine). Some inpatient programmes use opioid antagonists under sedation or general anaesthesia (so-called ultra-rapid detoxification). In some countries, opiate products (including tincture of opium) are used as a detoxification agent. Withdrawal from benzodiazepines is usually achieved via use of a long-acting benzodiazepine (for example, diazepam).

On its own, detoxification is not in itself a rehabilitative treatment for drug dependence, and it is seldom effective in helping clients achieve lasting abstinence from drug use. Detoxification is better seen as a first phase of

treatment programmes that are aimed at abstinence and recovery.

Outpatient or community-based detoxification

Persons with a substance-induced disorder who are considered likely to be able to withdraw successfully in the community are suitable for assessment for outpatient or community-based detoxification services. Detoxification is usually initiated at the programme facilities or at the home of the client, with a period of stabilization using substitution agents. Following stabilization, the client is gradually withdrawn over a period ranging from a few weeks to several months. During that time, the client can be encouraged to receive counselling, medical treatment and other support services. In many ways some of those programmes are broadly comparable to outpatient or community-based maintenance programmes.

Short-term inpatient or residential detoxification

Persons who have a substance-induced disorder associated with a withdrawal syndrome or symptoms thereof, who are unlikely to be able to withdraw successfully in the community, and who may therefore need a controlled and medically supervised environment, are suitable for assessment for a short-term inpatient or residential programme. Most of those programmes proceed through a detoxification stage to a fairly brief structured relapse prevention, counselling and education phase with the offer of onward referral. It is important to note that some people in withdrawal will have additional physical and psychological problems (which may interact with the management of drug or alcohol withdrawal), and short-term inpatient programmes can provide an important opportunity for screening or managing those problems.

(b) Rehabilitation: relapse prevention phase of treatment

The rehabilitation or relapse prevention phase of treatment is oriented to the needs of persons who have either completed a formal detoxification or who have dependence but no formal withdrawal symptoms requiring access to the previous phase of treatment. Relapse prevention or rehabilitation programmes are designed to change the behaviour of clients to enable them to regain control of their urge to use substances. Psychosocial and pharmacological interventions are involved in that phase of treatment.

Psychosocial interventions

Community or day programmes. Community or day programmes offer a programme of psychotherapy or general counselling based on a care plan. The programme is usually individually configured to meet the needs of each participant using a case management approach. Case management is based on a comprehensive initial and ongoing assessment of existing problems, personal resources, social supports and stressors undertaken by a specialist clinician or worker. The assessment results in a set of personal treatment goals for the client, and progress towards those goals are monitored and reviewed at regular points over the course of treatment. Case management functions also include liaison and referral to other ancillary support services that are needed by the client and onward referral to other specialized programmes as required.

In many countries, most drug abuse counsellors use a client-centred, cognitive behavioural and motivational framework, and offer treatment that varies in duration from a brief intervention lasting from one to three sessions to a formal structured programme lasting several months. Structured drug-free day programmes are found in many countries. In the most intensive programmes, clients are expected to attend sessions on four or five days a week, for several hours each day. Treatment goals are based on helping the client to increase understanding and awareness of their drug-using behaviour, so as to reduce the negative consequences of drug use and to avoid drug-taking. In addition, individual and group counselling and education sessions may focus on HIV/AIDS issues, family relationships, vocational training, job integration, housing support and legal issues.

Planned counselling services offer formal structured counselling approaches with assessment, clearly defined treatment plans and goals and regular reviews, in contrast to advice and information, drop-in support and informal counselling. Community-based programmes may be provided as an alternative to residential rehabilitation programmes or as a stage following them.

Residential rehabilitation programmes. Two types of residential programme are available: short-term residential rehabilitation and long-term residential rehabilitation. Short-term residential rehabilitation programmes usually include a detoxification programme as a first stage and last for between 30 and 90 days. Long-term residential rehabilitation programmes generally do not provide medically supervised withdrawal and last for between six months and one year. The long-term residential rehabilitation model most commonly used is the "therapeutic community". Residential rehabilitation services share several features in common, including: communal living with other drug users in recov-

ery; group and individual counselling on relapse prevention; individual case management; improved skills for daily living; training and vocational experience; housing and resettlement services; and aftercare support. They are usually closely aligned with mutual-help groups such as Narcotics Anonymous and Cocaine Anonymous. Some residential programmes have second-stage or so-called halfway houses, which are semi-independent group living environments that are usually close to the main residential programme. They offer the client group the opportunity to prepare for their return to the community, while continuing to provide formal support as needed.

Pharmacological interventions

Substitution and maintenance programmes. Although abstinence is the primary goal in the majority of rehabilitation treatment programmes, substitution agents for maintenance purposes, such as methadone and buprenorphine, may be prescribed for people with opioid dependence. Clients suitable for maintenance treatment may present a history of failure in abstinence-oriented programmes. In a maintenance prescribing programme, a substitute substance is administered at a suitable and stable level for a period of several months and sometimes years. It is important to regard community prescribing as a platform for psychosocial counselling interventions to be provided in combination with maintenance programmes. Most maintenance programmes offer clients an appointment-based programme of regular counselling sessions with a designated key worker, together with access to self-help groups, primary and other medical care and social advocacy support.

There has been some clinical interest in the United Kingdom and Australia to assess the suitability and impact of dexamphetamine for certain adult dependent amphetamine abusers who do not have major psychopathology. There is not a sufficient evidence base to judge the wisdom of that practice and the characteristics of those abusers who can be judged suitable for it is poorly understood.

Antagonist pharmacotherapy. An opioid dependent person who is now drug-free (that is, fully detoxified) can be prescribed an antagonist medication (naltrexone) as part of continuing relapse prevention treatment. That antagonist blocks the opiate receptors in the brain and prevents any effect from heroin or other opiates from occurring should the individual consume them. The prescription of naltrexone (which has no abuse liability) can be a component of continuing outpatient treatment and may be used in combination with family therapy (although it may be initiated in a residential setting following detoxification). Medication is taken on a daily basis for several months or longer, blocks the effects of opiates, and thereby assists in long-term recovery by helping the person to maintain a drug-free state. The involvement of the spouse and family of the person in ensuring compliance with treatment is important.

The research evidence points to problems with naltrexone compliance and programmes suffer from a high level of dropout. However, among highly motivated or compliant patients, naltrexone effectiveness is generally high, suggesting an assessment and matching effect of patient and treatment.

Substantial efforts have been made to develop cocaine antagonists. However, no cocaine blocking agents have yet been empirically proven to be effective.

(c) Aftercare arrangements

Some structured treatment programmes distinguish a period of less intensive treatment after a client has completed the main programme, called aftercare. It may be limited to a month or substantially longer after treatment has finished, but is based on the intention to provide ongoing support to clients at the level required to maintain the earlier benefits and goals. Regular phone contact, scheduled appointments and unscheduled or drop-in visits may all be available. In addition to aftercare services offered by the structured programme, clients may also be encouraged to access self-help groups and other general community support and advice services in their home locality as required. The effectiveness of such services has not been subject to formal evaluation to date, but there is a general commitment to their value and availability. Clearly, a supportive family and community environment will also be conducive to helping in the recovery of people who have received drug abuse treatment.

(d) Comprehensive treatment models

In recent years, there have been specific efforts to develop comprehensive treatment services. Those services represent the integration of different treatment approaches, such as community-based counselling and residential rehabilitative services designed to help people achieve lasting abstinence. See box 19 below for an example of a model used for abusers of psychostimulants.

Box 19
The matrix model

The matrix treatment model for stimulant abusers is a multicomponent framework treatment for helping them achieve abstinence and physical and psychological well-being. The model addresses the needs of stimulant abusers in a systematic way, separating the problem areas into distinct categories. The chosen categories are behavioural, cognitive, emotional and relationship categories. The treatment focuses on particular issues emerging in each of those areas during the "stages of recovery" encountered by recovering clients during the first year of stimulant abstinence. The model emphasizes individual contact with a therapist, education about drug abuse, relapse prevention, social support, twelve-step participation and issues critical to addiction and relapse. The programme includes education and support for family members. A typical programme schedule is given below.

Phase 1 (months 1-6). The therapeutic sessions are typically scheduled as follows:

- Weeks 1-2: twice-a-week individual sessions, weekly twelve-step meeting, family education group, stabilization group and urine test;
- Weeks 3-16: twice-a-week relapse prevention group, weekly individual session, twelve-step meeting, family education group and urine test;
- Weeks 17-26: twice-a-week relapse prevention group, weekly social support group, twelve-step meeting and monthly individual session.

Phase 2 (months 7-12). The therapeutic sessions are typically scheduled as follows:

Weekly twelve-step meeting, social support group, counselling for individuals and couples and urine test as needed.

Sources: A. Huber and others, *Integrating treatments for methamphetamine abuse: A psychosocial perspective, Journal of Addictive Diseases,* vol. 16 (1997), pp. 41-50; and R. Rawson and others, An intensive outpatient approach for cocaine abuse: the matrix model. *Journal of Substance Abuse Treatment,* vol. 12, No. 2 (1995), pp. 117-127.

http://www.matrixcentre.com/

(e) Special setting for treatment: the criminal justice system

Large numbers of drug users have contact with the legal authorities and the criminal justice system. In many countries, there is interest in developing treatment interventions in criminal justice settings. Several contact points and stages in the criminal justice system may be used as intervention opportunities, including the following:

- Arrest. Proactive assessment and referral from workers who work alongside the police can refer individuals to treatment services at arrest;
- Pre-sentence (probation referral). These are schemes that involve the referral of offenders, whose drug abuse is identified by a probation officer between the point of arrest and sentencing, to a treatment service;
- Community sentence. Structured treatment programmes can be organized as part of a community sentence and other probation orders using a linked treatment condition;
- Custodial and post-sentence intervention. A basic treatment framework can be used to provide detoxification, counselling while in prison and aftercare support. Arrangements may be in place to continue treatment for prisoners who are released before the full completion of their prison sentence (treatment on parole);
- Drug treatment courts. A drug treatment court is a mandated judicial supervision and addiction treatment alternative to incarceration for drug offenders. Drug treatment courts began in the United States in 1989 as one way of stopping crime by stopping its underlying drug abuse. They now exist or are planned in a growing number of countries, including: Australia and Canada in 1999; Ireland in 2000; Bermuda, Brazil, Cayman Islands, Jamaica and United Kingdom (Scotland) in 2001; and Mauritius, New Zealand and United Kingdom (England, Wales and Northern Ireland) in 2002 (see box 20).

B. Accessing information about effective treatments

Globally, there is a substantial and growing research literature on the effectiveness of treatments for drug abuse problems. Traditionally, that material has been available in three general forms:

- Academic reports published in professional journals;
- Research studies published in the form of reports or monographs;
- Various book chapters and review articles summarizing a particular type of treatment or body of research.

Accessing the literature is becoming easier as more published reports are available online using the Internet. Several reference sources can now be accessed on the Internet, which is a fast-growing resource with new services constantly becoming available. A highly valuable resource is the Cochrane Library (see box 49 below), which contains a listing of reviews that have been compiled on a variety of health-care topics including drug abuse.

Box 20

Rehabilitation instead of incarceration in Jamaica

Recognition that one has a drug problem is the most important prerequisite for being accepted in the Drug Court Programme in Jamaica. In two designated Magistrate Courts in Kingston and Montego Bay, it is now possible to avoid incarceration or a heavy fine for possession of marijuana, cocaine or heroin, or even crimes committed while under the influence of drugs if an individual is accepted into a court-approved rehabilitation programme.

The programme, which was established with the advisory assistance of UNDCP and the Drug Court in Toronto, Canada, has already handled dozens of cases. Informal guidelines have been developed in recent months to suit the local situation. A permanent address, a family connection or a person willing to take responsibility for the client and regular participation in the counselling sessions are important criteria for acceptance and staying in the programme.

During its recent visit to the courts, UNDCP saw one participant dropped from the programme for dealing in drugs and another sent back to jail for one night to impress upon him the importance of consistent attendance in the rehabilitation sessions, while three others "graduated" to biweekly visits to the court (otherwise they are required to return once a week). One participant walks four miles each way to attend the group counselling sessions held three times per week. In addition to the regular drug testing, peer pressure appears to keep the recovering addicts "clean" and "honest".

Most of the clients are cocaine addicts and so there is a high degree of probability that many may relapse. The counsellors know that several of those accepted are "borderline" cases. The biggest problem in Jamaica is finding a suitable living and work environment and, for many, there is no alternative to the drug-ridden slums in Kingston and Montego Bay. The principal debate among the treatment providers is whether to put the participants in a 24-hour residential care facility, but eventually they must return to life "outside". Therefore, the attitude of the client is most important. If the addict is willing to commit to "staying off drugs" to avoid jail, the law in Jamaica provides a person with a "second chance".

Source: ODCCP Update, December 2001.

Key points

The key points in chapter IV of the *Guide* are as follows:

- The basic elements of a comprehensive treatment approach can be built together in a treatment system depending on the nature and extent of the problem, the level of fiscal resources available and the cultural and political context;
- Open access services are important elements of an integrated treatment response. Those services act as important points of first contact for people who have drug-related problems and for those concerned about the drug use of another. They are also important strategies for the prevention of the adverse health and social consequences of drug abuse;
- There are a range of treatment services and specific therapeutic interventions for drug abuse. Evaluation studies conducted in several countries provide support for the delivery of:
    - Medically supervised detoxification programmes for management of withdrawal symptoms and stabilization;
    - Rehabilitation programmes for relapse prevention in a community or residential setting;
    - Pharmacological interventions including maintenance therapy and antagonist pharmacotherapy;
- Information about the impact of treatment can be accessed from specialist journals and library resources. The Internet is increasingly the medium of first choice for retrieving information about effectiveness.

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Internet resources

Addiction Search: links to addiction information on the Internet.
http://www.addictionsearch.com

Centre for Substance Abuse Treatment
http://www.samhsa.gov/centers/csat2002/

The National Clearinghouse for Alcohol and Drug Information
http://www.health.org/dbases/

National Treatment Agency
http://www.nta.nhs.uk/

Royal College of General Practitioners: Substance Misuse Management in General Practice
http://www.smmgp.demon.co.uk

Chapter V

Developing and implementing treatment services

Chapter IV of the *Guide* presented a summary of the effective treatments that have been developed to respond to drug abuse. Chapter V of the *Guide* takes the discussion forward and asks the question: "How should a treatment service or system be developed?"

The benefits to gain from reading chapter V of the *Guide* are as follows:

- Appreciation of the value of involving the community in a new treatment development;
- Understanding of how to include existing primary care resources to complement specialist substance abuse treatment;
- Guidance for a step-by-step approach to planning, establishing and implementing treatment services or systems;
- Overview of the key tasks required when setting up a treatment service;
- Clarity about the value of organizational goals, staff training, support and supervision.

In such a discussion, justice cannot be done to the detail of the tasks to be performed in either developing a new service, or re-energizing treatment services that have become unresponsive to changing problems in the population. Interestingly, many successful services have been set up by charismatic individuals who manage to disregard some of the more conventional aspects of organizational design and development. Their zeal and commitment carries the day, but over time such personality-based approaches can run into trouble. Overall, it is better if the services can have well-developed policies and procedures and a process for reviewing such policies so that the system can evolve and mature over time.

In some countries, central planning has a decisive influence on new project development, whereas, in other settings, individual and community enterprise may generate many projects in the absence of any generalized or systematic strategic development plan. In other places, it may be that services are developed by non-governmental organizations. Whatever the detail or the level of variation, there is always a need to develop a coordinated approach with all the major partners involved if resources are to be best used.

Treatment systems and services need to reflect the health, social and community infrastructures into which they will be introduced. A new treatment programme should complement and link with existing health, welfare and legal networks. That will maximize efficiency in the use of limited resources, as well as facilitate the integration of drug abuse recovery into existing community services.

The level of development of health and social care varies dramatically in different parts of the world. There is a need to recognize that there may be stark differences in the amount of financial and human resources available. The type of services put in place will obviously be determined by the amount of local or national resources made available for such purposes.

However, regardless of scale, UNDCP advocates a systematic approach to ensure the best utilization of resources. Such an approach can and in many cases should be developmental, growing from a basic response through primary care in resource-limited situations, through an intermediate solution by the development of a single treatment service, to a more sophisticated, comprehensive approach in the form of a treatment system.

Chapter V is divided into three sections. Section A outlines important principles for the involvement of the community and primary care in the provision of a basic service. Section B presents information on how to develop a new treatment service that aims at offering more specialized services to people with drug problems. Section C presents some basic guidelines for effective operation of a treatment service. The information presented in section C will then be expanded in chapter VI, devoted to the integration and coordination of the different elements in a treatment system.

A. Involving the community and integrating drug abuse treatment in primary care

The majority of the material in chapter V of the *Guide* relates to a step-by-step approach to developing a treatment service. Before the material is presented, it is worth considering a situation in which no resources are available to develop a new treatment service. In that context, it may be possible to facilitate and build on community responses and support primary-care personnel to offer a basic service. In many areas of the world, the only treatment resources available are through generalist primary-care personnel who may be thinly spread in focusing on a wide range of medical problems. However, in many systems, primary-care services are often the first point of contact for drug abusers. In some communities, the extent of drug abuse problems will place a heavy burden on primary care services.

1. Involving the community

Community resources are important elements to draw from when developing drug abuse treatment services. Their importance becomes even more salient in situations of reduced financial resources. In a community-driven approach, the family and the community are part of the treatment system and are actively involved in planning, implementation and evaluation of the programme. Significantly, treatment development must recognize the cultural context and setting for the service and may well wish to harness existing, traditional treatments and integrate with the local community, which may already have taken action.

Box 21
Community mobilization, Chiang Mai, northern Thailand

In the northern part of Thailand on the border with Myanmar, there is a well-developed health-care network with a three-tiered approach involving a regional, a district and a village service, with a primary-care focus at the district and village level and more specialized services at the regional level. Over the past decade, the problem of methamphetamine has grown to be a major epidemic, and some of the small districts have developed local responses in the face of widespread methamphetamine abuse among the village community. For example, the committee of the Oonkrang district (north of Chiang Mai) met in a summit to develop a community response to the methamphetamine problem. They developed a community reinforcement response, designed in particular to prevent drug distribution and selling and to promote support of treated individuals within the village.

Box 22
Involvement of traditional healers in Nigeria

In parts of rural Nigeria where the primary health-care team often consists of one nurse servicing a large population over a wide area, the primary care team has formed a partnership with some of the traditional healers. The aim is to equip the traditional healers with skills to enable them to participate in the primary health-care approach. Such approaches are pragmatic and resource-driven and involve harnessing respected or elder members of the community in developing a structured response. Similar approaches could be developed with a particular focus on drug abuse identification, short intervention and referral.

Examples of initiatives with the participation of significant community, primary care and traditional healers are given in boxes 21 and 22.

It is crucial to take into consideration the local circumstances and cultural values influencing drug abuse and dependence. For example, serious physical disease and pain may be medicated using local indigenous products that give rise to substantial levels of dependence problems within the community. In such cases, the treatment response to drug abuse will need to address that underlying factor. In that regard, a case example from the Lao People's Democratic Republic is given in box 23.

Box 23
Involving community health workers, Lao People's Democratic Republic

In the Lao People's Democratic Republic, opium was traditionally used to treat pain and major health problems and the limited availability of basic health services was a major contributor to opium addiction in the community. The provision and improvement of primary health-care systems will play an important role in the prevention of further opium addiction and relapse. Community-based primary health-care support is being implemented. Village health volunteers have been established and supported in order to improve the health situation. The volunteers provide a resource to improve health-related development and support a health promotion strategy designed to improve the effectiveness, relevance and accessibility of health information and education available to communities at village level. That approach includes a demand reduction component with community involvement by increasing community awareness of the problem of drug addiction.

Box 24
Royal College of General Practitioners—learning objectives for primary care workers

In 2001 in the United Kingdom, the Royal College of General Practitioners undertook to train some 400 general practitioners and 60 prison doctors as "specialist generalists" in the treatment of substance abuse. The training involved a series of pre-class conferences, master classes and continuous assessment methods. As part of that initiative and the accreditation of competence, a learning portfolio was prepared setting out the professional competence requirements and the learning objectives for the training scheme. The learning objectives included:

- Critically appraising the clinical guidelines of the United Kingdom on the treatment of substance abuse;
- Clarifying good practice in relation to prescribing substitution treatment;
- Understanding of the role of the general practitioner in the care of the drug abuser;
- Developing a broader understanding of "shared care" arrangements between general practice and specialist treatment agencies;
- Reviewing the harmful consequences of drug abuse, including the role of general practitioners in the prevention of drug-related deaths.

For further information, go to
http://www.smmgp.demon.co.uk

2. Key elements for primary care involvements

In a basic scenario, the objective is to rely on primary care teams for the identification (screening) of people who are affected by drug abuse problems and for the provision of a basic health-care response. A major advantage of the integration of drug abuse treatment in primary care is the common use of existing infrastructures and local resources. To make that possible, adequate training, material support and referral services are needed. Primary care workers (and also community health volunteers) in the target area need the following: to be aware of drug use issues and able to screen their clients for problems; to know how to provide a minimal health-care response to those with problems (for example, to provide a brief intervention, as defined in the glossary at the end of the present *Guide*); and, ideally, to receive support and assistance to manage complex cases.

An example of an initiative to train primary care workers in the United Kingdom is given in box 24.

3. Balance between specialist and general services

Ideally, there should be a good balance between specialist resources and primary health-care resources. Indeed, where there are major resource constraints, the foundations of services will need to be developed through primary care frameworks. However, wherever possible, some form of specialist activity is desirable to facilitate the development of a core expertise to treat substance abuse problems in the local area. The specialist resource can be a valuable source of training and support for general primary-care workers.

In practice there may be a transfer of clients across specialist and general primary-care services. In some treatment systems, clients who have been successfully rehabilitated by a specialist service, but still require medical and other care, may be referred to a primary health-care team that will continue to provide the service, with support from the specialist service as required. The reverse situation can also occur, in which a client of a primary-care service has needs that cannot be realistically managed in that setting and a referral to a specialist agency is undertaken on a temporary or longer-term basis.

The utilization of primary care personnel in the treatment system in Ireland is summarized in box 25.

B. Developing a new treatment service

In this section, general project principles and activities are applied to the specific context of how best to establish a dedicated programme for treating substance abuse. The guidelines do not focus on a specific modality of treatment. In practice, the majority of key aspects of a development process are generic issues. Specific examples in the form of short case summaries are provided to give examples of how new resources have been established in different country contexts.

Being clear about the realistic aims and objectives of the project is essential, no matter how basic or complex the initiative. The process of developing a treatment service can be complex and time-consuming. To help to ensure a successful outcome, it is recommended that one person be appointed (or seconded) to manage the development phase. The person appointed to that position should have organizational, management and communication skills and the vision to bring the project to completion.

Box 25
Development of treatment services in Ireland

In Ireland a series of national reports promoted the development of services to respond to a major heroin problem in Dublin. There was major investment in service development between 1995 and 2000 with the capacity of the system more than doubling. Much of that was achieved through the development of a policy on primary care that laid down clear procedures for the involvement of general practitioners in the management of drug dependence, provided training and also paid general practitioners for the time that they spent on that complex problem.

In subsequent policy reviews, it became apparent that services had developed in Dublin, but the drug problems were expanding to other parts of the country. A revised national drug strategy was developed that took forward the experience of developing services in one locality and recommended that a regional and local integrated drug and alcohol service be developed in all regions.

A national task force and regional drug coordination system was also set up as part of the process of facilitation and development. The coordination structure was an important part of the national monitoring and implementation process.

1. Specifying the needs of the target population

As outlined in chapter III, a clear understanding of the nature of the client groups that the treatment programme is intended to serve is required. That can be done partly by reflecting on the likely referral and treatment access routes that are going to be used and partly by conducting a needs assessment. That process should help to identify the likely treatment needs of special population groups, including young people, women, injecting drug users, HIV-positive drug abusers, people with psychiatric co-morbidity, homeless people, people in the criminal justice system and people from ethnic minorities. A specific assessment of needs of female drug abusers in Pakistan is summarized in box 26.

2. Drawing up a project specification

A written specification should define the scope of the project and specify what it is intended to do and achieve. It is also important to state if there are things that the project will not be expected to do. The document should further set out who the key development personnel are and describe their responsibilities and what they are expected to do. It should describe the quality standards and the evidence base to be followed for the project, and clarify how it will be known when the project has been completed. Such a clear statement of all of the project deliverables is extremely valuable.

It will also be necessary to undertake a risk assessment, even if it is fairly informal. In project management terms, "risk" is the likelihood of a hazard or undesirable event happening, and "risk control and management" involves taking steps to reduce risk, stage contingency plans and monitor how the project unfolds. Whatever the level of complexity of the project, a project steering committee should be established to identify the likelihood of risk for the project. The committee should address the following questions:

Box 26
Developing services for female drug abusers in Pakistan

In Pakistan, female drug abuse has a substantially lower prevalence than male drug abuse and is a more hidden behaviour. Prescription drugs, followed by heroin, are the substances most commonly reported to be used by women. Unlike the male pattern of use, hashish, or charas, is not commonly reported as the main drug type used by women.

In the country, there was a perception that many drug-abusing women do not seek treatment because of concerns that their children will be taken into State care. They also fear reprisals from their spouses and punishment from authorities in the community. In that context, it seemed essential to provide a confidential service that female drug abusers could trust and have easy access to.

Keeping in view the limited facilities available for women drug abusers in Pakistan, UNDCP, in collaboration with a local non-governmental organization, established a telephone hotline service in the city of Lahore. The objective of that one-year pilot project was to provide realistic information to women about drugs and how to handle the problem if drug abuse exists within a family. The non-governmental organization assigned counsellors and psychologists, who were trained in drug demand reduction, to answer questions from women drug abusers or their families and to provide support. The non-governmental organization also established a system for the referral of women drug abusers to public and private treatment facilities. Success factors for the project included the availability of well-trained counsellors around the clock and a high degree of perceived confidentiality.

- Is the project likely to be effective and feasible from a technical viewpoint?
  - Will it achieve the desired results?
  - Will it achieve other benefits?
  - When will the benefit be realized?
  - Is the project sustainable?
- Is the project politically acceptable?
- Is there community support for the project?
- Is there likely to be demand for the project among the target service users?
- To what extent are the benefits assured?
- Is the project affordable?

3. Mobilizing funds and getting started

In the early project planning phases, fundamental questions about the budget and available resources need to be addressed. Early discussions should also be held with representatives of government agencies and staff of other services (as provided) to identify existing gaps in provision. Examples of how finance was secured for a development in Africa and how a modest initiative has grown in Mauritius are shown in boxes 27 and 28.

4. Project timetable

Several useful techniques have been developed by project management specialists to help to ensure that projects are delivered on time and according to specifications. One such technique is a Gantt chart. For project management purposes, it is a diagram with activities represented by a bar that is positioned along a horizontal timescale, with the length of the bar indicating the duration of each activity. The chart compares the baseline to the current schedule, with one of the bars running from start to finish and the second bar running from the currently scheduled start to finish. If the two bars for a task run on top of one another, the task is on schedule. The extent of non-overlapping indicates the amount of delay or slippage that has occurred for the task area. There are several commercial project management software products that can be used and will enable such a chart to be drawn and managed.

5. Defining therapeutic services to be provided

An initial appraisal or needs assessment of the nature and extent of drug abuse problems in the locality will inform discussions of which types of therapeutic services are required. In addition to a core outpatient and day-care programme, it is usual to include direct provision or access to some form of residential setting treatment. It is not uncommon for a treatment service to evolve over time from an initial core service-perhaps a community counselling service with referral to inpatient care as required-to the direct provision of outpatient and residential services that are linked together and form a logical programme.

Box 27
Identifying sources of funding in Kenya

Kenya has very limited services for the rehabilitation of persons with a substance abuse disorder. In 1996, a group of four mental health experts, three psychiatrists and a clinical social worker decided to build a centre of excellence dedicated to the treatment of the problem. At the time, the concept of borrowing money for a project of that nature was novel in the Kenyan banking system. No bank would consider lending any money to the four promoters, as they saw the project as being uncertain and of too great a risk.

The African Project Development Facility (APDF) is an affiliate of the World Bank and was approached to formally evaluate the project concept on behalf of the mental health experts. Following a favourable review, APDF facilitated the financial structuring of the project by the local banking sector. The project was developed and has made a substantial contribution to the setting of standards of rehabilitation in the East African region.

Box 28
Community and professional mobilization to develop a treatment centre in Mauritius

The Dr. Idrice Goomany Centre in Mauritius offers an example of how a treatment and rehabilitation centre can be developed as the result of a community initiative. The Mayor of Port Louis, concerned about a sudden increase in drug abuse, convened a number of social workers and professionals to a meeting to discuss how to address the problem. The outcome was a decision to initiate a treatment centre on an outpatient basis, using the premises of a municipal kindergarten. A volunteer team started operations without financial support. The team gradually matured, services were improved and eventually the Government started to provide funds for the recruitment of a small full-time staff. A new building was built on a plot of land leased to the centre by the municipality and a full-time staff team was created. The programme still operates on a modest budget and is very well regarded and much used by the community.

Box 29
Development of a National Treatment and Rehabilitation Centre in the United Arab Emirates

In 2000, the Government of the United Arab Emirates initiated a development plan to create a new National Treatment and Rehabilitation Centre in Abu Dhabi. Available data suggested that the country has a low prevalence of drug abuse problems, but the project is seen with long-term prevention goals in mind. In close consultation with the officials of the United Arab Emirates, an international team of experts in the field initiated a needs assessment and developed a project implementation plan. Problems of opioid, cannabis and benzodiazepine dependence were identified and a small but rising treatment population was being managed by several existing services in the country, with the prison and criminal justice systems also closely involved. The view taken by the Government was to establish a temporary facility with a core developmental staff team to launch the new service pending the design and construction of a permanent facility. The initial resource contains five separate elements: programme administration and business management; client assessment and treatment planning; an outpatient counselling unit; a detoxification unit; and a rehabilitation unit.

The programme has nine functional components: a referral and assessment service; detoxification and basic physical assessment; an outpatient programme and a day programme; a residential programme; aftercare follow-up; community development and outreach; overall integrated care coordination; a telephone helpline and advice centre; and research and development.

Following refurbishment of an existing building in a central location in the city, the treatment centre began operations in 2002 with a mixed team of nationals and substance abuse treatment professionals from several countries. Concurrently, work is under way to configure and construct the new permanent, dedicated facility on the outskirts of the city. It is possible that the initial treatment centre may remain as a "satellite" service.

An example of a range of services that has been developed in the Middle East is shown in box 29. In the example, a range of therapeutic elements were designed for delivery to the new centre. However, those elements were not brought into operation immediately. The mix of services was delivered according to the needs and volume of referrals received in the early months of the service. A flexible and developmental approach was therefore used as an efficient means of managing resources and the staff team.

6. Establishing the policies and procedures of the treatment centre

A key task in the development process of the treatment centre will be to write a protocol specifying the aims and objectives of the service, as well as its operational procedures. The type of staff employed will depend upon the programme type, the components and the resources available. An assessment should be undertaken to identify what staff levels and competences and expertise are required.

An early identification is clearly needed of the financial resources that will be available for capital and revenue aspects of the service. There are many examples of treatment programmes that have floundered because preparations have not been sufficient to clarify or agree on work service contracts, operational revenue and payment mechanisms with funding organizations. A specific business function devoted to funding management issues is almost always needed.

In terms of sustaining the service over time, it is worth noting that the scale and nature of problems to be addressed will change. The vision of the service should recognize that adaptations will be needed to ensure that the services continue to be responsive. Services ideally would be supported by a coherent national plan that allows for long-term planning and implementation and does not change too readily.

A summary of the general specifications of a treatment programme is shown in the table below. When developing a new treatment, or reviewing an existing service, the table can be used as a checklist of components. There are, naturally, considerable differences across countries in how treatments are specified, but the table captures the core elements that are common in most contexts.

An illustrative example of a residential rehabilitation programme is provided in annex III to the present *Guide* to help clarify how the principles listed above can be applied. While the components outlined above (except accommodation and food) apply to any type of treatment

Specifications of a treatment programme

Element	*Content*
Description of client groups served	A description should be developed to characterize the client group that is served by the programme.
Philosophy	The operational philosophy should be outlined, together with the specific approach that is used by the service and accounts for why the programme is successful.
Standards governance	A description is needed of the executive and operational management structure of the programme and how that is regulated.
Strategic management	The programme should be able to outline an overall mission statement and a strategic plan.
Staffing	The composition and size of the staff team should be described.
Access and referral information	A clear description should be developed to show how referrals are made to the programme; what are the minimum and maximum timescales for response; which staff are involved and how the referral will be managed; and how the referral process will be documented and referral outcomes monitored and communicated back to the referring agency.
Assessment criteria	A method for how clients are to be assessed is clearly required and that needs to include what specific complaints will be screened for and assessed.
Care planning and review	A care plan is a written description of the treatment to be provided and its anticipated course. Care plans set out the specific needs of individual clients and the ways in which they are going to be addressed by the service (and by other service providers as required). The care planning process needs to be carefully monitored, evaluated and revised as necessary.
Completing treatment	Departure from the programme and onward referral should be a planned event, and should be overseen by a key worker responsible for clients.
Human resource management and development	The programme will need to have a management, staff and volunteer team (if used) that have the skills and abilities to meet the objectives of the service. A policy sets out the staff recruitment and selection and employment policies and they comply with equal opportunities and employment rights legislation; a human resource, management policy and supervision and appraisal system should be described that monitors, motivates and supports performance; and an annual training plan should also be developed with sufficient financial resources to support it, subject to periodic review.
Physical environment	The premises and other environmental resources will need to meet the requirements of appropriate regulatory bodies.
Accommodation and food	The accommodation provided in the programme will be comfortable and should meet the needs of the resident in terms of his/her right to privacy, dignity, respect and personal independence. Food and drink provided to the users should be nutritious and healthy.
Performance monitoring and quality	The programme will develop and maintain criteria and procedures for documenting and reporting service outputs and outcomes. Criteria should be agreed with commissioners and other relevant external bodies. Output and outcome monitoring reports will be provided to the management body and to relevant external audiences as specified in the contracts.
Operational policies	The core policies and procedures can encompass the following: • Admission and discharge criteria; • Statement of rights; • Confidentiality (record-keeping etc.); • Complaints procedure; • Service users involvement procedures; • Service users privacy policy; • Equal opportunities policy; • Programme environment and personnel; • Policy on visitors to the programme.

centre, a community-based service may need to develop protocols for additional components. For example, in addition to seeing individuals with substance dependence, a community-based service may also manage people with substance abuse problems relating to intoxication and earlier stages of abuse of those substances. In consequence, protocols for early interventions, including brief interventions, to treat those drug-related problems or low levels of dependency will most likely be needed. Community-based programmes are also more likely to participate in community development and other health promotion activities, and policies and procedures to govern their participation will be needed.

An effective community-based programme will have written protocols for the following components:

- Assessment, treatment and care;
- Early identification and intervention (unique to community-based programmes);
- Health promotion and prevention of health and social consequences (unique to community-based programmes);
- Community liaison and participation (unique to community-based programmes);
- Family interventions;
- Vocational training;
- Social reintegration;
- Client rights and responsibilities;
- Client and programme records;
- Staff education, training and development;
- Planning, evaluation and quality improvement;
- Management.

Key questions to be addressed in the conceptualization of a treatment centre are summarized in box 30.

Box 30
Treatment centre development and management: key questions to address

Treatment protocol development

- What will be the service style, content and coordination mechanisms?
- Do they reflect current research evidence?
- Do they respond to consumer demand?
- What will be the assessment and treatment protocols?
- Who will be involved in the phases of treatment (see chapter VI of the present Guide)?
- Are there clear written statements of service regarding philosophy, policies, procedures and the target population?
- In case a variety of treatment modalities are offered, criteria and consistent algorithms to place or match patients to different modalities should be made explicit.

Staff team[a]

What type of staff team is needed? Staff members can include:

- Programme director, manager and administrator;
- Secretaries and office support;
- Physician and psychiatrist;
- General and psychiatric nurse;
- Social workers and family liaison worker;
- Psychologist and psychotherapist;
- Occupational therapist;
- Other support staff.

Overall management

- What will be the management structure?
- Will staff and management and the broader community exchange ideas on service style and content?
- Are the areas of responsibility clearly defined?

Box 30 *(continued)*
Treatment centre development and management: key questions to address

Financial management

- What are the implications for human and capital resource requirements that are needed to provide the service?
- What will be the accountability mechanisms?
- Is there a budgeting process that includes a mechanism for performance monitoring?

Monitoring system management

- Are there mechanisms for monitoring, evaluation and feedback on service and system performance?
- What record systems exist for clients, human resources management and the payroll?

Staff management

- Are staff appraisal mechanisms in place?
- Are there opportunities for orientation, education, training and support of staff?

Quality management

- What will be the quality improvement systems?
- Are there special licensing conditions associated with the service?
- What are the information management and information technology requirements?
- What external data, including demographic and epidemiological data, are available for planning?
- What internal data are available for monitoring and evaluation?

[a]The composition of a staff team in terms of medical/nursing and social work/occupational therapy professions will vary. In some contexts, a predominantly medical structure will be common; other programmes will be more oriented towards social work.

C. Treatment programme operation

1. Organizational climate

A drug abuse treatment service requires an accountable, efficient, effective method of management that facilitates the achievement of its goals. That requires an organizational structure with clear lines of responsibility. An important priority is to ensure that staff and management facilitate a positive working environment. Aspects that contribute to such an environment include the following:

- The value of the contribution of each staff member to the success of the programme is acknowledged;
- There are opportunities for open discussion between team members;
- There are mechanisms for conflict resolution;
- There is a regular assessment of team member satisfaction;
- Appropriate staff incentives and rewards are offered.

2. Staff training

It is self-evident that one of the main determinants of a successful drug abuse treatment programme is a competent and appropriately trained staff team that is adequately resourced. There should be shared understanding about the collective and individual role and responsibilities of the team. It is the role of management to ensure that the staff is supported in carrying out its tasks. In that regard, a policy that is properly resourced for staff training and support should be based on the following:

- Training and other non-formal learning opportunities are offered in accordance with the needs of the staff in fulfilling its roles;
- All staff members have access to supervision and regular feedback;
- There is an allocated budget for training;
- Networking with other treatment agency staff is encouraged.

In recent years, developed treatment systems in many countries have been reviewing the training and profes-

sional competencies of workers in the field of substance abuse treatment. It is important to review the professional competencies that each worker should possess in their role in a programme. Areas of required competence can include:

- Screening and assessment procedures for each programme;
- Detailed knowledge of eligibility criteria for client treatment;
- Methods of establishing personal goals for clients and reviewing and managing progress;
- Counselling skills and specific psychotherapeutic approaches.

3. Staff supervision

At the heart of staff supervision is the provision of adequate support and feedback to staff members in order to improve the quality of care, increase staff satisfaction and prevent staff burnout. Staff supervision is defined as the process of ensuring that personnel involved in the operation of a treatment centre are able to undertake their responsibilities appropriately and effectively and with regard to the core competencies required. Staff supervision issues and the elements of a supervision system are summarized in box 31.

Box 31
Staff supervision system

The structure for clinical supervision is usually on a personal interview basis between staff members and a senior staff officer, although a group discussion format may be used. Various methods are employed as part of supervision, including reviews of the current caseload of the staff member, as well as issues-based discussions of problems recently encountered and resolved.

The supervision system for staff should:

- Offer support, feedback, problem-solving and instruction;
- Use successes and mistakes as learning opportunities;
- Provide regular planned supervision sessions;
- Use an action cycle of performance feedback to staff members to help their development.

The supervision should be undertaken by someone who is more experienced than those who receive it.

The benefits expected from the supervision system will be to:

- Improve the quality of care;
- Increase staff confidence and job satisfaction;
- Create a workplace that values open reflection;
- Identify staff educational needs.

4. Financial and budgetary management

Almost all treatment services require policies and procedures to manage the flow of financial resources into and out of the programme. Providers are responsible for ensuring that resources are appropriately used and monitored.

In an ideal situation, service providers would develop a medium- to long-term financial strategy that considers financial planning over a three- to five-year period. The plan would also take into account what action would be taken and the impact upon services etc. if there were to be a loss of current funding, as well as the opportunities that may arise with regard to alternative funding sources.

A good-quality provider must be able to:

- Establish systems for authorizing the payment of bills, signing cheques, managing petty cash etc., with sufficient safeguards;
- Prepare an annual budget (clearly identifying projected income and expenditure) to *Guide* service delivery;
- Produce a monthly cash flow and financial operating statement that compares projected and actual expenditure;
- Prepare an annual, independent, audited financial report showing compliance with the applicable tax regulations.

A good-quality provider should be able to cost the various components of their programmes. An important concept in that regard is that of "unit cost", which is calculated by listing all the "inputs" to the programme (for example, staff, equipment, medications, supplies, office space and accommodation, utilities and other supports) and the units of service (number of therapy sessions etc.) that are used for a specific period of time, such as a 24-hour period, in the operation of an inpatient unit. The unit cost figure can then be used to arrive at the overall cost of a programme or system for a number of persons over a specific reporting period, such as a financial year.

Key points

The key points covered in chapter V of the *Guide* are as follows:

- Treatment service development has to be pragmatically based within the network of available health and social services;
- The size and scale of the response depends on the patterns and extent of the drug abuse problems, as well as on the resources available;
- Globally, the type and scale of services will vary enormously in accordance with differing needs, resources and sociocultural conditions;
- Key components of services relevant to the local circumstances should be identified and put in place. An overall plan should ensure that the different components are logically and practically linked. In that context:
    - Community-based primary care responses should be the foundation of services and could be supported through more specialized district or regional services;
    - Dedicated treatment services constitute the next stage of development;
    - Comprehensive, diversified and coordinated treatment systems will be required in situations of high demand for services;
- Good planning, organization and coordination is critical to good service development. In particular:
    - Clear objectives and clearly defined approaches to achieving those objectives will set the foundation for a good treatment service to be developed over time;
    - A written timetable with clear outcomes and development tasks that are time-framed and that identify who is responsible for action will help to keep the project on track;
    - Rational management and good staff management will facilitate high-quality services;
- Long-term approaches should include strategies for training and staff development and for broader research and development.

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Rainey, H. G., *Understanding and Managing Public Organizations* (San Francisco, Jossey-Bass, 1996).

Internet resources

Association for Project Management
http://www.apm.org.uk/

European Addiction Training Institute
http://www.eati.org

Chapter VI

Effective integration of treatment services

It is fair to say that all treatment systems, however well developed and resourced, can be better integrated. In many countries with long-standing and developed systems, current efforts concentrate on encouraging treatment services and agencies to work together in a more systematic way. The need for better integration and coordination has been highlighted at several points in the preceding chapters of the *Guide* and reflect the fact that many people with substance abuse problems need a combination-or a sequence-of treatment services that are delivered according to a care plan for each client. The need for a number of linked treatments generally reflects the chronicity and severity of the problems faced by a client.

Chapter VI of the *Guide* asks the question: "How can individual treatment programmes and systems be most effectively coordinated?"

The benefits to be derived from reading chapter VI are as follows:

- Conceptual clarification of the structure and elements of a treatment system;
- Understanding of how the treatment system is likely to operate;
- Understanding of how to identify and achieve outcomes desired by individual clients in the treatment system.

Depending on the size of the target population and the nature and extent of drug-related problems, a comprehensive treatment response may include the provision of each of the main types of open access and structured treatment that were outlined in chapter II. Those responses should be seen as part of the broader health, social and legal response to drug use and, as such, should be integrated into those systems. Some types of treatment—usually residential rehabilitation programmes—are often accessed on a regional basis. That involves a referral to a programme at a distant location and the need to link to community-based services for aftercare and social reintegration.

Chapter VI is divided into two sections. Section A looks at the definition and general characteristics of a treatment system and how it must respond to changing conditions in the population. Referral routes and an example of an integrated system in operation are then described. Section B turns to operational issues and discusses client screening and assessment, treatment planning and care coordination issues. Section B also presents an approach to planning the development and implementation of a whole treatment system, or components of that system.

A. Definition and characteristics of an integrated treatment system

People with drug problems tend to have a wide range of additional problems, are often significantly involved with the criminal justice system, and are homeless or without welfare and other support. It is important therefore that the treatment system is holistic and brings key local agencies into working partnerships in order to maximize the overall effectiveness of the service response.

1. Definition of a treatment system

A treatment system is a group of interrelated, or interdependent treatment and rehabilitative "elements" that form a combined response to substance abuse problems in a defined region or country. If the evolution from a single treatment service to an array of multiple providers of treatment is considered, the forces for expansion are driven by increases in the nature and volume of demand for treatment in the population that outstrips the capacity or competence of any one provider.

2. Elements of an integrated treatment system

Many individuals may require the provision of several different types of treatment service over time (that is, a continuum of care). It is quite common for an individual receiving treatment from one provider to receive additional welfare support and other social inclusion services provided by other agencies (for example, hous-

ing support and legal advice). It is also frequent that treatment services provided by different agencies are provided in sequence (for example, detoxification, residential care and outpatient counselling). Those supports are important elements in an effective package of care services that can evolve over the course of treatment of an individual. An example of the basic structure of a treatment system integrating different types of services is shown in box 32. Box 33 presents an example of a more sophisticated integrated treatment system.

In an integrated care system all agencies have a role to play in staging a coordinated response. Individuals in need of treatment for drug abuse may resort to any one of the mainly identification and referral services shown at the bottom of box 32. The precise nature of formal linkages will need to be determined by the system and the prevailing contractual and partnership arrangements that exist.

A fully integrated system is characterized by good coordination, linkage and integration of the various specialist and generic treatment and support elements. In large-scale treatment systems, that involves a range of agencies and supporting strategic and funding organizations, working in conjunction. It is also sometimes the case that there is a single specialist provider agency for a locality that operates a wide range of treatment units and administrative support functions including research. However, it is more common for several providers to be in operation. Those single or multiple providers are likely to link with an array of non-substance-abuse specialist and generic services in the course of their work. It is important to stress that effective coordination is also advantageous in relatively small treatment systems. For example, in the context of a primary care team, a specialist agency, a general social welfare support service, effective linkages and cross-referral of clients according to their treatment and rehabilitation needs is advantageous.

Linkages to education, employment and welfare agencies, as well as to the criminal justice system, are important components of the system, if integrated care is to be developed. Box 34 illustrates the process of diversifying and linking treatment services.

Box 32
Example of the elements of a treatment system

Below is an example of a treatment system that could be delivered for areas with a population of between 300,000 and 500,000.

Nature of service	*Provider/organization*
Specialist residential	Inpatient/residential programmes Residential rehabilitation programmes
Specialist community	Counselling programmes/day programmes Specialist community treatment programmes
Generic and specialist community services	Social services/welfare agencies Community mental health services
Generic open access services	Primary health care Hospital emergency services Other hospital care services
Screening and referral	Criminal justice agencies Youth services Education and employment organizations Community organizations

Box 33

Example of an integrated treatment system in operation: the models-of-care framework in the United Kingdom

The following description shows how a treatment system could be conceptualized in terms of levels or "tiers" of service. The ideas behind the example have been developed by several organizations and projects and are presented for illustrative purposes. In the following description, a tiered system has been advocated in the United Kingdom, which reflects how the system is designed to operate.

The system contains an array of generic and specialist providers, together with agencies and services that may come into contact with drug users during the course of their work (for example, voluntary agencies and telephone helplines). The latter services are important, since they can provide brief advice for individuals and referral into the treatment system, as appropriate.

The elements of the system are not presented in a fixed vertical way, and referrals can be made to one of the services depicted in each tier from any one of the generic or specialist services in a tier above or below.

A. Non-drug-abuse-specific generic services

Non-drug-abuse-specific generic services can contain a broad array of generic services that may come into contact with large numbers of individuals with drug abuse problems with a full range of problem severity. Probation, parole, social welfare agencies and primary health care are all examples of services that can provide a screening service and provide opportunistic intervention for problematic drug use. They also provide a point of entry into the formal drug treatment system.

B. Open access services

The second tier contains specialist agencies (often provided by non-governmental organizations) that target drug abusers. The set of services responds to the basic needs of people with drug problems as well as the harms associated with drug use, without necessarily focusing on attempts to cease drug use. Examples of such services include advice and information, drop-in services, motivational interviewing and brief interventions, street outreach services, needle exchange (through pharmacies, agencies and outreach), low threshold prescribing and assessment and care management specific to substance abuse.

C. Structured community-based drug services

Structured community-based drug services contain specialist (usually multidisciplinary) services that are resourced to offer specialist treatment and referral. Services in this tier include planned counselling and psychotherapy, structured day programmes, structured community-based detoxification, structured prescribing and methadone maintenance and structured aftercare programme.

D. Specialized residential drug services

The fourth tier essentially comprises specialist services that offer intensive and structured programmes that are delivered in residential, hospital inpatient or other controlled environments. Some crisis intervention services in this tier may have open access and others require formal referral via a health or social care agency. Examples of services within this tier are inpatient drug-dependence units and designated psychiatric beds, residential rehabilitation, mother and child rehabilitation services, dependency units for young people, specialized crisis centres and residential co-morbidity services.

At any one time, the model advocates that a client should be able simultaneously to attend services that are in the same or a different tier according to need. The model can be accessed at:
http://www.doh.gov.uk/nta/modelsofcarefull.pdf.

Box 34

Diversifying and linking services for injecting drug users: opiate substitution treatment in Lithuania

In 1995, two Lithuanian experts participated in a study tour of programmes for drug users in London and Amsterdam, supported by the Phare Programme of the European Commission. Thereafter, the Ministry of Health held a series of meetings to discuss the possibility of introducing pilot substitution treatment programmes in Lithuania. The Ministry organized training on substitution treatment in Sweden; and furthermore elaborated the first national guidelines on substitution treatment in May 1995.

Substitution treatment and outreach needle exchange were introduced as additional services to the existing programmes of the narcology centre. Existing resources (staff and facilities) were used, and substitution treatment currently constitutes, together with inpatient detoxification and drug-free rehabilitation, a main treatment option in Lithuania. The existing wider spectrum of services and links with other community-based institutions and organizations provides better opportunities to meet the needs of clients at different stages of the treatment process. With the introduction of new modalities, a larger number of injecting drug users can be reached and HIV prevention activities can be carried out among the group.

When a drug user applies for treatment, the physician assesses the user. Clients are referred to relevant services according to their motivation and needs. If the client meets the clinical criteria for substitution treatment, he or she is referred to a substitution treatment commission, which examines whether the client will be admitted into the programme. The client is then assigned to a physician, who takes care of the treatment plan and its implementation. The treatment plan includes screening for HIV, sexually transmitted diseases and tuberculosis, as well as routine medical examinations and consultations with an internist as needed. The plan also includes an assessment by a social worker in order to draw up recommendations for social rehabilitation. Social workers encourage and assist clients in registering at the unemployment agency, which has a possibility to offer vocational training and assistance in finding a job. Furthermore, the Lithuanian AIDS Centre, the Vilnius Municipal Social Care Centre and several charitable institutions assist clients in their respective areas of work.

New substitution treatment clients usually initiate treatment at the specialized narcology clinic, and after the physical and social status of the client becomes stable, he or she can be transferred to a primary health-care centre under the care of a general practitioner. Three primary health-care centres cooperate with the Vilnius Substance Abuse Treatment Centre in the substitution programme, whereas other primary health-care centres provide general health care at the request of staff of the Vilnius Substance Abuse Treatment Centre. Primary health-care centres offer a non-stigmatizing setting for the treatment of injecting drug users. The two-phase programme of initiation of substitution treatment at a specialized clinic, combined with referral of stable clients to a non-specialized institution involving general practitioners, is considered to provide an increased level of individualized care.

The evaluations of the substitution treatment programme, based on treatment statistics, are annually presented to the Ministry of Health. Currently, 2,000 injecting drug users are registered in Vilnius, while there is an estimated 4,500 to 5,000 injecting drug users. In 2001, 525 outpatient clients were in substitution treatment and 3,600 injecting drug users were reached through outreach, including 360 regular clients, who used outreach services several times per month. Thus, the substitution treatment programme, together with the outreach needle exchange, reached about 50-60 per cent of the estimated number of injecting drug users in Vilnius. The retention rate in treatment in 2000-2001 was around 75 per cent, which was considered satisfactory, with a dropout rate of 4-6 per cent per year.

Source: Drug Abuse and HIV/AIDS: Lessons Learned, Case Studies Booklet—Central and Eastern Europe and the Central Asian States (United Nations, 2001), pp. 26-30.

3. Referral routes into the treatment system

It is important to specify the main referral routes into the treatment system. In practice, there may be quite complex referral and assessment decision-making processes that operate when individuals resort to the treatment system. Assessment and appropriate placement of a client within the system is crucial and will be influenced by immediate needs and those emerging over the course of a treatment episode and aftercare.

A treatment system should be able to receive referrals from the following: self-referral; family and friends;

primary care physicians (and primary health-care teams); community services; specialist service providers; criminal justice agencies; cross referral within a treatment system.

4. Integrated care pathways

In many areas of health and social care, an integrated-care-pathway approach is increasingly being used to identify and achieve outcomes desired by individual clients. Integrated care pathways are known by various names, including critical care pathways, treatment protocols, anticipated recovery pathways, treatment algorithms, care standards and benchmarks. All of those are designed to create professional consensus and standardize elements of care to improve efficiency, effectiveness and value for money.

Essentially, an integrated care pathway describes the nature and course of treatment for a particular client, a pre-determined plan of treatment and the anticipated outcomes. The components of care available in the different levels of treatment should provide for a coordinated care approach where there is both horizontal and vertical integration and linkage of services. That requires appropriate referral mechanisms as well as feedback on outcome to the referral source. The development of integrated care pathways in the drug abuse field is recommended for several reasons:

- People with drug problems may have multiple difficulties that require effective coordination of treatment;
- Several specialist and generic service providers may be involved for an optimum treatment and rehabilitation response;
- A person may have continuing care needs requiring referral to a different level of service over time.

Integrated care pathways resemble a detailed flow chart showing how patients move through the treatment programme. Importantly, integrated care pathways can also show how patients can move from one treatment service to another in cases of continuing treatment need. For example, an integrated care pathway for a methadone programme might show how patients flow across the following stages: intake and methadone dose induction; stabilization/maintenance; reduction/withdrawal; and community aftercare support. A special feature of integrated care pathways is called variance tracking. Variance tracking involves monitoring departures from the expected course of treatment and examining the causes for the departures and thus improving the pathway of care. In that regard, integrated-care-pathway initiatives are similar to audit activities. As an example, a simplified pathway for a community opioid substitution programme is shown in *box 35*. That example represents a model pathway for illustrative purposes only.

Box 35
Example of integrated care pathways for community opiate substitution programmes

Step 1: Screening and triage
⇩
Step 2: Comprehensive assessment (waiting list support)
⇩
Step 3: Intake: dose induction and treatment planning
⇩
Step 4: Stabilization (maintenance) Counselling and support services
⇩
Step 5: Monitoring and review (every 90 days) (cycling through step 4)
⇩
Step 6: Medically supervised withdrawal (inpatient or community)
⇩
Step 7: Departure planning: (continuing care/relapse prevention)
⇩
Step 8: Community-based support programme or residential rehabilitation programme
⇩
Step 9: Periodic follow-up

5. Responding to local conditions

However complex and integrated a treatment is, it should be flexible and able to respond to changing conditions in the nature of drug abuse nationally and in local communities. For example, new drugs may appear in the drug use market in a country as a result of illegal distribution channels, and there may be a rise in the prevalence of using certain drugs in combination. There may be also a change in the configuration of services that are able to respond to drug use. A good example is the growth of criminal justice interventions in several countries in recent years, requiring careful integration into the existing treatment system. A good example of changes in drug problems has been seen in Thailand (see box 36).

Box 36
From heroin to methamphetamine: the changing profile of drug problems in Thailand

Until recently, opioids were the most serious drug problem in Thailand. In the first half of the 1990s, more than 90 per cent of those seeking treatment were opioid users. Most clients were unemployed or labourers in early to middle adulthood and many were polysubstance users. Since a number of them injected heroin, HIV infection caused by intravenous drug use was an issue of concern. Inpatient detoxification and short-term rehabilitation programmes in large treatment settings were the main treatment approaches provided.

Since the mid-1990s, illicit drug problems in Thailand have changed drastically, with methamphetamine users having surpassed the numbers of heroin users. While the numbers of cases involving heroin seizures decreased from 40,904 in 1995 to 6,571 in 1999, the numbers of cases involving methamphetamine seizures significantly increased from 20,379 to 129,204 during the same period. Methamphetamine-related admissions rose from a negligible 0.2 per cent of overall treatment demand in 1990 to 9 per cent by 1996 and 33 per cent in 1999. The characteristics of methamphetamine users are very different from opioid users. There has been a notable trend of increased methamphetamine use among youth, especially in students. The overall drug use among high-school and college students doubled between 1994 and 1998 (from 72,000 cases to 190,000 cases) and it appears to have doubled again in 1999 (463,000 cases). Many of them use methamphetamine only. Because methamphetamine users in Thailand rarely use that drug by injection, HIV infection caused by intravenous drug use is not of particular concern. However, risk of infection via unsafe sex may be high. Another problem is that most methamphetamine users do not recognize their use as problematic.

To cope with the emerging problem of methamphetamine, the psychosocial treatment programmes provided for the treatment of opioid abuse have been adapted for the treatment of methamphetamine users. Two major approaches for the treatment of illicit drugs (mainly methamphetamine) problems have recently been launched. Under the guidance and training of United States consultants, hundreds of health professionals across the country have been trained to provide a psychosocial treatment programme adapted from the Matrix Model programme developed for psychostimulant users in the United States.

B. Operating the system: client assessment processes

An integrated treatment system should be able to screen people for problems, undertake a suitable brief triage assessment and then stage a comprehensive and continuing care assessment as one or more treatment and support services are provided. Those aspects are described below.

1. Screening

Screening involves the use of a rapid procedure designed to detect individuals who have a health disorder. In general medicine, that normally involves the identification of a risk factor, a marker of the condition, or some symptomatic early stage. A cost-effective screening test should be simple, precise and validated. It should also be acceptable to the population being tested and it should link with further procedures for diagnostic assessment.

Screening is not a sufficient condition for the diagnosis of disorders related to substance use, but it alerts those involved to assess the person's needs. Screening should involve the use of a rapid detection procedure to: *(a)* identify individuals who are likely to have a substance-related disorder; and *(b)* refer the screened individual to an appropriate service for any immediate treatment that may be required and further triage assessment. It is important to note that the person being screened may well have immediate independent or indirectly linked personal or social problems that need attention by non-specialist services.

In the context of a substitution treatment programme, screening involves detecting the presence of the signs and symptoms of dependence. For example, in opioid substitution, the critical procedure of screening ensures that opioid-naïve individuals (that is, those with no opioid tolerance) are exited from the assessment procedure for substitution prescribing. Screening can involve either self-reporting or biological investigations, or both.

There is a growing expectation that generic health and social care professionals (that is, non-substance abuse specialist service providers including general practitioners, accident and emergency departments, children and families social services) should be able to conduct a basic drug abuse screening.

The Alcohol, Smoking and Substance Involvement Screening Test has recently been published and it is the first generalized screening questionnaire to look at all psychoactive substances [13]. The items in the Test are summarized in box 37 and a further example of a short screening form is given in annex IV.

Box 37
Alcohol, Smoking and Substance Involvement Screening Test

Q1. In your life, which of the following substances have you ever used? (tobacco products, alcoholic beverages, cannabis, cocaine, stimulants, inhalants, sedatives/hypnotics, hallucinogens, opioids and "other" drugs; non-medical use only)? 0 = No; 1 = Yes.

Q2. In the past three months have you used the substances you mentioned? 0 = Never; 1 = Once or twice; 2 = Monthly; 3 = Weekly; 4 = Daily or almost daily.

Q3. During the past three months, how often have you had a strong desire or urge to use (first drug etc.)? 0 = Never; 1 = Once or twice; 2 = Monthly; 3 = Weekly; 4 = Daily or almost daily.

Q4. During the past three months, how often has your use of (first drug etc.) led to health, social, legal or financial problems? 0 = Never; 1 = Once or twice; 2 = Monthly; 3 = Weekly; 4 = Daily or almost daily.

Q5. During the past three months, have you failed to do what was normally expected of you because of your use of (first drug, second drug etc.)? 0 = Never; 1 = Once or twice; 2 = Monthly; 3 = Weekly; 4 = Daily or almost daily.

Q6. Has a friend or relative or anyone else ever expressed concern about your use of (first drug etc.)? 0 = No, never; 2 = Yes, in the past three months; 1 = Yes, but not in the past three months.

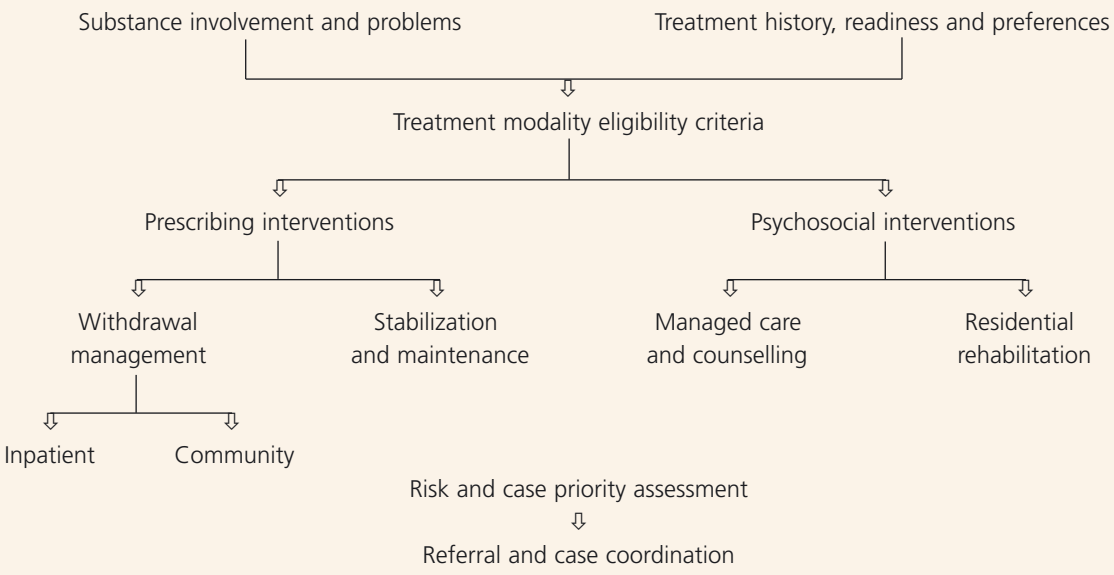
Q7. Have you ever tried to control, cut down, or stop using (first drug etc.)? 0 = No, never; 2 = Yes, in the past three months; 1 = Yes, but not in the past three months.

Q8. Have you ever used any drug by injection (non-medical use only)? 0 = No, never; 2 = Yes, in the past three months; 1 = Yes, but not in the past three months.

2. Triage

Substance abuse triage assessment is conducted by specialist services providing treatment for substance abuse problems. The purpose here is to identify, at the point of first contact with the service, which type of treatment is best matched to the needs and preferences of the individual, together with the level of urgency of the case that relates to the response needed. That process involves a diagnosis of the nature and severity of the problem. An example of a triage assessment form is provided in annex V and a summary of the basic assessment process is shown in box 38.

Box 38
Simple structure of an assessment process



3. Comprehensive assessment

The third type of assessment can be labelled a comprehensive substance abuse assessment. That is an assessment undertaken by trained substance abuse service professionals and is appropriate for those individuals who have problems in several areas and whose complex needs are likely to require more structured and intensive treatment interventions. Six core measurement domains that describe the personal and social functioning of a client are usually addressed in comprehensive assessments: *(a)* medical status; *(b)* employment and support status; *(c)* drug and alcohol consumption and problems; *(d)* legal status and crime involvement; *(e)* family and social relationships; and *(f)* psychiatric status.

The primary purpose of assessment is to carry out a functional analysis and determine the best type of response. That involves a detailed analysis of the antecedents, context, expectations and consequences of an individual's drug use. Since many people are heavy and problematic users of more than one drug, assessment should profile the consequences arising from a range of substances. Assessment of the route of drug administration is also of clinical importance, since injecting drug use may lead to specific medical problems, including viral hepatitis, HIV, septicaemia, subcutaneous abscesses and endocarditis.

In addition to assessing the consequences arising from drug use, the threat of HIV infection and other communicable diseases has made it important to assess certain drug use and sexual risk behaviours (for example, sharing injection equipment and unsafe sexual behaviour). An important task during assessment is the identification of barriers to change and the maintenance of change. They may include psychological problems (for example, anxiety, negative mood states and psychiatric co-morbidity), social and relationship issues (for example, living with a drug-using or addicted sexual partner), and environmental issues (for example, physical access to drugs).

Several comprehensive assessment tools have been developed. One of the most widely used is the Addiction Severity Index and its short version known as the Addiction Severity Index Lite. The Addiction Severity Index assesses the extent of a client's problems in seven areas: medical status; employment and support; drug use; alcohol use; legal status; family/social status; and psychiatric status. A trained interviewer can gather a range of valuable information about a client's areas of need. The Addiction Severity Index Lite is shown in annex VI. Another example of a very detailed, multidimensional assessment tool, developed in Chicago, is known as the Global Assessment of Individual Needs. That tool combines assessments of clinical and social problems with research scales and behavioural measures that record current and follow-up problems for outcome monitoring and evaluation applications (see http://www.chestnut.org/LI/gain/index.html).

4. Characteristics and eligibility criteria

A client usually needs to satisfy eligibility criteria for admission to a structured treatment programme. An example of eligibility criteria that might be considered as part of the client-treatment assignment process is shown in box 39 below. It is presented for illustrative purposes only, and should not be used for clinical management of clients without necessary adaptations to the

Box 39*a*
Eligibility criteria for community setting detoxification

The client must meet the following criteria *(a)-(d)* and either *(e)* or *(f)*:

(a) Over the past six months, criteria for substance dependence (with physiological dependence) is met and current, objectively verified use is confirmed;
(b) The client is currently tolerant to one or more substance classes such that an abrupt cessation of use will lead to the onset of withdrawal symptoms;
(c) The client expresses a preference for a community detoxification programme or is willing to receive that type of treatment;
(d) There is a reasonable expectation that the client will be able to comply with and complete a community detoxification programme;
(e) Withdrawal symptoms following cessation of the main substance(s) used are likely to be relatively uncomplicated;
(f) The client's living environment is characterized by reasonable levels of family and/or social supports.

Box 39*b*
Eligibility criteria for inpatient detoxification

The client must meet the following criteria *(a)-(d)* and either *(e)* or *(f)*

(a) Over the past six months, criteria for substance dependence (with physiological dependence) is met and current, objectively verified use is confirmed;

(b) The client is currently tolerant to one or more substance classes such that an abrupt cessation of use will lead to the onset of withdrawal symptoms;

(c) The client expresses a clear preference to withdraw from substances in an inpatient programme, or is willing to receive that type of treatment;

(d) Previous treatment or detoxification experience situation and/or the client's drug use involvement, or personal resources suggest that he/she will be unlikely to complete a community setting detoxification;

(e) Withdrawal symptoms of a severe and/or complex nature are likely to follow cessation of the main substance(s) used;

(f) The client's social environment contains one or more people (for example, a partner or friends/acquaintances) who are current substance users and who are likely to hinder the client's resolve or ability to participate in an outpatient programme and present an immediate risk of relapse.

Box 39*c*
Eligibility criteria for community counselling (drug-free)

The client must meet the following criteria *(a)-(d)*:

(a) Client meets diagnostic criteria for past six months substance dependence or abuse;

(b) The client expresses a preference for treatment in a community counselling programme or will accept an assessment for that type of treatment;

(c) The client has sufficient motivation to address harm reduction behavioural changes (safer drug use) or abstinence from their main problem substance(s) (according to the required orientation/approach of the counselling programme);

(d) There are reasonable grounds to assume that the client will be able to attend treatment and comply with the rules and regulations operating in the counselling programme;

(e) There are reasonable levels of family, relationship or friendship supports that do not represent substantial risk of sustained drug abuse or relapse to further drug abuse that will prevent attendance at the programme.

Box 39*d*
Eligibility criteria for substitution prescribing

The client must meet the following criteria *(a)-(c)* and either *(d)* or *(e)*:

(a) Over the past six months, diagnostic criteria for substance dependence (with physiological dependence) is met for the opioid or amphetamine class;

(b) The client expresses a preference for a substitute prescription or will accept an assessment for a community stabilization/maintenance programme;

(c) The client is currently tolerant to opioid or amphetamines (having demonstrated that via objective verification) and abrupt cessation of use will lead to the onset of a characteristic withdrawal syndrome;

(d) There are reasonable grounds to assume that the client will be able to attend treatment and comply with the rules and regulations operating in the prescribing programme;

(e) Due to the nature of the client's substance dependence, he/she is not able to make an immediate commitment to abstinence and requires a period of stabilization/maintenance and monitoring based on appropriate substitution and other adjunctive pharmacotherapy pending further assessment of treatment goals.

Box 39e
Eligibility criteria for residential rehabilitation (drug-free)

The client must meet the following criteria *(a)*-*(e)* and either *(f)* or *(g)*.

(a) Over the past six months, the client has met diagnostic criteria for substance dependence;
(b) The client expresses a desire to maintain abstinence from previously dependent drugs and expresses a preference for admission to a residential rehabilitation programme or agrees to enter that type of treatment;
(c) The client has completed detoxification and is not experiencing marked withdrawal discomfort;
(d) The client is likely to have substantial problems maintaining abstinence due to the severity of his/her substance dependence;
(e) The client requires a programme of psychosocial counselling and rehabilitation that is most suitably delivered in a 24-hour residential environment;
(f) The client's living environment is characterized by social deprivation, including accommodation problems or accommodation instability, and that represents a threat to relapse;
(g) The client's social environment contains one or more people (for example, a partner; friends/acquaintances) who are substance users and who are likely to hinder his/her resolve or ability to maintain abstinence

particular treatment system in question. In that regard, the reader should consult resource materials listed at the end of chapter VI of the *Guide*.

5. Treatment plan

All structured treatments should be delivered according to a written, individual treatment plan for each client. That should be a collaborative process and involve an assessment with the client, not of the client. It should take into account the views and motivations of the clients and their personal and social supports and problems. The treatment plan document should:

- Describe the clients and their personal, social, economic and legal situation;
- Show sensitivity and awareness of the clients' culture, ethnic background and religious affiliation, as well as their gender and sexuality;
- Describe the client's current problems (as known at intake);
- Specify authorized sharing of information (what information will be sought and/or given to other professionals/agencies, and under which circumstances);
- Describe the specific interventions that are planned;
- Set out the goals of treatment and progress "milestones" that can be achieved;
- Describe how the care plan will be reviewed over time.

When building an individual plan, it is necessary to address the client's movements both within and between treatment modalities. Within-treatment movements refer to screening, assessment, intake and programme and discharge planning. Between-treatment movements refer to the potential for sharing the care of the client between two or more services.

The care plan concept reflects the fact that many people have continuing care needs even when a treatment episode has been completed. It also acknowledges that individuals can enter the treatment system at different points and can travel across the treatment system over time. That movement can occur both within an episode of care as well as in subsequent care episodes. For example, someone completing an inpatient detoxification programme may well benefit from a short- or long-term residential rehabilitation placement to maintain and build on the immediate outcomes achieved by the inpatient programme. They may subsequently be followed up in a community programme. Relapse into drug use may lead them to seek the so-called open access services. Therefore, a particular inter-agency pathway may involve moving across the treatment system as the client progresses (or relapses) over time. An example of how treatments may be linked for an individual client—for illustrative purposes only—is shown in box 40.

6. Care coordination

Care coordination is the process of assessment, treatment planning and management of a client who is receiving treatment. It is similar to case management but is a wider concept that can involve the facilitation of treatment across more than one provider. The function of care coordination is a key role in an integrated, effective treatment programme. A care coordinator's responsibilities would be:

- To develop, manage and review documented care plans based on ongoing assessment (including risk assessment);
- To ensure that the care plan takes account of the client's ethnicity, gender and sexuality;
- To advise other professionals also involved in the treatment plan of any known changes in circumstances of the client that may require a review or change of the care arrangements;
- To carry out an early follow-up of discharged clients (where feasible);
- To aim at re-engaging people who have dropped out of the treatment system.

The level or intensity of care coordination required will reflect the nature of the client's current problem. A "standard care coordination" response would be envisaged for clients who:

- Require treatment from a single treatment modality;
- Are relatively stable;
- Pose little danger to themselves or others.

In contrast, a "multifaceted care coordination" model, of higher support and intensity of care, would be more appropriate for clients who have:

- Multiple needs that cannot be provided successfully by one service provider;
- Multiple needs but are only willing to engage with one agency;
- Contact with a number of agencies at referral;
- A severe co-morbidity;
- The potential for harm to themselves or others.

When a client is transferred from one treatment programme to another (for example, from a residential programme to a community-based counselling programme), the day-to-day coordination of treatment is passed to the new service with the intention that a new caseworker in the receiving service will assume that responsibility. However, the overall care coordination of the client's continuing needs can remain with the original agency, and that is particularly relevant in cases where the person is returning to the local area following treatment in another locality and may require aftercare support.

Box 40

Example of a treatment link for an individual client

Initial treatment required		*Then possible additional treatments needed (care pathway)*
	Community detoxification	→ Aftercare/support → Community drug-free counselling → Aftercare/support → Residential rehabilitation → Aftercare/support → Residential rehabilitation → Community drug-free counselling → Aftercare/support
	Inpatient detoxification	→ Aftercare/support → Community drug-free counselling → Aftercare/support → Residential rehabilitation → Community drug-free counselling → Aftercare/support
	Community drug-free counselling	→ Aftercare/support → Residential rehabilitation → Aftercare/support
	Community prescribing	→ Community detoxification → Aftercare/support → Community detoxification → Community drug-free counselling → Aftercare/support → Community detoxification → Residential rehabilitation → Aftercare/support → Inpatient detoxification → Community drug-free counselling → Aftercare/support
	Residential rehabilitation	→ Aftercare/support → Community drug-free counselling → Aftercare/support

Key points

The key points covered in chapter VI of the *Guide* are as follows:

- A comprehensive treatment response includes the provision of several types of structured treatments in a specific area according to needs;
- Responses should be seen as part of the broader health, social and legal response;
- It is important to specify the main referral routes into the treatment system;
- Clarifying and formalizing the referral and linkages procedures between treatment services is a key part in the development of treatment systems;
- The integrated care pathway approach is increasingly being used to identify and achieve individual client desired outcomes. Elements of such pathways are:
    - Client assessment: screening, triage and comprehensive assessment;
    - Care planning: structured treatments should be delivered according to a written, individual care plan;
    - Care coordination: coordination of care should be a central function of a treatment response.

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Chapter VII

Monitoring treatment activity and outcome

Almost all treatment services record information about their clients, their problems and the services to be provided, and usually store narrative information and other notes about treatment progress in the client's file. However, many treatment services struggle to find ways to practically use the information they gather to assess the impact of their treatment and to provide an overview of how they are performing as a service.

Today, there is concern about that situation in many countries. In almost all developed and developing countries, treatment systems place emphasis on improving the day-to-day recording of service delivery and assessing the impact and outcome of treatment. The value and importance of gathering and applying information about the effectiveness of services is highlighted in the Declaration on the Guiding Principles of Drug Demand Reduction and the Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction.

Chapter VII of the *Guide* asks the question: "How can the performance of treatment services be assessed?" That question is approached first from the perspective of a basic set of information and recording procedures that can be included in the day-to-day operation of a treatment service. More complex and sophisticated monitoring and research activities are then described. Ways of accessing summaries of the research literature are also discussed.

The benefits to be gained from reading this section are as follows:

- Guidance on how to ensure that information can be collected to show that services meet their stated objectives and other general outcomes;
- Clarification of the key outcome measures that can be used;
- Understanding of how to establish an incremental model to gather outcome information and communicate results to key audiences.

The material in chapter VII is intended to be relevant to new treatment developments as well as existing treatments and systems. As with earlier chapters of the *Guide*, the coverage and sophistication of monitoring activities can range at all points from basic to complex.

Chapter VII is divided into three sections. Section A presents the case for establishing a performance monitoring system and discusses definitional and conceptual issues. Section B presents a summary of the elements of a performance and outcome monitoring system and offers guidance for a basic, intermediate and formal system. Section C considers information management and communication issues and how to access evaluation and outcome research information.

A. Purpose of monitoring treatment activity

In general, the purpose of activity monitoring is to assess whether (and to what extent) the services are actually doing what they originally aimed to do. Monitoring can range from basic types to more sophisticated forms that will require considerable resources to run. Guidance is offered for implementation of a basic form of monitoring first. From that base, more complex and expensive outcome monitoring systems can be built if resources permit. Monitoring systems also evolve over time, with expanding depth and coverage as required.

As described in the two companion documents to the *Guide*, there is good research evidence about the effectiveness of treatment of people with substance-related problems. However, that evidence needs to be validated in different sociocultural circumstances and day-to-day practice. To do so, collection and documentation of actual practices are essential. The key message of chapter VII is that a basic set of information about services can and should be subject to routine collection, as part of the day-to-day running of each programme.

1. Resources on monitoring and evaluation

Step-by-step guidance on how to plan and carry out evaluations is not included in this *Guide*. The reader is referred to more specific resources on that subject. For

example, guidelines and workbooks on treatment evaluation have been developed by WHO, UNDCP and EMCDDA (see box 41).

2. Audiences for activity and outcome assessment information

There are three audiences with an interest in activity and outcome information:

- The individual client and his or her family may well be interested in learning about the activity of a service;
- Both clinical and managerial staff will have an interest in charting the progress of the service over time;
- Government service planners and funding organizations will be interested in learning about the overall performance of the service.

3. Evaluation and treatment monitoring concepts

Several terms are used in the evaluation and monitoring field that characterize how treatments are viewed and their impact is assessed.

(a) Inputs

An input is a measure of the resources used to provide a particular treatment or service. Inputs can refer to capital and revenue monies; human resources (that is, people required to deliver treatment); buildings; equipment and supplies and materials. The total cost of programme inputs provides an indicator of the economy of the service. Inputs enable staff to run the services in order to meet the aims and objectives of the programme.

(b) Output

Output measures are an indicator of the level, amount or volume of activities undertaken by the treatment programme, such as the number of new clients seen and the actual number of consultations. Output measures usually reflect workload expressed in terms of time or cost. It is important to note that outputs do not necessarily indicate whether the objectives of a treatment programme have been met or the extent to which they are effective or of acceptable quality.

The conversion of inputs to outputs provides an indicator of the efficiency of the programme. In addition, resource inputs also enable the service to be provided to

Box 41
WHO/UNDCP/EMCDDA international guidelines and workbooks for the evaluation of treatment services and systems for psychoactive substance use disorders

In 2000, joint publications from WHO, UNDCP and EMCDDA presented guidelines and a series of workbooks on treatment evaluation. The publications are part of a strategy by WHO, UNDCP and EMCDDA to develop tools for programme managers to carry out evaluations of their services and to assist in decisions concerning the allocation of treatment resources.

The guidelines focus on formal research studies and seek to characterize the main components of a well-conducted evaluation and how results can be best communicated.

For further information, go to:

http://www.undcp.org/drug_demand_treatment_and_rehabilitation.html
http://www.who.int/substance_abuse/PDFfiles/guideevaloftreatment.pdf

The series of workbooks is intended to guide programme planners, managers, staff and other decision makers through the process of planning and implementing evaluations. It also provides a valuable training resource for people interested in evaluation as well as service planners and providers.

The following main types of evaluation are described in the series of workbooks: needs assessment; process evaluation; evaluation of client satisfaction; outcome evaluation; naturalistic and observation studies; experimental and controlled designs; economic evaluations (cost analysis and cost-effectiveness).

For further information, go to

http://www.undcp.org/drug_demand_treatment_and_rehabilitation.html
http://www.who.int/substance_abuse/topic_treatment.htm

a certain level of quality. Measures of quality reflect the extent to which the service meets the desired standards set for the programme and the expectations of the clients and other key audiences and stakeholders. Quality measures can be used across the programme environment to measure the competences of the staff and the timeliness and appropriateness of the services received.

(c) Outcome

An outcome may be defined as the results or the effects from therapeutic activities and can be either positive or negative. Outcome measures need to be relevant to individual treatments and sensitive to the desired goals of clients. In some programmes, there may be few resources available to assess true outcomes (that is, those measured using a scientifically reliable instrument or procedure), and often proxy outcome measures are used as an alternative. For example, in outcome research, a measure of change in the frequency of substance use is often assessed by means of a standardized instrument. That requires measurement of the frequency of using the drug at intake to treatment and again when the client leaves treatment. Some agencies that are unable to take those measurements may relay their assessment in reporting the status of the clients when they leave (for example, improved, stayed the same or deteriorated).

B. Elements of a performance and outcome monitoring system

A performance and outcome monitoring system is a core element of a treatment service that wishes to understand how well it is serving the needs of its clients on a day-to-day basis. The information collected can be used to:

- Improve the client assessment and care coordination process;
- Help treatment providers explore ways of improving their services (for example, for particular types of clients who may not achieve the outcomes of the majority);
- Provide knowledge about the overall impact of the treatment system and to help treatment planners and government agencies judge the investment return on funding treatment;
- Help identify gaps in effective provision of treatment and the need for additional or new types of care programme.

It can be undertaken at several levels and may involve a single agency, a consortium of agencies in a specified geographic area, or a regional or national initiative.

The initiative can be conducted by a treatment agency itself or by some external service provider. The external service provider model can be of value when several treatment agencies are involved in a locality.

Effective outcome monitoring systems are characterized by the following "success factors":

- Staff commitment and enthusiasm to gather information as part of routine service delivery;
- Integration of data collection for outcome monitoring as part of routine assessment and care coordination arrangements;
- Use of minimum data sets (that is, using a small number of critical or essential indicators of outcome only);
- Sustainable scope of the initiative (for example, focus on outcome assessment during treatment);
- Government-level financial support of costs of training, data management and the communication of results;
- Partnership and mutual learning values;
- Rapid feedback of information to guide further development of services.

It may be helpful to think of the nature and volume of data gathered in a performance and outcome monitoring system as a pyramid. The greatest volume of information is collected as part of the routine, day-to-day clinical work and operation of a treatment system. A small volume of key performance indicators are then transmitted to treatment funders and other external audiences. Finally, a core set of key performance indicators are reported to governmental and other organizations, as part of a public accountability and national treatment reporting approach.

Guidance on three levels of treatment monitoring is presented below. Those levels are additive and increase in complexity from a basic approach through to a more complex (and resource-intensive) performance and outcome monitoring system.

1. Basic monitoring system (level one)

The purpose of level one is to collect a basic set of key information about the delivery of treatment with which to infer something about its impact. All providers of services-no matter how limited their financial, technical and human resources-should be capable of collecting and reporting on a basic set of activities and outcome information for any type of treatment. For a basic level

of reporting, there are seven types of descriptive information required:

- Summary information about referrals and assessment activities;
- Basic sociodemographic characteristics and drug use profile of the client;
- Previous treatment information and whether the first-ever treatment episode is involved;
- The setting and general nature of the treatment programme;
- The total amount of treatment (that is, the number of individual, group and other therapeutic sessions and their duration);
- The total time spent in treatment;
- The status of the client at the end of treatment under the programme (or the stage completed, such as detoxification).

All services should record a basic set of information about the client referral, assessment and treatment activity of the programme for a specified reporting period (for example, per annum). That information should include the number of people: referred to the programme for assessment; referred to another service; who commence treatment; and who complete treatment. It is recommended that that information be presented by referral source and gender as a minimum.

Box 42
Example of a minimum data set required for each client

Area covered	*Relevant factor or component*
Client	
Sociodemographics	Gender Age (at last birthday/year of birth)
Primary drug problem	Cannabis type, heroin, other opioids, cocaine type, amphetamine, methamphetamine, Ecstasy type, sedatives/tranquillizers, hallucinogens, solvents/inhalants, other
Risk behaviour	Injecting drug use
Treatment experience	First time in treatment
Treatment	
Programme type	Low threshold/drop-in Withdrawal (detoxification) Counselling/psychotherapy Agonist maintenance prescribing Antagonist relapse prevention prescribing Rehabilitation (drug free)
Setting	Hospital inpatient Outpatient treatment centre General practitioner Community residential Prison/detention
Duration of stay	Days/weeks/months in treatment under that programme on discharge
Result	
Status of clients leaving treatment within the reporting period	Planned departures (that is, successfully completed treatment) Unplanned departures (that is, client dropped out or otherwise stopped treatment) Transferred to another treatment (described) Administrative/disciplinary discharge (non-compliance with treatment plan or rules of the service)

At that basic level, no attempt is made to report per se on changes in the problem behaviours of clients. Instead, the status of each client is recorded at the point of departure from the service. But it does not involve a quantitative description of changes in drug use and other problem behaviours. Box 42 shows an example of a minimum set of data required for each client who leaves or completes treatment during a reporting period (for example, yearly).

An informative picture of the results of treatment can be obtained from such information. The aggregation and presentation of the information can be approached in several ways. Box 43 presents some fictitious example data for a sample of 220 female clients who left treatment from a community programme.

The row at the bottom of box 43 shows the overall outcome from the programme and indicates that 63.6 per cent of the clients completed treatment. The row percentages by age group also show the relative impact of the programme for the three age groups. The data presented in the example suggest that increasing age is associated with a better outcome. Naturally, other ways of presenting the data are possible.

International reporting-country indicators

In addition to local outcome monitoring initiatives, it is important to note the requirements for country-level reporting to international bodies.

For example, part II of the UNDCP annual reports questionnaire concerns the extent, patterns and trends in drug abuse. It is the primary regular reporting mechanism for the demand side of drug abuse data from the Member States. The data are recorded under the UNDCP international drug abuse assessment system.

The Commission on Narcotic Drugs sends the annual reports questionnaire each year to the Governments of Member States for completion. The annual reports questionnaire, inter alia, collects information on treatment demand in each country. One of the aims of the Global Assessment Programme on Drug Abuse coordinated by UNDCP is to support Member States in their data collection efforts. The activities of the Global Assessment Programme include the development of a protocol for the collection of data from treatment centres. The proposed protocol is designed to facilitate the collection of data reported through the annual reports questionnaire. The structure of part II of the annual reports questionnaire is shown in box 44.

Box 43

Community programme: twelve-month outcome report for female clients by age group

(Number of clients: assessed for treatment—310; commencing treatment—250;[a] leaving treatment in reporting period—220)

Outcome status of clients leaving treatment during year by age group (n = 220)

	Outcome status			
Age group	*Planned departures (percentage in parentheses)*	*Unplanned departures (percentage in parentheses)*	*Administrative discharge (percentage in parentheses)*	*Total*
18-24	30 (50.0)	20 (33.3)	10 (16.7)	60
25-35	50 (62.5)	20 (25.0)	10 (12.5)	80
36+	60 (75.0)	15 (18.8)	5 (6.3)	80
Total	140 (63.6)	55 (25.0)	25 (11.4)	220

[a] The number of individual episodes of treatment may also need to be shown for the reporting period, since a client may have been treated under the programme on two (or more) occasions.

Box 44
Annual reports questionnaire—Part II (drug abuse)

Part II of the annual reports questionnaire comprises nine sections. Section 8 concerns treatment.

Drug treatment

Q48. Have people received treatment for drug problems in the past year? (Any drugs, cannabis type, heroin, other opioids, cocaine type, amphetamine, methamphetamine, Ecstasy type, other drugs)

Q49. How are drugs ranked in order of the primary cause of receiving treatment? (Cannabis type, heroin, other opioids, cocaine type, amphetamine, methamphetamine, Ecstasy type)

Q50. What has been the trend over the past year in the numbers of people receiving treatment? (Any drugs, cannabis type, heroin, other opioids, cocaine type, amphetamine, methamphetamine, Ecstasy type, other drugs)

Q51. Do you have an estimate of the number of people receiving treatment for drug problems? (No, Yes—an estimate for the country as a whole, Yes—an estimate for a part of the country for a selection of treatment facilities) If No, proceed to Q 59

Q52. For which year does the estimate apply? Which part of the country or selection of treatment facilities is covered by the estimate? (Year of the national estimate, year of the partial estimate, part of the country for which the estimate applies, types of treatment facilities included and/or excluded in the estimate)

Q53. What is the estimated number of people receiving treatment for drug problems? (Any drugs, cannabis type, heroin, other opioids, cocaine type, amphetamine, methamphetamine, Ecstasy type, other drugs)

Q54. What is the estimated percentage of people receiving treatment for the first time ever among people in treatment? (Any drugs, cannabis type, heroin, other opioids, cocaine type, amphetamine, methamphetamine, Ecstasy type, other drugs)

Q55. What is the estimated percentage of females among people in treatment? (Any drugs, cannabis type, heroin, other opioids, cocaine type, amphetamine, methamphetamine, Ecstasy type, other drugs)

Q56. What is the estimated mean age of people in treatment? (Any drugs, cannabis type, heroin, other opioids, cocaine type, amphetamine, methamphetamine, Ecstasy type, other drugs)

Q57. What is the estimated percentage of drug injectors among people in treatment? (Any drugs, cannabis type, heroin, other opioids, cocaine type, amphetamine, methamphetamine, Ecstasy type, other drugs)

Q58. Which definition of "people treated for drug problems" applies to the figures in the columns of Q53-Q57 above? (All people receiving treatment during the year, people starting treatment during the year, people in treatment at census date in the year, people discharged from treatment during the year, other)

Another example of international reporting is shown in annex VII. It has been developed for use in Europe and can be adapted for use elsewhere as required.

2. Intermediate monitoring system (level two)

The next level of reporting carries the features of level one forward and incorporates additional information to document and describe treatment activities. The purpose of level two is to add further details to the client and treatment description and gather a basic measure of behavioural change as a direct measure of outcome.

In addition to reporting under level one, the following can also be recorded:

- Sociodemographic information (nationality and ethnic description, relationship and living status, labour status and educational level);
- Drug-related information (routes of administration, frequency of use, age of first use of main problem drug, drug injecting status and frequency);
- Treatment referral information;
- Average waiting time to commence treatment (from assessment);
- A description of the specific types of services received by the client.

The information should also be presented by the main problem drug used by the clients under the following categories: cannabis-type; opioids; cocaine-type;

amphetamine-type; sedatives and tranquillizers; hallucinogens; solvents and inhalants; and other drugs.

In addition to describing the status of clients at their departure from the programme, it would be informative to report on some basic behavioural changes. Stopping or reducing problem drug use is the obvious behavioural change and outcome objective, but improvement in personal and social problems is also important. As an example, the basic information outlined in box 45 could be reported from a short interview with each client at intake and prior to departure (if feasible).

3. Formal monitoring system (level three)

The third level represents a formal performance and outcome monitoring system. Its purpose is to operate a formal and sustainable system of recording how well the treatment service is operating and meeting the needs of its clients. Using a structured approach to outcome monitoring also has benefits for clinical practice, since staff can feed the information back to clients at the beginning of treatment and at follow-up as a means of building and sustaining motivation for change.

Level three contains the features and records described for the previous two levels, but also provides greater characterization of the client and a wider range of behavioural and other changes with which to describe their outcome. Readers interested in establishing such a system should also review the material in chapter VI relating to comprehensive assessment processes and to integrated care pathways and the importance of describing continuing treatment episodes for clients who require several linked treatment services. An informative picture of outcome can be obtained from looking at treatment from that perspective.

It is important to caution against devising a level-three system without a careful feasibility assessment. That assessment should examine the following:

- The specific questions to be addressed;
- The size and scope of the monitoring system required;
- The human resources that will be needed;
- The skills needed by the personnel involved;
- The financial resources needed;
- The implementation and reporting timetable.

Box 45
Basic description of drug use, employment and crime

(last 30 days before intake and before departure from treatment)

Measure	*Number of days during the past month before treatment*	*Number of days during the past month before discharge*
Drug use Used main problem drug		
Employment Had paid work		
Crime Committed illegal activity		

Patient recall can be assisted by showing the prompt below.

None	1 day only	2 days only	3 days only	1 day a week	2 days a week	3 days a week	4 days a week	5 days a week	6 days a week	Every day
0	1	2	3	4	9	13	17	21	26	30

The most logical and practical means of assessing treatment outcome is to gather a set of measures from a client and his or her family at intake to a programme (baseline) and then collect the same measures again from the client at one or more points during and ideally following treatment. In that way, outcome monitoring is conceptualized as reassessment and can be incorporated as part of routine clinical practice (please refer to material on client assessment in chapter VI). It is most desirable that outcome assessments involve an active appraisal of the client from a face-to-face or telephone interview or a self-completion of an assessment questionnaire by the client. Other methods, such as estimating outcome from case notes, are unlikely to be valid or accurate and are not recommended.

(a) Characterizing outcomes

When considering which outcomes to report, it is valuable to follow a consensus from formal research studies about key measures. Researchers have focused on three core problem domains: substance use behaviour; physical and psychological health problems; and personal and social functioning (a broad set of problems spanning family and relationships, accommodation, employment, crime involvement and other public safety issues). The risk of exposure to HIV and other infections, including hepatitis C, has led to the assessment of injection-related and sexual risk behaviours for contagion and transmission of blood-borne infections. It is important to recognize that outcome expectations can differ across individual, family, community, service-related and criminal justice perspectives.

(b Choosing appropriate assessment points

For outcome monitoring, client changes can be assessed at one or more points during treatment. Unlike research studies, most treatment outcome monitoring initiatives do not attempt to evaluate outcome after a client has left treatment, largely because of the resources required in organizing face-to-face interviews (although telephone or mail-based assessments may be considered).

(c) Using treatment objectives for monitoring purposes

The WHO/UNDCP/EMCDDA guidelines on treatment evaluation mentioned in box 41 advocate the use of the programme-logic-model approach to help clarify the objectives of a treatment programme. A logic model is a diagram that sets out the different components of a programme, the purpose of each component (implementation objectives) and short- and long-term outcomes. Logic models are useful when setting objectives and targets for each component and for outcome and can be powerful communication aids when describing the programme to professional audiences. A theoretical example of a logic model, prepared to characterize the operation of a residential rehabilitation service, is shown in box 46.

4. Assessment instruments for outcome monitoring

The majority of variables suitable for repeated assessment will be continuous, or scale measures, which are sensitive to assessing change over time. A satisfactory assessment of outcome requires status measures to be recorded at intake, at some point during treatment, at treatment completion and possibly at follow-up.

There are a variety of assessment instruments and techniques such as face-to-face interviews, behavioural observation, questionnaires and psychological tests.

Although substantial training is required in order to utilize the data collection methods properly and effectively, well-constructed questionnaires can collect useful data even when administered by less trained staff members. Choice of suitable outcome questionnaires should be guided by the following principles:

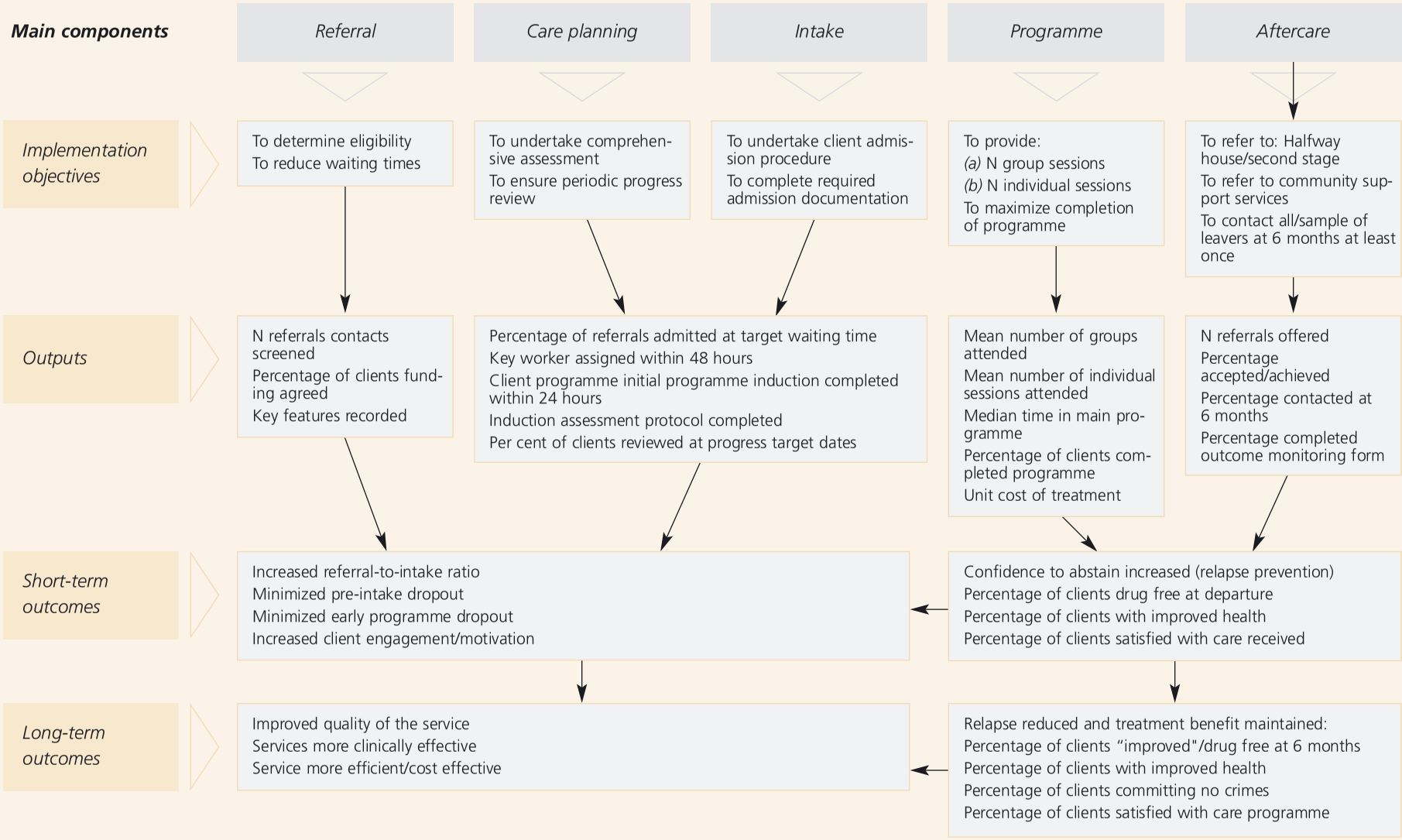
- Relevance to the target population and treatment programme;
- Relevance to the programme philosophy and capability to direct reporting against targets and priorities;
- Suitability for face-to-face interviewing with a client or self-completion by the client;
- The instrument must have established psychometric properties (validity and reliability);
- The measures must be sensitive to change over time;
- Administration of the questionnaire must be as brief as possible;
- The client and other non-professional audiences should be able to understand assessment methodologies and reports without marked difficulty.

There are several instrument banks available that contain information about research questionnaires and instruments. An example resource is shown in box 47.

In annexes VI and VIII of the present *Guide,* examples are shown of the structure of two established instruments for outcome monitoring, the Addiction Severity Index and the Maudsley Addiction Profile. Both instruments can be used free of charge for non-commercial research and outcome monitoring purposes. They are similar in several respects, and the Addiction Severity Index Lite version contains a more comprehensive set of background and client functioning measures for indi-

Box 46

Example of a logic model for a residential rehabilitation programme



Box 47
Evaluation Instruments Bank of the European Monitoring Centre for Drugs and Drug Addiction

The EMCDDA Evaluation Instruments Bank is a document archive of tools created to encourage evaluation using reliable methods and to help to standardize those tools at the European level. The Evaluation Instruments Bank contains tools for evaluating both prevention and treatment programmes. By entering the specific criteria of the intervention to be evaluated, the database provides the user with suitable evaluation tools, together with comments on its use and references to related studies. The Evaluation Instruments Bank is a flexible and living tool that has expanded since its launch in June 2000; it now includes all 12 EMCDDA languages. The Evaluation Instruments Bank is regularly updated and currently holds 150 evaluation instruments from the treatment field and 35 from the prevention field. It has keyword, category and full text search facilities.

For further information, go to
http://eibdata.emcdda.org/databases_eib.shtml

vidual treatment planning. The Maudsley Addiction Profile is a brief instrument that has been designed for outcome purposes and takes approximately 12 minutes for completion.

C. Managing information and communicating results

A computerized database management application is almost always needed to manage the information set from the performance and outcome monitoring system at each of the three levels. The computerized database represents an efficient means of validating, storing and analysing the information and producing reports for different audiences. Developing a database application would be reasonably straightforward for level-one applications, but is likely to require the support of a specialist developer for levels two or three. In the past, much money has been wasted by agencies that are uncertain about either their information or their reporting requirements. That results in a database that is unsatisfactory and sometimes never actually implemented. Today, many computer database developers use a core application that has already been written, adapting it to the specific (and

Box 48
Electronic treatment data collection in the United States

The Drug Evaluation Network System (DENS) is an ongoing, multi-site, electronic data collection and reporting system providing standardized, automated, timely data via modem, on patients entering addiction treatment and on treatment programmes in the United States.

Sponsored by the White House Office of National Drug Control Policy, and the Center for Substance Abuse Treatment, the goal of the project is to provide practical and current clinical and administrative information on patients entering into substance abuse treatment throughout the country. Ultimately, the system will include alcohol and drug treatment programmes representatively sampled from all areas of the country, and from different treatment modalities and facility types, including the criminal justice system.

DENS collects real-time information on the nature, number and severity of patients' problems at the time of treatment admission, their length of stay and type of discharge. The collection of such data aims at providing policy makers at the federal and state levels with the information necessary to recognize important trends occurring that may be relevant in planning and administering systems that deal with substance abuse problems.

To serve such needs, DENS information is relevant to the multiple clinical, administrative, fiscal, evaluative and policy questions that so regularly arise; it is also available rapidly and continuously to enable observation of changes over time.

In addition, DENS offers a framework for a future, ongoing, nationwide system for monitoring treatment outcomes. As such, the DENS system can be utilized as a starting point for specific, targeted outcome studies, or for large, regional, or state-level outcome projects.

For further information, go to:

http://www.whitehousedrugpolicy.gov/ctac/dens.html
http://www.densonline.org

Box 49
Cochrane Database of Systematic Reviews

The Cochrane Database of Systematic Reviews contains articles that review the impact of health-care treatments and procedures. The reviews are highly structured and systematic and published research is included on the basis of explicit quality criteria to ensure the reliability of the conclusions reached and to minimize bias. Information from studies are usually combined statistically using a technique called meta-analysis.

As part of the Cochrane Collaboration, a Cochrane Drug and Alcohol Group has been established and has published a range of reviews and evidence-based practice guidelines in the form of full reviews, technical abstracts and brief summaries. The latter are written in a plain language style and constitute a valuable tool for those who have responsibility for the funding or planning of treatment services.

For further information, go to **http://www.cochranelibrary.com**

Key points

The key points covered in chapter VII of the *Guide* are as follows:

- There is increasing emphasis on improving the day-to-day recording of service delivery and communicating essential information about outcome;
- Outcome monitoring is an initiative designed to gather information on the impact of services provided in order to understand how a service operates and to identify gaps in effective provision and ways of improving treatment effectiveness. The scope and depth of such an initiative can vary from a basic system (level one) to more comprehensive solutions (levels two and three);
- Successful outcome monitoring systems are characterized by staff commitment, the integration of outcome information as part of routine assessment and care coordination arrangements; partnership and mutual learning values; and rapid feedback of information to guide further development of services;
- Performance and outcome monitoring initiatives can be tailored in terms of the range and depth of reporting according to resources;
- Most service providers should be able to implement a basic performance and outcome monitoring system to report on during-treatment outcomes;
- Attention to the evidence for treatment outcomes, as reported by formal research studies, is critical, and systematic reviews can be valuable sources of summary information about a particular treatment or approach.

future) needs of the specific treatment provider. Most current applications are based on the entry of data for a client to a secure database programme operating on computers in the treatment centre. Some agencies also use secure Intranet or web-based applications, and that is likely to become more common in the future.

Box 48 illustrates an example of a data collection and monitoring system that is electronically based and that evolved from the Addiction Severity Index, a clinical and evaluation tool developed in the United States and used in a wide range of countries.

Regardless of the complexity of the information to be collected, the key requirement is to be clear about what types of report are needed and their format. Most reports from an outcome monitoring database can be in a standard format and can, for example, summarize the client group and its main outcomes for a particular time period. The key audiences for the reports include the client (through personalized feedback); provider staff and management; and funding bodies and government bodies.

1. Accessing information about treatment outcome

One of the most important reasons for gathering information about the impact of services is to help to optimize treatment for specific groups of people and to ensure that the more effective and affordable treatment alternatives are given priority. In recent years, there has been an increasing interest in using the published findings of formal evaluation studies together with clinical expertise and clients' preferences as a means of guiding resource allocation and decisions relating to health and social wel-

fare services and systems. Treatment planners are increasingly motivated to direct resources to treatment services that have an evidence base for their effectiveness. Evidence-based practice relies on a systematic appraisal of the research literature for the impact of a particular treatment. The appraisal can then lead to the preparation of guidelines and protocols for a particular treatment.

Naturally, there are limitations to the body of evidence. Knowledge of all treatments, with all the various population groups and individual priority needs, is far from complete. Moreover, most robust studies of treatment outcome have been conducted in a relatively small number of countries with developed treatment systems. There are natural limits in the way that findings from a treatment study in one part of the world can be applied to treatment services in another country. In part, that has led to investment in research studies and other monitoring activities that assess the same questions in different cultural and economic contexts. Nevertheless, much can be learned from reviews that aggregate the findings from different countries (see box 49).

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http://www.drugabuse.gov/IMPCOST/IMPCOSTIndex.html

Wolfe, B. L., and Miller, W. R., *Program Evaluation, A Do-It-Yourself Manual for Substance Abuse Programs* (Albuquerque, University of New Mexico, Department of Psychology).

http://casaa.unm.edu/download/programeval.pdf

Internet resources

Drug Abuse Treatment Outcome Studies, United States

http://www.datos.org/

Drug Evaluation Network System (DENS)

http://www.whitehousedrugpolicy.gov/ctac/dens.html

http://www.densonline.org

European Monitoring Centre for Drugs and Drug Addiction-Evaluation Instruments Bank

http://eibdata.emcdda.org/databases_eib.shtml

Addiction Severity Index (ASI)

http://eibdata.emcdda.org/Treatment/Needs/tasi.shtml

Drug Abuse Screening Test (DAST)

http://eibdata.emcdda.org/Treatment/Needs/tdast.shtml

Institute of Behavioral Research, Texas Christian University-The Methadone Outpatient Forms

http://www.ibr.tcu.edu/pubs/datacoll/TCU-DATARforms.html

Notes

1. Forthcoming.
2. In the *Guide*, a range of successful treatments is described. Assuming that cultural and economic conditions are favourable, all of these should be made available, although the size of the required capacity will need to be judged locally. There is no preference given to any treatment approach. The *Guide* considers that services should be tailored to the current needs of individuals and the severity of the problem.
3. Generally, the *Guide* refers to a service user as a "client". However, UNDCP recognizes the term "patient" to be more appropriate in the context of medical treatments and procedures. While individual substance abuse treatment programmes may have a preference for describing their service users as clients or patients, the terms are used interchangeably in the *Guide*, with no preference being advocated for either.
4. Forthcoming.
5. *WHO Expert Committee on Drug Dependence, Thirtieth Report,* WHO Technical Report Series, No. 873 (Geneva, WHO, 1998), p. 3.
6. *Demand Reduction, A Glossary of Terms* (United Nations publication, Sales No. E.00.XI.9), p. 73.
7. United Nations, *Treaty Series,* vol. 520, No. 7515.
8. United Nations, *Treaty Series,* vol. 1019, No. 14956.
9. *Official Records of the United Nations Conference for the Adoption of a Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, Vienna, 25 November-20 December 1988,* vol. I (United Nations publication, Sales No. E.94.XI.5).
10. Article 38 of the 1961 Convention, relating to measures against the abuse of drugs, and article 20 of the 1971 Convention, relating to measures against the abuse of psychotropic substances.
11. See Opioid Treatment Programs Accreditation Project: Program Information, at http://www.samhsa.gov/centers/csat/content/opat/otpaccr.html.
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13. UNDCP, *Drug Abuse Rapid Situation Assessments and Responses* (Vienna, 1999). See web site: http://www.odccp.org/report_1999-03-31_1.html
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Annex I

People with specific treatment needs

Young people and children

Drugs strategies need to consider how best to provide services to young people and children who may have, or who are at risk of developing, drug-related problems. It may be helpful to distinguish the following priority subgroups: children (aged 12 or less); young people (aged 13 to 17) and young adults (aged 18 to 24). Among young people and children, the following high-risk groups have been identified:

- Young people who have a poor attendance record at school or who are excluded;
- Young people who are looked after by welfare authorities;
- The young homeless, especially street children;
- Young people and children in conflict and post-conflict situations;
- Under-age children in a labour market;
- Young people living in environments with high levels of drug abuse;
- Young offenders.

It is important to recognize that there are substantial challenges for the appropriate assessment of multiple risks and problems that may be experienced by young people and children. There are also real challenges in designing appropriately matched treatments and supports for young people and children, and there is little experience of service delivery.

Effective solutions lie in the integration of general services for young people and children with specialist expertise in the treatment of drug abuse, together with the involvement of supportive family and community structures.

Women

In most treatment systems, the incidence of females resorting to treatment services is markedly lower than that of males. That partly reflects greater numbers of men developing serious drug problems at the overall population level, as well as a reluctance of female users to go to treatment services. There are different reasons for that situation. Some women may feel or fear that there is considerable stigma towards them and may be reluctant to seek help. Because of the higher level of referrals of men, some services may be less sensitive to women's needs and less able to respond appropriately.

Pregnant drug users should be specially targeted by services at an early stage. Levels of support for pregnant users vary quite widely between specialist services in most countries. That situation, coupled with a fear of the consequences if drug abuse is disclosed, may deter many pregnant users from going to maternity and treatment services at an early point, and that may increase the risk of obstetric and neonatal complications. Since some pregnant users go to treatment precisely because of their pregnancy, that should be seen as an important opportunity to offer treatment and support. The importance of meeting the needs of young people also extends to issues of childcare. For example, nursery scheme facilities for drug users attending treatment services may not be commonly available. Treatment agencies need to respond to that situation by encouraging pregnant drug users to seek help and remain in contact with specialist and generalist support agencies.

Seniors

The prevalence of drug abuse varies with age. While vulnerability to drug use is highest among young people, older people who either have a late onset of drug abuse or have experienced a long using history, should not be ignored. Seniors with drug abuse problems are a fairly hidden population and their needs are generally not well understood.

People who have drug problems and other psychiatric problems

There is widespread concern about improving services and outcomes for people who have co-morbid psychiatric and substance abuse disorders. Both the research and the clinical evidence base are limited with regard to the effective management and care of people who have

psychoactive substance abuse co-morbidity. There is some evidence that people with substance use problems and co-morbid psychiatric disorders appear to have a relatively high contact with medical services and may require more intensive treatment. However, it would appear that substance abuse among people admitted for psychiatric treatment is of a less severe nature than among those entering treatment for primary substance abuse problems. It is also important to consider and plan for the possibility that people with drug abuse and severe mental illness will not respond well or comply with traditional care plans and arrangements.

People who are homeless

There is major concern in many regions and countries about drug and mental health problems among homeless populations. There is also some evidence that drug abuse is a risk factor for accommodation instability. Homeless people encompass those who use night shelters and temporary hostels and rely on the accommodation of friends and acquaintances, as well as those sleeping rough on the streets. The most common health-related problems cited by people who sleep rough concern psychological issues, alcohol consumption and drug use.

People from racial and ethnic minority populations

Many minority people live far away from urban areas and may differ from majority people in numerous ways, for example, ethnicity, language, culture and beliefs. In some areas, the prevalence of drug use among minorities may be considerably higher than among the rest of the population. The services needed by those minority people may also differ from others. For example, minority people may prefer community-based outreach programmes to hospital or other residential treatment programmes.

People who are HIV-positive

People in drug treatment services who are known to be HIV-positive need primary attention to their drug addiction while maintaining appropriate care for their HIV status. HIV-positive clients have specific issues to deal with in treatment, many of which fall under the heading of grief work. They will need to deal with multiple current and anticipated losses associated with the diagnosis—longevity, health, career and family plans, including relationships and children.

The double stigma and shame associated with drug abuse and HIV/AIDS require extensive therapeutic work, as do fears of progression to AIDS, disability and death. The counsellor working with HIV-positive clients requires preparation and supervision in meeting their needs. In addition, the clients may be under treatment with antiretroviral agents as well as prophylactic agents against a variety of opportunistic infections. Possible interactions with pharmacological treatment of their substance dependence need to be taken into account. Close links and coordination between substance abuse treatment and HIV/AIDS care services need to be established.

People in the criminal justice system

Many people in contact with the criminal justice system have drug abuse problems and histories. Detention without treatment frequently leads to the relapse into drug abuse after an offender returns to his or her community. Treatment programmes will help to reduce not only drug abuse but also drug-related crimes. The cooperation between treatment providers and criminal justice systems is an important part of the treatment programmes for those individuals. There are issues involving the detection and management of drug abusers in police custody, in prison and within probation services. Drug abuse problems present a major problem for criminal justice authorities in virtually all countries.

Annex II

Population subgroups of drug abusers

Non-dependent drug abusers

The group of non-dependent drug abusers comprises individuals who are experiencing drug-related problems but who do not meet the criteria for dependence. That group may include large numbers of younger users who have begun to use drugs relatively recently. Many young people abusing drugs, in particular for recreational purposes, do not perceive it as a problem and do not actively seek help. Since members of that group (both adults and, in particular, young people) are at risk of advancing their drug involvement to more serious levels, they may be ideal clients for early intervention services, especially community-based early identification and intervention.

Injecting drug abusers

The group of injecting drug abusers comprises individuals who are injecting drugs and who may be at risk of acquiring and transmitting blood-borne diseases. Individuals who inject drugs are much more likely to be dependent and experience drug-related harms. They constitute a subgroup to be attracted to outreach programmes aimed at reducing the health consequence of drug abuse, and to structured treatment programmes, as appropriate.

Dependent drug abusers

The group of dependent drug abusers comprises individuals who have drug-related problems and meet a set of criteria for drug dependence. The majority of people going to specialist drug abuse services are in that group. They may require intensive community and/or residential treatment and aftercare support together with social inclusion services to mitigate problems of housing, employment and training. Two examples of the criteria for dependence are given below.

Opioid dependence (International Classification of Diseases (ICD)-10 code, F11.2; Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV code, 304.00) is defined under DSM in the following manner: most individuals with opioid dependence have significant levels of tolerance and will experience withdrawal on abrupt discontinuation of opioid substances. Opioid dependence includes signs and symptoms that reflect compulsive, prolonged self-administration of opioid substances. Clinical features may include: a subjective awareness of compulsion to use; a diminished capacity to control use; and salience of drug-seeking behaviour.

Cocaine dependence (ICD-10 code, F14.2; DSM-IV code, 304.20) is characterized by the following features: substantial impairment in the ability to control amounts used; high dose, usually episodic consumption pattern; increased anxiety, depression; paranoid-type ideation (in some users); and weight loss. The existence of a defined withdrawal syndrome following termination of heavy and prolonged cocaine use has been somewhat controversial. No coherent syndrome is usually seen and there are marked intra- and inter-individual variations in the type and severity of problems experienced.

Acutely intoxicated drug abusers

The specific needs of acutely intoxicated drug abusers are identified because of the morbidity and mortality risks due to adverse reactions and drug overdose. There is evidence that some two thirds of heroin users have experienced an overdose and, in addition, intoxicated stimulant users with psychotic symptoms can be classified in that subgroup. Acute intoxication is a discrete event, although an individual's needs may advance to those associated with dependence, co-morbidity and withdrawal management and support. Most services provided to the intoxicated drug user will be found outside specialist drug or mental health services (for example, accident and emergency departments and police custody).

Drug abusers in withdrawal

The group of drug abusers in withdrawal comprises people who are undergoing withdrawal after stopping the use of one or more classes of drug. For example, cessation of opiate use produces a withdrawal syndrome characterized by observable physiological and subjective effects, including somatic flu-like symptoms of varying severity, together with sleep disturbance and anxiety. Drug abusers in that category may require acute medical attention and planned detoxification support in an inpatient or a community treatment programme according to need.

Drug abusers in recovery

The group of drug abusers in recovery comprises individuals who have achieved a state of abstinence from their main problem drug (or all drugs), usually through successful completion of a treatment episode. They may require residential rehabilitation services, vocational training or community-based aftercare programmes and other supports.

Annex III

Example of a residential rehabilitation programme

The present annex describes, for illustrative purposes, a residential programme that has been prepared for potential referring and funding agencies. It is a concise description of the purpose of the programme, who it is intended for, and how it operates. Such a document is intended for professional audiences. A separate information pack for clients would also be needed.

Introduction

The programme involves a 20-bed facility for adult males who are recovering from substance dependence. More information about the programme is available in the client information pack. The programme is organized in two stages. The first (primary) stage lasts for three months. Those wishing, and given support, to continue in treatment can enter a second stage that is designed to promote semi-independent living and is a preparatory stage before returning to the community. The duration of the second stage is optional but normally lasts for eight weeks. The main elements of the programme are described below.

Description of client group served

The programme is intended for adults who have diagnosed substance dependence (meeting DSM-IV criteria).

Philosophy

The programme recognizes that some people with complex drug-abuse-related problems require respite and an intense programme of support and care that cannot be realistically delivered in a community or outpatient setting.

Standards governance

The programme has a management body comprising a mix of members of diverse background in terms of race, gender and professional expertise. The membership of the committee is open to election each year and an annual meeting and its composition are subject to periodic review.

Core mission and strategic management

The mission of the programme is to facilitate the recovery of people with substance use disorders and their rehabilitation into mainstream society. The programme has an internal core mission statement, a three- to five-year strategic plan and an annual plan.

Therapeutic approach

The programme adheres to a twelve-step philosophy and approach, the core elements of which are as follows:

- Maintenance of abstinence from illicit drugs in a controlled therapeutic environment;
- Communal living with other drug users in recovery;
- Emphasis on shared responsibility by peers and group counselling;
- Counselling and support oriented towards relapse prevention;
- Individual support and promotion of education, training and vocational experience;
- Improved skills for activities of daily living;
- Housing advocacy and resettlement work.

Staffing

A multidisciplinary team delivers the therapeutic programme and comprises the following posts:

- One co-coordinator/manager;
- Two administrators/secretaries;
- One clinical psychologist;
- Three social workers;
- One occupational therapist;
- Four drug workers/care workers;
- Three community psychiatric nurses.

The staff team has an appropriate compositional balance in terms of race and gender.

Access and referral information

Access to the programme is made via the social services department of the local government. The social services team undertakes all initial screening and assessment functions.

Assessment criteria

All clients seeking treatment will be asked to complete a comprehensive assessment with a member of the staff team. That assessment looks at health, social, economic, psychological, employment, family, relationship and legal considerations.

Care planning and review

For each client, a written care plan will be prepared, specifying their needs, the ways in which those needs are to be addressed by the service (and by other service providers as required), and how the plan will be monitored, evaluated and revised as necessary. All clients will have a nominated key worker and receive a copy of their written care plan. Dates for the review of the care plan will be stated at the outset.

Completing treatment

Departure from the programme and onward referral will be a planned element of the programme. The key worker will normally oversee those aspects, although some providers may have dedicated workers who facilitate referral and aftercare support.

Human resource management and development

The programme has written staff recruitment, selection and employment policies that comply with equal opportunity and employment rights legislation, as well as a human resource management policy and a supervision and appraisal system that monitors, motivates and supports performance.

Physical environment

The premises and other environmental resources meet the requirements of standards and relevant registration requirements including: health and safety legislation; environmental health; and fire regulations. The premises are kept in good decorative order, with furniture replaced as required and the environment maintained safely, with repairs conducted promptly. Decor and furniture are conducive to the needs of residents, and the programme makes a concerted effort to appear and feel like a comfortable home environment.

Accommodation and food

All accommodation for clients provided under the programme is comfortable and meets the needs of the resident in terms of his or her right to privacy, dignity, respect and personal independence. Food and drink provided to the users are nutritious and healthy. The diet provided is varied and well balanced.

Performance monitoring and quality

The programme has developed criteria and procedures for documenting and reporting service outputs and outcomes. Criteria have been agreed with commissioners and other relevant external bodies. Output and outcome monitoring reports are provided to the management body and to relevant external audiences as specified within contracts.

Operational policies

The core policies and procedures encompass:

- Client-related matters:
  - Rights statement;
  - Working with special and priority groups (for example, children and young people; pregnant drug users; drug-using parents; and people with co-morbid psychiatric problems);
  - Confidentiality;
  - Complaints procedure;
  - Procedures for the involvement of service users;
  - Policy on visitors to the programme;
  - Privacy policy for service users;
  - Equal opportunities policy;
- Programme environment and personnel matters:
  - Health and safety;
  - Recruitment and employment procedures;
  - Staff appraisal system;
  - Grievance and disciplinary system;
  - Redundancy policy;
  - Staff training strategy;
  - Employment of people who have previously had substance-related problems;
  - Violence at work;
  - Procedure for working in the community (covering, for example, outreach and home visits).

All policies are dated and subject to regular review (for example, annually).

Annex IV

Example of a client screening form

The form below is presented as an example of the type of screening form used in the United Kingdom

Forename: _____ Surname: _____

Date of birth: _____ Case screening reference (if used): _____

Gender: Male ❒ Female ❒ Age group: 17 or less ❒ 18-24 ❒ 25-29 ❒ 30 and over ❒

Client has childcare responsibilities: yes ❒ no ❒

Usually resident in: _____ [locality]

Substance use in past 3 months

	Used?	*Problem?**	*Ranked (1,2,3)*
Opioids			
Cocaine			
Amphetamines			
Sedatives/tranquillizers			
Hallucinogens			
Solvents/inhalants			
Cannabis			
Alcohol			

*Problem defined as substance-related difficulties in one or more of the following areas: physical health; psychological health; family/relationships; housing; work/employment; finances

Priority checklist

Client is pregnant . . . . . ❒

Children may be at risk . . . . . ❒

Client is currently injecting drugs . . . . . ❒

Client has physical health conditions/symptoms that are likely to require treatment . . . . . ❒

Client has psychiatric problems that are likely to require treatment . . . . . ❒

There is concern about the client's risk of self-harm . . . . . ❒

There is concern that the client may represent a safety threat to others . . . . . ❒

Action

1. Client is currently in treatment/contact with:

Specialist substance abuse service: ❒
GP ❒
Community mental health team ❒
Criminal justice programme ❒
Social services ❒
Other type of treatment ❒ (specify): _____

Details of treatment/service: _____

2. Referral priority

Substance abuse problems—circle

0 = No referral required (no identified drug problems requiring further assessment)
1 = Standard referral (substance problems requiring triage assessment by substance abuse service)
2 = Priority referral (substantial problems requiring priority assessment by substance abuse service)
3 = Immediate referral (acute, urgent problems requiring immediate assessment by substance abuse service)

Other medical/social problems—0, 1, 2, 3

3. Referred to:

Specialist substance abuse service ❒ GP ❒ Hospital Accident/ER Department ❒
Social Services ❒

Details: _____

Screened by: _____ Date: _____

Annex V

Example of a triage assessment form

The form below is presented as an example of the type of triage form used in the United Kingdom.

Referral details

Date screened (if relevant): _____ Date of present assessment: _____

Referring agency: _____

Client information

Forename: _____ Surname: _____

Date of birth: _____ Case screening reference (if used): _____

Gender: Male ❒ Female ❒

Age group: 17 or under ❒ 18-24 ❒ 25-29 ❒ 30 and over ❒

Ethnic category:

White	A-British, B-Irish, C-Other White
Mixed	D-White and Black Caribbean, E-White and Black African, F-White and Asian, G-Other mixed
Asian/Asian British	H-Indian, J-Pakistani, K-Bangladeshi, L-Other Asian
Black/Black British	M-Caribbean, N-African, P-Other Black
Other-ethnic	R-Chinese, S-Any Other, Z-Not stated

Client has childcare responsibilities: yes ❒ no ❒

Usually resident in: _____ [locality]

Employment status: Employed ❒ Casual work ❒ Unemployed ❒ Other ❒ *specify* _____

Person to be contacted in an emergency: _____

_____

Substance use involvement and problems

Substance	Used	No. of days used in past 4 weeks	Day of last use (1 = today; 2 = yesterday; etc.)	Is this causing problems?	Rank main problem drug(s) [first three]
Alcohol					
Amphetamines					
Cannabis					
Cocaine					
Hallucinogens					
Solvents/inhalants					
Opioids					
Sedatives/tranquillizers					

Main problem substance: _____
Details of any prescribed drug use in the past 4 weeks:

Dependence checklist

In the past 6 months
If yes score 1

(a) Have you needed to use more [main drug] to get the desired effect, or has taking your usual amount had less of an effect than it used to?

(b) Have you felt sick or unwell when the effects of [main drug] have worn off, or have you taken more of it, or a similar drug, to relieve or avoid feeling unwell?

(c) Have you used [main drug] in larger amounts or for a longer period of time than you intended?

(d) Have you had a persistent or strong desire to take [main drug] or have you had problems cutting down, or controlling how often or how much you use?

(e) Have you spent a large amount of time obtaining, or using, or recovering from the effects of [main drug]?

(f) Have you given up work, recreational, or social activities as a result of your [main drug] use?

(g) Have you continued to use [main drug] despite having physical or psychological problems as a result?

Total score = _____

If total score is 3 or more, dependence is diagnosed ❒
Specify if:

With physiological dependence:
evidence of tolerance or withdrawal (that is, either item (a) or item (b) is present) ❒
Without physiological dependence:
no evidence of tolerance or withdrawal (that is, neither item [a] or item [b] is present) ❒

If dependence is NOT diagnosed, assess for substance abuse

Abuse checklist

In the past 6 months
If yes score 1

(a) Have you found that using [main drug] has led you to neglect things or caused problems socially, or at home, or work?

(b) Have you used [main drug] in a risky or dangerous situation (for example driving a car when under the effects, or operating machinery)?

(c) Have you been arrested or questioned by the police in connection with your use of [main drug]?

(d) Have you continued to use [main drug] despite having problems with it in your social life or in relationships?

Total score = _____

If total score is 1 or more, abuse for the main drug is diagnosed ❒

Treatment history and criteria-based treatment assessment

Specialist substance abuse treatment

Treatment modality	Ever received?	Currently in treatment?	Number of episodes?	Month/year of most recent treatment	Reason for leaving most recent tx*
Inpatient detoxification					
Community detoxification					
Community prescribing					
Residential					
Care planned					
Structured day					

*Code as follows: 1 = planned departure [completed care plan at the agency]; 2 = unplanned departure [client dropped out or otherwise stopped treatment]; 3 = transferred to another agency/treatment; 4 = administrative/disciplinary discharge [non-compliance with treatment plan or rules of the service].

Mental health treatment

Treatment modality	Ever received?	Currently treatment?	Number of episodes?	Month/year of most recent treatment	Reason for leaving most recent treatment*
Inpatient treatment					
Community mental health team					
GP					
Other (specify) _____					

*Code as follows: 1 = planned departure [completed care plan at the agency]; 2 = unplanned departure [client dropped out or otherwise stopped treatment]; 3 = transferred to another agency/treatment; 4 = administrative/disciplinary discharge [non-compliance with treatment plan or rules of the service].

Current treatment readiness and perceived needs

Circle

Client is highly motivated to receive treatment as a priority
Client is reasonably well motivated to receive treatment but has some ambivalence
Client expressed no preference for any particular treatment modality, but is willing to participate in further assessment arrangements
Client describes little motivation or readiness to accept treatment at this point

Client's preferred type of treatment

Inpatient treatment ❒
Community detoxification ❒
Community prescribing (specialist service, GP, GP shared care) ❒
Residential rehabilitation ❒
Structured day programmes ❒
No preference stated ❒

Referral priority status

Check all priority status items that apply to the client's situation:
Pregnant
Client is HIV/Hepatitis-B/Hepatitis-C seropositive
Current drug injector
Has shared injection equipment in past 4 weeks
Combination depressant substance use (for example opioids; benzodiazepines; alcohol)
Existing medical (physical) conditions requiring monitoring/treatment
Client is a frequent offender
Client is in a situation of acute family/relationship crisis
The client has childcare problems

Total priority score

Risk assessment

Risk to self
Score

0 = no indication of any risk to self
1 = low risk (occasional suicidal ideation and/or self-harm thoughts but likely to ameliorate in treatment)
2 = moderate (frequent thoughts of suicide)
3 = high (active suicide risk)

Risk to others
Score

0 = no indication of any risk to others
1 = low risk (occasional verbal aggression, but no history of violence)
2 = moderate (some verbal and physical violence)
3 = high (evidence of recent violence, may pose a significant danger to staff and other clients)

Annex VI

Addiction Severity Index—*Lite*

A version of the Addiction Severity Index—*Lite* is given below.

Addiction Severity Index—*Lite*

Items underscored are used for outcome assessment

1. Medical status

M1. How many times in your life have you been hospitalized for medical problems? _____
M3. Do you have any chronic medical problems which continue to interfere with your life?
0. No 1. Yes—if yes specify: _____
M4. Are you taking any prescribed medication on a regular basis for a physical problem?
0. No 1. Yes—if yes specify: _____
M5. Do you receive a pension for a physical disability?
0. No 1. Yes—if yes specify: _____
M6. How many days have you experienced medical problems in the past 30 days? _____
M7. How troubled or bothered have you been by these medical problems in the past 30 days?
0. Not at all 1. Slightly 2. Moderately 3. Considerably 4. Extremely
M8. How important to you now is treatment for these medical problems?
0. Not at all 1. Slightly 2. Moderately 3. Considerably 4. Extremely

Confidence ratings

Is the above information *significantly* distorted by:
M10. Client's misrepresentation? 0. No 1. Yes
M11. Client's inability to understand? 0. No 1. Yes

Employment/support status

E1. Education completed: Years ____ Months ____
E2. Training or technical education completed: Years ____ Months ____
E4. Do you have a valid driver's license? 0. No 1. Yes
E5. Do you have an automobile available? 0. No 1. Yes
E7. Usual or last occupation? _____
E9. Does this constitute the majority of your support? 0. No 1. Yes
E10. Usual employment pattern, past three years:
1. Full time (35+ hours) 2. Part time (regular hours) 3. Part time (irregular hours)
4. Student 5. Service 6. Retired/disability 7. Unemployed 8. In controlled environment
E11. How many days were you paid for working in the past 30 days? ____
E12. Employment (net or "take home" pay) _____
E13. Unemployment compensation _____
E14. Welfare _____
E15. Pensions, benefits or Social Security _____
E16. Mate, family or friends _____
E17. Illegal _____
E18. How many people depend on you for the majority of their food, shelter etc.? _____
E19. How many days have you experienced employment problems in the past 30? _____

E20. How troubled or bothered have you been by these employment problems in the past 30 days? 0. Not at all 1. Slightly 2. Moderately 3. Considerably 4. Extremely
E21. How important to you now is counselling for these employment problems?
0. Not at all 1.Slightly 2. Moderately 3. Considerably 4. Extremely

Confidence ratings

Is the above information significantly distorted by:
E23. Client's misrepresentation? 0. No 1. Yes
E24. Client's inability to understand? 0. No 1. Yes

Alcohol/drugs

Route of administration types: 1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV
D1. Alcohol (any use at all): Past 30 days: ____ Lifetime (years)
D2. Alcohol (to intoxication): Past 30 days: ____ Lifetime (years)
D3. Heroin: Past 30 days: ____ Lifetime (years) ____ Route of Admin ____
D4. Methadone: Past 30 days: ____ Lifetime (years) ____ Route of Admin ____
D5. Other opiates/analgesics: Past 30 days: ____ Lifetime (years) ____ Route of Admin ____
D6. Barbiturates: Past 30 days: ____ Lifetime (years) ____ Route of Admin ____
D7. Sedatives/hypnotics: Past 30 days: ____ Lifetime (years) ____ Route of Admin ____
D8. Cocaine: Past 30 days: ____ Lifetime (years) ____ Route of Admin ____
D9. Amphetamines: Past 30 days: ____ Lifetime (years) ____ Route of Admin ____
D10. Cannabis: Past 30 days: ____ Lifetime (years) ____ Route of Admin ____
D11. Hallucinogens: Past 30 days: ____ Lifetime (years) ____ Route of Admin ____
D12. Inhalants: Past 30 days: ____ Lifetime (years) ____ Route of Admin ____
D13. More than 1 substance per day (including alcohol): Past 30 days: ____ Lifetime (years) _____
D17. How many times have you had alcohol delirium tremens? _____

How many times have you been treated for
D19. Alcohol abuse? ____
D20. Drug abuse? ____

How many of these were detoxification only?
D21. Alcohol abuse? ____
D22. Drug abuse? ____

How much money would you say you spent during the past 30 days?
D23. Alcohol? ____
D24. Drugs? ____
D25. How many days have you been treated as an outpatient for alcohol or drugs in the past 30? ____

How many days in the past 30 have you experienced:
D26. Alcohol problems? ____
D27. Drug problems? ____

How troubled or bothered have you been in the past 30 days by these:
D28. Alcohol problems: 0. Not at all 1. Slightly 2. Moderately 3. Considerably 4. Extremely
D29. Drug problems: 0. Not at all 1. Slightly 2. Moderately 3. Considerably 4. Extremely

How important to you now is treatment for these:
D30. Alcohol problems: 0. Not at all 1. Slightly 2. Moderately 3. Considerably 4. Extremely
D31. Drug problems: 0. Not at all 1. Slightly 2. Moderately 3. Considerably 4. Extremely

Confidence ratings

Is the above information significantly distorted by:
D34. Client's misrepresentation? 0. No 1. Yes
D35. Client's inability to understand? 0. No 1. Yes

2. Legal status

L1. Was this admission prompted or suggested by the criminal justice system? 0. No 1. Yes
L2. Are you on parole or probation? 0. No 1. Yes

How many times in your life have you been arrested and charged with the following:

L3.	Shoplift/vandalism	L10.	Assault
L4.	Parole/probation	L11.	Arson
L5.	Drugs charges	L12.	Rape
L6.	Forgery	L13.	Homicide/manslaughter
L7.	Weapons offence	L14.	Prostitution
L8.	Burglary/larceny/breaking and entering	L15.	Contempt of court
L9.	Robbery	L16.	Other

L17. How many of those charges resulted in convictions? ____

How many times in your life have you been charged with the following:
L18. Disorderly conduct, vagrancy, public intoxication? ____
L19. Driving while intoxicated? ____
L20. Major driving violations? ____
L21. How many months were you incarcerated in your life? ____
L24. Are you presently awaiting charges, trial, or sentence? 0. No 1. Yes
L25. What for? ____
L26. How many days in the past 30 were you detained or incarcerated? ____
L27. How many days in the past 30 have you engaged in illegal activities for profit? ____
L28. How serious do your feel your present legal problems are?
0. Not at all 1. Slightly 2. Moderately 3. Considerably 4. Extremely
L29. How important to you now is counselling or referral for those legal problems?
0. Not at all 1. Slightly 2. Moderately 3. Considerably 4. Extremely

Confidence ratings

Is the above information significantly distorted by:
L31. Client's misrepresentation? 0. No 1. Yes
L32. Client's inability to understand? 0. No 1. Yes

3. Family/social relationships

F1. Marital status:
1. Married 2. Remarried 3. Widowed 4. Separated 5. Divorced 6. Never married

F3. Are you satisfied with that situation? 0. No 1. Indifferent 2. Yes
F4. Usual living arrangements (past 3 years)
1. With sexual partner and children 2. With sexual partner alone 3. With children alone
4. With parents 5. With family 6. With friends 7. Alone 8. Controlled environment
9. No stable arrangement
F6. Are you satisfied with that situation? 0. No 1. Indifferent 2. Yes

F9. With whom do you spend most of your free time? 1. Family 2. Friends 3. Alone
F10. Are you satisfied with spending your free time in that way? 0. No 1. Indifferent 2. Yes

Do you live with anyone who:
F7. Has a current alcohol problem? 0. No 1. Yes
F8. Uses non-prescribed drugs? 0. No 1. Yes

Have you had significant periods in which you have experienced serious problems getting along with: 0. No 1. Yes

		Past 30 days	In your life
F18.	Mother	____	____
F19.	Father	____	____
F20.	Brother/Sister	____	____
F21.	Sexual partner/Spouse	____	____
F22.	Children	____	____
F23.	Other significant family members	____	____
F24.	Close friends	____	____
F25.	Neighbours	____	____
F26.	Co-workers	____	____

Did anyone abuse you

		Past 30 days	In your life
F28.	Physically?	____	____
F29.	Sexually?	____	____

How many days in the past 30 have you had serious conflicts:
F30. With your family? ____
F31. With other people? ____

How troubled or bothered have you been in the past 30 days by:
F32. Family problems? 0. Not at all 1. Slightly 2. Moderately 3. Considerably 4. Extremely
F33. Social problems? 0. Not at all 1. Slightly 2. Moderately 3. Considerably 4. Extremely

How important to you now is treatment or counselling for those:
F34. Family problems? 0. Not at all 1. Slightly 2. Moderately 3. Considerably 4. Extremely
F35. Social problems? 0. Not at all 1. Slightly 2. Moderately 3. Considerably 4. Extremely

Confidence ratings

Is the above information significantly distorted by:
F37. Client's misrepresentation? 0. No 1. Yes
F38. Client's inability to understand? 0. No 1. Yes

Psychiatric status

How many times have you been treated for any psychological or emotional problems?
P1. In a hospital or inpatient setting? ____
P2. Outpatient/private client? ____
P3. Do you receive a pension for a psychiatric disability? 0. No 1. Yes

Have you had a significant period of time (that was not a direct result of alcohol/drug use) in which you have:
0. No 1. Yes

		Past 30 days	Lifetime
P4.	Experienced serious depression-sadness, hopelessness, loss of interest, difficulty with any function?	____	____

P5.	Experienced serious anxiety/tension-uptight, unreasonably worried, inability to feel relaxed?	____	____
P6.	Experienced hallucinations-saw things or heard voices that were not there?	____	____
P7.	Experienced trouble understanding, concentrating or remembering?	____	____
P8.	Experienced trouble controlling violent behaviour?		
P9.	Experienced serious thoughts of suicide?	____	____
P10.	Attempted suicide?	____	____
P11.	Been prescribed any medication for any psychological or emotional problems?	____	____
P12.	How many days in the past 30 have you experienced those psychological or emotional problems?	____	____
P13.	How much have you been troubled or bothered by those psychological or emotional problems?		
	0. Not at all 1. Slightly 2. Moderately 3. Considerably 4. Extremely		
P14.	How important to you now is treatment for these problems?		
	0. Not at all 1. Slightly 2. Moderately 3. Considerably 4. Extremely		

Confidence ratings

Is the above information significantly distorted by:

P22.	Client's misrepresentation?	0. No	1. Yes
P23.	Client's inability to understand?	0. No	1. Yes

Annex VII

Pompidou Group-EMCDDA Treatment Demand Indicator project

The purpose of the Treatment Demand Indicator (TDI) project is to generate consistent and comparable information on clients seeking treatment in Europe. A panel of experts has developed a basic set of treatment contact, sociodemographic and drug-related information about the characteristics of people presenting to treatment services. The TDI is offered as a core set of information from which member States can gather additional information as required. The TDI core set is as follows:

Treatment contact details

1. Treatment centre type
   (1. Outpatient treatment centres 2. Inpatient treatment centres 3. Low- threshold/drop in/street agencies 4. General practitioners 5. Treatment units in prison)
2. Date of treatment-month
3. Date of treatment-year
4. Ever previously treated-(1. Never 2. Previously treated 0. Not known)
5. Source of referral-(1. Self-referred 2. Family/friends 3. Other drug-treatment centre 4. General practitioner 5. Hospital/other medical source 6. Social services 7. Court/probation/police 8. Other 9. Not known)

Socio-demographic and basic epidemiological information

6. Gender (1. Male 2. Female 0. Not known)
7. Age
8. Year of birth
9. Living status (with whom)-(1. Alone 2. With parents 3. Alone with child 4. With partner (alone) 5. With partner and child(ren) 6. With friends 7. Other 0. Not known)
10. Living status (past 30 days before starting treatment)—(1. Stable accommodation 2. Unstable accommodation 3. Institutions (prison, clinic) 0. Not known)
11. Nationality—(1. National of this country 2. EU national 3. National of another country 0. Not known)
12. Labour status—(1. Regular employment 2. Pupil/student 3. Economically inactive (pensioners, housewives/men, invalids) 4. Unemployed 5. Other 0. Not known)
13. Highest educational level completed—(1. Never went to school/never completed primary school 2. Primary level of education 3. Secondary level of education 4. Higher level of education 0. Not known)

Drug-related information

14. Primary drug—(1. Opioids (heroin/methadone/other opioids) 2. Cocaine (cocaine/crack) 3. Stimulants (amphetamines/MDMA and other derivatives/other stimulants) 4. Hypnotics and sedatives (barbiturates/benzodiazepines/others) 5. Hallucinogens (LSD/others) 6. Volatile inhalants 7. Cannabis 8. Other substances)
15. Already receiving substitution treatment—(a) heroin (b) methadone (c) other opiates (d) other substances—(1. Yes 2. No 0. Not known)
16. Usual route of administration (primary drug)—(1. Inject 2. Smoke/inhale 3. Eat/drink 4. Sniff 5. Others 0. Not known)

17. Frequency of use (primary drug)—(1. Not used in past month (occasional) 2. Used once a week or less 3. Used 2-6 days a week 4. Used daily 0. Not known)
18. Age at first use of primary drug
19. Other (= secondary) drugs currently used—see list in 14 above
20. Ever injected/currently injected (last 30 days) injecting—(1. Ever injected but not currently 2. Currently injecting 3. Never injected 0. Not known)

For further information, go to:
http://www.emcdda.org/multimedia/project_reports/situation/treatment_indicator_report.pdf

Annex VIII

Maudsley Addiction Profile

A version of the Maudsley Addiction Profile is shown below.
For further information, go to http://www.ntors.org.uk/map.pdf.

Maudsley Addiction Profile

A. Management information

Incorporate standard details about client identification, demographics, referral source and treatment programme descriptors as required.

B. Substance use

1. Oral 2. Snort/sniff 3. Smoke/chase 4. Intravenous 5. Intramuscular

		Days used (past 30)	Amount used on typical day	Route
B1.	Alcohol	____	____	____
B2.	Heroin	____	____	____
B3.	Illicit methadone	____	____	____
B4.	Cocaine powder	____	____	____
B5.	Crack cocaine	____	____	____
B6.	Amphetamine	____	____	____
B7.	Cannabis	____	____	____
B8.	Other (specify) _____	____	____	____

C. Health risk behaviour

C1. Days injected drugs in the past 30 days ____
C2. Times injected on a typical day in the past 30 days ____
C3. Times injected with a needle/syringe already used by someone else ____
C4. Number of people had sex with and not used condom ____
C5. Total number of times had sex with and not used condom ____

D. Health symptoms

D1. How often experienced the following physical health symptoms
0. Never 1. Rarely 2. Sometimes 3. Often 4. Always

(a) Poor appetite ___
(b) Tiredness/fatigue ___
(c) Nausea (feeling sick) ___
(d) Stomach pains ___
(e) Difficulty breathing ___
(f) Chest pains ___

(g) Joint/bone pains ___
(h) Muscle pains ___
(i) Numbness/tingling ___
(j) Tremors/shakes ___

D2. How often experienced the following emotional or psychological health symptoms
0. Never 1. Rarely 2. Sometimes 3. Often 4. Always

(a) Feeling tense ___
(b) Suddenly scared for no reason ___
(c) Feeling fearful ___
(d) Nervousness or shakiness inside ___
(e) Spells of terror or panic ___
(f) Feeling hopeless about the future ___
(g) Feelings of worthlessness ___
(h) Feeling no interest in things ___
(i) Feeling lonely ___
(j) Thoughts of ending your life ___

E. Personal and social functioning

Relationships

E1. Days had contact with partner in the past 30 days ___
E2. Number of those days where there was conflict with partner ___
E3. Days had contact with relatives in the past 30 days ___
E4. Number of those days where there was conflict with relatives ___
E5. Days had contact with friends in the past 30 days ___

Employment

E7. Number of days of paid work in past 30 days ___
E8. Days missed from work because of sickness or unauthorised absence ___
E9. Days formally unemployed in the past 30 days ___

Crime

E10. Crimes committed in the past 30 days

		Days	Times/ typical day
(a)	Selling drugs	___	___
(b)	Fraud/forgery	___	___
(c)	Shoplifting	___	___
(d)	Theft from a property	___	___
(e)	Theft from a vehicle	___	___
(f)	Other crimes (list)	___	___

Annex IX

Glossary of terms

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Abstinence[a]

The term refers to the act of refraining from alcohol or other drug use, whether for health, personal, social, religious, moral, legal or other reasons.

Someone who is currently abstinent may be called an "abstainer", a "total abstainer", or, an old-fashioned term relating only to alcohol, a "teetotaller". The term "current abstainer" is sometimes used for research purposes and is usually defined as a person who has not used drugs for a specified period of time, for example, 3, 6 or 12 months. In some studies, persons who drink or use other drugs only once or twice per year are also classified as abstainers.

Abuse[a]

A term in wide use but of varying meaning. In international drug control conventions "abuse" refers to any consumption of a controlled substance no matter how infrequent. In the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994), "psychoactive substance abuse" is defined as "a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following within a 12 month period: (1) recurrent substance use resulting in a failure to fulfil major role obligations at work, school or home; (2) recurrent substance use in situations in which it is physically hazardous; (3) recurrent substance-related legal problems; (4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance". It is a residual category, with dependence taking precedence whenever applicable.

The term "abuse" is sometimes used disapprovingly to refer to any use at all, in particular of illicit drugs. Because of its ambiguity, the term is only used in the ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines (WHO, 1992) for non-dependence-producing substances. "Harmful" and "hazardous use" are the equivalent terms in WHO usage, although they usually relate only to effects on health and not to social consequences. The term "abuse" is also discouraged by the Centre for Substance Abuse Prevention in the United States, although the term "substance abuse" remains in wide use and refers generally to problems of psychoactive substance use. The term "drug abuse" has also been criticized as being circular when it is used without reference to specific problems arising from drug use.

See also: **Drug abuse.**

Accreditation

The process of recognition that a programme meets specific operational and organizational standards that have been established to ensure the quality of services within a particular region or treatment system. Accreditation is usually awarded by an external professional body on the basis of a review or audit and is usually for a specific period.

Addiction[a]

One of the oldest and most commonly used terms to describe and explain the phenomenon of long-standing drug abuse. In some professional circles it has been replaced by the term "drug dependence". According to the WHO *Lexicon of Alcohol and Drug Terms,* "addiction" is defined as: the repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means.

Key indicators of "addiction" have traditionally been thought to be tolerance and experience of a withdrawal syndrome, that is, it is often equated with physical dependence. More recently, some drug researchers have suggested that "compulsion to use drugs" is a more central indicator of addiction. Addiction is otherwise regarded by the self-help or "recovery" movement as a discrete disease, a debilitating and progressive disorder rooted in the pharmacological effects of the drug for which the only cure is total abstinence. That view is most notably associated with the "self-help" or "recovery" movement, for example, Narcotics Anonymous and Alcoholics Anonymous. In the 1960s, WHO recommended that the term "addiction" be abandoned in favour of dependence, which can exist in various degrees of severity as opposed to an "all or nothing" disease entity.

Addiction is not a diagnostic term in the ICD-10, but continues to be very widely employed by professionals and the general public alike.

See also: **Dependence, Dependence syndrome.**

Advice services[a]

The range of information and non-medical treatment services which can variously provide drug information, details of services available, referral to other agencies, and direct clinical casework or psychotherapy. Services may be provided in a direct face-to-face setting or indirectly by telephone to individuals, families, groups, other workers or agencies. The term "advice" is usually reserved for the provision of factual information on specific issues. It also incorporates brief and specific advice to change behaviour, for example in brief interventions (see below). Advice is usually distinguished from "counselling" where the emphasis is more on assisting individuals to evaluate their own situation and reach their own decisions about how to cope.

See also: **Brief intervention, Counselling and psychotherapy, Treatment.**

[a] *Demand Reduction: a Glossary of Terms* (United Nations publication, Sales No. E.00.XI.9).

Aftercare

A broad range of community-based service supports designed to maintain benefit when a structured treatment has been completed. Aftercare may involve a continuation of individual or group counselling and other supports, but usually at a lower intensity and often by other agencies. Self-help groups such as Narcotics Anonymous are an important provider of aftercare.

See also: **Self-help group.**

Agonist[a]

A substance that acts on receptor sites to produce certain responses; for example, both methadone and heroin are agonists for opioid receptors.

AIDS[a]

The common abbreviation for a fatal viral condition known as acquired immunodeficiency syndrome in which the immune system is weakened and unable to combat infectious diseases. The sharing of injecting equipment among injecting drug users is a major route of transmission for human immunodeficiency virus (HIV). That is the virus that causes AIDS, and in many countries has led to programmes discouraging injecting and to the establishment of programmes to make clean injecting equipment more readily available for injecting drug users in order to reduce the likelihood of transmission of the virus through the sharing of used needles and other equipment.

See also: **Harm reduction, Needle exchange, Risk reduction, Safer use.**

Antagonist[a]

A substance that counteracts the effects of another agent. Pharmacologically, an antagonist interacts with a neuronal receptor to inhibit the action of agents (agonists) that produce specific physiological or behavioural effects mediated by that receptor.

Brief intervention[b]

A treatment strategy in which structured therapy of a limited number of sessions (usually one to four) of short duration (typically 5-30 minutes) is offered with the aim of assisting an individual to cease or reduce the use of a psychoactive substance or (less commonly) to deal with other life issues. It is designed, in particular, for general practitioners and other primary health care workers.

[b] *Lexicon of Alcohol and Drug Terms* (Geneva, World Health Organization, 1994).

Buprenorphine[a]

Buprenorphine is a mixed agonist/antagonist which can be used in substitution treatment. It has been used extensively in many countries for the short-term treatment of moderate to severe pain. The mixed opioid-action/blocking-action appears to make buprenorphine safe in overdose and possibly less likely to be diverted than pure opioids. It may also provide an easier withdrawal phase, and due to a longer action, may allow for alternate day dosing. It is apparent from the research conducted to date that buprenorphine is at least as effective as methadone as a maintenance agent.

See also: **Drug substitution, Methadone.**

Capture recapture method

Capture recapture method (CRM) is an epidemiological technique which is used to estimate the prevalence of a specific behaviour within a defined population (for example, the number of injecting drug users in a specified geographic area). CRM uses the overlap between two or more samples or registers of people to derive an estimate of the total population.

Care coordination

The process of oversight and practical management of patients within a particular treatment and across different treatments over time. For a particular patient, care coordination can involve assessment, referral, progress monitoring and review activities. In some treatment systems, the care coordinator has some degree of authority over the system that pays for the treatment of patients.

Client satisfaction

A broad concept that refers to whether a treatment meets the expectations and needs of a particular client (patient). Client satisfaction is usually assessed by a self-report questionnaire during or at completion of treatment. Client satisfaction is sometimes used as an outcome measure alongside primary clinical, social and economic outcome assessments.

Cognitive-behavioural techniques

A type of psychotherapy that stresses that the way in which people think about a problem is instrumental in causing feelings and behaviours that are unwanted. Cognitive-behavioural techniques (CBT) therefore aims to help a patient replace those unhelpful thoughts with others that lead to more desirable reactions. In the substance abuse field the CBT therapist helps a patient to acquire new skills to alter or maintain changes in their behaviour. In that respect, relapse prevention programmes may contain a CBT element to help patients resist urges to use substances.

Community-based treatment

Any treatment that is based in a non-residential setting. Outpatient treatments (day attendance-based services provided from a hospital) are often bracketed with community-based treatments. Examples of community-based treatments are opioid substitution programmes; counselling programmes and aftercare services.

Community empowerment[a]

Interventions which encourage a community (for example, people in a locality, drug injectors, sex workers) to develop collective ownership and control over health-related choices and activities. To achieve that result, the community may also need to gain collective control of the wider social, political and economic factors which influence their access to health. "Empowerment" is a process of increasing personal, interpersonal or political power so that individuals can take action to improve their lives.

Co-morbidity

See: **Dual diagnosis.**

Correctional system

The organization of police, judiciary and penal structures that operate in a particular State. The terms "correctional system" and "criminal justice system" are synonymous.

Counselling and psychotherapy[a]

Counselling is an intensive interpersonal process concerned with assisting normal people to achieve their goals or function more effectively. Psychotherapy is generally a longer-term process concerned with reconstruction of the person and larger changes in more fundamental psychological attributes such as personality structure. Psychotherapy is often restricted in conception to those with pathological problems.

Court diversion[a]

A programme of treatment, re-education or community service for individuals referred from criminal courts (criminal diversion) after being charged with driving under the influence of alcohol (drinking-driver diversion) or another drug, with the sale or use of drugs (drug diversion), or with another crime. Individuals are assigned to diversion programmes in lieu of prosecution, which is usually held in abeyance pending successful completion of the diversion programme. Pre-charge diversion refers to the systematic referral of those detected by the police to an alternative programme without arrest. In some countries, the term "custody diversion" is used to make explicit that in many diversion schemes the individual may attend court but be diverted away from custody into a programme of treatment or re-education.

Custody diversion

See: **Court diversion.**

Dependence, dependence syndrome[a]

According to the WHO *Lexicon of Alcohol and Drug Terms,* "dependence, dependence syndrome" is defined as follows: as applied to alcohol and other drugs, a need for repeated doses of the drug to feel good or to avoid feeling bad.

The terms "dependence" and "dependence syndrome" have gained favour with WHO and in other circles as alternatives to addiction since the 1960s.

In the DSM-IV, dependence is defined as "a cluster of cognitive, behavioural and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems".

See also: **Addiction.**

Detoxification

The process by which a person who is dependent on a psychoactive substance ceases use, in such a way that minimizes the symptoms of withdrawal and risk of harm. While the term "detoxification" literally implies a removal of toxic effects from an episode of drug use, in fact it has come to be used to refer to the management of rebound symptoms of neuroadaptation, that is, withdrawal and any associated physical and mental health problems.

Drug abuse

Current international drug control treaties do not define drug abuse but make reference to a variety of terms, including abuse, misuse and illicit use. In the context of international drug control, drug abuse constitutes the use of any substance under international control for purposes other than medical and scientific, including use without prescription, in excessive dose levels, or over an unjustified period of time.

Drug substitution[a]

Treatment of drug dependence by prescription of a substitute drug for which cross-dependence and cross-tolerance exist. The term is sometimes used in reference to a less hazardous form of the same drug used in the treatment. The goals of drug substitution are to eliminate or reduce use of a particular substance, especially if it is illegal, or to reduce harm from a particular method of administration, the attendant dangers to health (for example, from needle sharing), and the social

consequences. Drug substitution is often accompanied by psychological and other treatment.

DSM-IV

The Diagnostic and Statistical Manual of Mental Disorders is the standard classification of mental disorders used by mental health professionals in the United States. It is also widely used in other parts of the world. It is intended to be applicable in a wide array of contexts and used by clinicians and researchers of many different orientations (for example, biological, psychodynamic, cognitive, behavioural, interpersonal, family/systems). DSM-IV (fourth edition), compiled and published by the American Psychiatric Association in 1994, was designed for use across settings. It is also a tool for collecting and communicating accurate public health statistics. The DSM consists of three major components: the diagnostic classification, the diagnostic criteria sets and the descriptive text.

See also: **Abuse.**

Dual diagnosis

A person diagnosed as having an alcohol or drug abuse problem in addition to some other diagnosis, usually psychiatric, for example, mood disorder, schizophrenia. Making differential diagnoses is often complicated by overlapping signs and symptoms of dependence and diagnostic entries, for example, anxiety is a prominent feature of drug withdrawal. A further complication is with shared or reciprocal casual processes, for example, a mild disorder of mood leads to some drug use which eventually leads to an exacerbation of the mood disturbance, to further drug use, dependence and severe mood disturbance.

Early intervention[b]

A therapeutic strategy that combines early detection of hazardous or harmful substance use and treatment of those involved. Treatment is offered or provided before such time as patients might present of their own volition and in many cases before they are aware that their substance use might cause problems. It is directed in particular at individuals who have not developed physical dependence or major psychosocial complications.

Eligibility criteria

A set of medical, social and psychological conditions that are used to judge the appropriateness of a treatment for a particular individual. Eligibility criteria usually take into account the severity of patients' problems, their personal motivations or readiness for treatment, and the nature and extent of their social supports and stressors in terms of their suitability for a particular treatment. Use of eligibility criteria is part of a commitment to matching patients to the best or more appropriate treatment in the context of two or more alternatives.

Evaluation[c]

The systematic and scientific process of determining the extent to which an action or sets of actions were successful in the achievement of predetermined objectives. It involves measurement of adequacy, effectiveness and efficiency of programmes or services. Evaluation is to be distinguished from assessment and appraisal: both terms are used as more general terms than evaluation, connoting the drawing of conclusions from the examination of a situation or its elements. Evaluation, then, is a particular type of assessment.

Evaluation instrument

An interviewer or patient self-report questionnaire that is used to record past behaviours and/or perceptions that assess the impact of a treatment. Ratings on an evaluation instrument for a recall period before treatment are commonly contrasted with ratings on the same measures during treatment and/or after treatment has ended.

Family liaison worker

A professional counsellor, social worker or nurse whose role is to support the family (dependants and carer(s) of a patient). The worker assists family members who are affected by a substance abuse problem and may provide information, supportive counselling and referral services. Helping the family understand and provide support to a member with a substance abuse problem is a core function.

Focus group

A discussion-based, qualitative research data gathering method designed to explore a topic of interest and generate a range of opinions. A small number of members of a particular group meet together and their discussion is facilitated by a researcher known as a "moderator".

Generic service

A social, welfare or health care service that does not have as its primary function the treatment of substance abuse problems but may in the course of its work come into contact with people who are affected. Generic services may develop expertise in screening, assessing and treating substance abuse problems (so that the boundary between generic and speciality services may

[c] J. Hogarth, *Glossary of Health Care Terminology* (Copenhagen, WHO Regional Office for Europe, 1978).

be difficult to draw) and may also have formal referral links with specialist substance abuse services.

Half-way house[a]

Often, a place of residence that acts as an intermediate stage between an inpatient or residential therapeutic programme and fully independent living in the community. The term applies to accommodation for alcohol- or drug-dependent individuals endeavouring to maintain their sobriety (compare therapeutic community). There are also half-way houses for individuals with psychiatric disorders and for individuals who are leaving prison.

Harm reduction[a]

In the context of alcohol or other drugs, harm reduction refers to policies or programmes that focus directly on reducing the harm resulting from the use of alcohol or other drugs, both to the individual and the larger community. The term is used in particular for policies or programmes that aim to reduce the harm without necessarily requiring abstinence. Some harm reduction strategies designed to achieve safer drug use may, however, precede subsequent efforts to achieve total abstinence. Examples of harm reduction include needle/syringe exchanges to reduce rates of needle sharing among injecting drug users.

Harmful use[a]

According to the WHO *Lexicon of Alcohol and Drug Terms,* "harmful use" is defined as follows: a pattern of psychoactive substance use that is causing damage to the health of the drug user. The damage may be physical (for example, hepatitis following injection of drugs) or mental (for example, depressive episodes secondary to heavy alcohol intake). Harmful use generally has adverse social consequences as well.

The term was introduced in the ICD-10 and supplanted "non-dependent use" as a diagnostic term. The closest equivalent in other diagnostic systems (for example, in the DSM-IV) is substance abuse, which usually includes social consequences.

ICD-10

The Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems is the latest in a series that was formalized in 1893 as the Bertillon Classification or International List of Causes of Death. While the title has been amended to make clearer the context and purpose and to reflect the progressive extension of the scope of the classification beyond diseases and injuries, the familiar abbreviation "ICD" has been retained. ICD was developed by the World Health Organization (WHO) and is designed to promote international comparability in the collection, processing, classification, and presentation of morbidity and mortality statistics. The reported conditions are translated into medical codes through use of the classification structure and the selection and modification rules contained in the application of ICD. The tenth revision (ICD-10) was published in 1992.

Impact evaluation

Impact evaluation is a form of outcome evaluation that assesses the net effect of a programme by comparing programme outcomes with an estimate of what would have happened in the absence of the programme. The time horizon for impact evaluations are often in the medium or longer term.

Incidence[a]

The rate at which a condition or illness occur, often expressed in terms of the number of cases per 10,000 people per year.

Integrated care pathways

A description of the nature and anticipated course of substance abuse treatment. An integrated care pathway describes a predetermined plan of treatment for a particular patient group entering structured treatment and the anticipated outcomes that are expected. The pathway may relate to several treatment components to be delivered by a single agency programme or it may include several treatments delivered by two or more agencies. Integrated care pathways form part of the set of documents and protocols that describe what a treatment programme intends to do as well as the intended results.

Integrated treatment system

An integrated treatment system is one that contains several treatment services, both specialist and generic, that operate in a structured and organized way. Most integrated treatment systems will contain community-based and residential services and have established referral and patient transfer arrangements.

Intoxication[a]

According to the WHO *Lexicon of Alcohol and Drug Terms,* "intoxication" is defined as follows: a condition that follows the administration of a sufficient amount of a psychoactive substance and which results in disturbances in the level of consciousness, cognition, perception, judgement, affect, behaviour, or other psychophysiological functions and responses. The disturbances are related to the acute pharmacological effects of, and learned responses to, the substance and resolve with time, with complete recovery, except where tissue damage or other complications have arisen. The term is most commonly used with regard to alcohol use.

LAAM[a]

From the chemical name levo-alpha-acetylmethadol, LAAM is a synthetic pure opioid agonist (related to methadone) of the morphine type. It was extensively investigated in the 1970s as a pharmacological alternative to methadone, its chief advantage being that it has a longer half-life and consequently patients can be dosed every 48 to 72 hours rather than every 24 hours as is required with methadone.

See also: **Drug substitution, Methadone, Opiate, Opioid.**

Maintenance therapy

See: **Drug substitution.**

Mandated treatment

A characterization of treatment, sometimes called coercive treatment, that is organized by the criminal justice system. Typically, a court (or other criminal justice body) orders that an individual enters a therapeutic programme (sometimes as an alternative to a custodial sentence). Treatment is mandated in the sense that failure to enter the programme or comply with its rules and regulations may result in the individual receiving the criminal justice penalty that would normally be invoked.

Matrix model

The matrix model is a multi-component framework treatment for managing substance abusers, in particular stimulant abusers in treatment and helping them achieve abstinence. The model addresses the needs of stimulant abusers in a systematic way, separating the problem areas into distinct categories. The chosen categories are: behavioural, cognitive, emotional and relationships. The treatment focuses on particular issues in each of those areas which emerge in the "stages of recovery" encountered by recovering clients during the first year of stimulant abstinence. The model emphasizes individual therapist contact and education about drug abuse, relapse prevention, social support, 12-step participation and focuses on issues critical to addiction and relapse. The programme includes educational sessions focusing on skills required to maintain abstinence and promoting recovery. Family members are encouraged to attend support and discussion groups and are provided with support as required.

Methadone[b]

A synthetic opiate drug used in maintenance therapy for those dependent on opioids. It has a long half-life, and can be given orally once daily with supervision. It is the most widely used treatment for opioid dependence in the developed world.

When given in an adequate dose to opioid dependent individuals, methadone tends to reduce desire to use heroin and other opiates, eliminates opioid withdrawal, and blocks the euphoric effects of the other opioid drugs.

See also: **Buprenorphine, Drug substitution, LAAM, Opiate, Opioid.**

Minimal intervention[a]

Usually used as a synonym for brief intervention. However, some authorities suggest that minimal intervention as a term should be restricted to person-to-person interventions lasting between 30 minutes and 3 hours, that is, somewhat longer than "brief intervention".

See also: **Brief intervention, Early intervention, Prevention.**

Modality

A categorization of a specific type of drug abuse treatment. A given treatment modality can be described in terms of its specific therapeutic approach or philosophy and purpose. In the United Kingdom, for example, the following treatment modalities are available: residential rehabilitation; inpatient stabilization and detoxification; community specialist prescribing; community general practitioners prescribing; structured counselling and structured day services.

Motivational interviewing[a]

A counselling and assessment technique which essentially follows a non-confrontational approach to questioning people about difficult issues like alcohol and other drug use and assisting them to make positive decisions to reduce or stop their drug use altogether. The underlying philosophy is closely linked with the Stages of Change Model which posits the view that decision-making about behavioural change proceeds through defined stages termed pre-contemplation, contemplation, preparation, action and maintenance. Motivational interviewing comprises a set of techniques designed to move the drug user, smoker or drinker through those stages by assisting them to make an accurate appraisal of the benefits and drawbacks of their behaviour in a non-judgemental interview.

See also: **Counselling and psychotherapy.**

Mutual-help group

A group in which participants support each other in recovering or maintaining recovery from personal problems. Those groups are often associated with alcohol and other drug dependence problems; however, they also operate in the context of other issues such as depression and various compulsive behaviours. Membership is usually established on a voluntary and confidential basis, with meetings organized with a prescribed format and time.

Naloxone[a]

Naloxone is a narcotic antagonist which reverses the respiratory, sedative and hypotensive effects of heroin overdose. It can be injected intramuscularly, intravenously or subcutaneously. A nasal spray preparation is now also available in some countries. It is an opioid receptor blocker that antagonizes the actions of opioid drugs. It reverses the features of opiate intoxication and is prescribed for the treatment of overdose with that group of drugs.

See also: **Antagonist, Naltrexone.**

Naltrexone[a]

A drug that antagonizes the effects of opioid drugs. Its effects are similar to those of naloxone, but it is more potent and has longer duration of action. It is used in various ways in the treatment of opioid dependence and also alcohol dependence. The most widely adopted use is to prescribe at a dose that will block the psychoactive effects of all opioid drugs. The idea is that while the drug needs to be taken daily to maintain that blockade, it will minimize the chance of impulsive decisions to relapse.

See also: **Antagonist, Drug substitution, Naloxone.**

Narcotics Anonymous (NA)

See: **Self-help group, Twelve-step group.**

Narcotic drug[a, b]

A chemical agent that can induce stupor, coma, or insensibility to pain. The term usually refers to opiates or opioids, which are called narcotic analgesics. In common parlance and legal usage it is often used imprecisely to mean illicit drugs, irrespective of their pharmacology. For example, narcotics control legislation in Canada, the United States and several other countries includes cocaine and cannabis as well as opioids. It is also a term adopted by the Single Convention on Narcotic Drugs, 1961.

Needle exchange[a]

Provision to reduce the transmission of infectious diseases by the repeated use and sharing of needles in order to reduce the transmission of blood-borne viruses. It was first developed in response to the advent of HIV/AIDS and quickly spread to many countries in which injecting drug use was experienced as a problem. The concept involves the provision of clean needles in exchange for used needles which are then safely disposed of. In practice, an "exchange" is not always required and clean injecting equipment is provided on demand, sometimes for a small payment.

See also: **AIDS, Harm reduction.**

Needs assessment

A systematic approach to determining the nature and extent of substance abuse problems in a target population or community that seeks to identify which (or how many) specific interventions should be made available to specific groups of people or how existing interventions and services can be better provided.

Non-governmental organization[a]

A service agency which is independent of government and operates in a broad social field. As most of them are non-profit, non-governmental organizations (NGOs) can be funded by Governments, public institutions and/or private donations. Often, such agencies have a mix of paid staff and voluntary workers and they have traditionally provided services in sectors where it would not be possible to provide funding for fully-paid staff.

Open access services

Substance abuse services that can be used by any member of a community without a formal specialist referral.

Opiate

According to the WHO *Lexicon of Alcohol and Drug Terms,* "opiate" is defined as follows: one of a group of alkaloids derived from the opium poppy *(Papaver somniferum)* with the ability to induce analgesia, euphoria, and, in higher doses, stupor, coma and respiratory depression. The term opiate excludes synthetic opioids such as heroin and methadone.

See also: **Heroin, Opioid, Opium.**

Opioid[a]

According to the WHO *Lexicon of Alcohol and Drug Terms,* "opioid" is defined as follows: the generic term applied to alkaloids from the opium poppy *(Papaver somniferum)*, their synthetic analogues, and compounds synthesized in the body, which interact with the same specific receptors in the brain, have the capacity to relieve pain, and produce a sense of well-being (euphoria). The opium alkaloids and their synthetic analogues also cause stupor, coma and respiratory depression in high doses.

See also: **Narcotic drug, Opiate.**

Opioid agonist

See: **Agonist.**

Opioid antagonist

See: **Antagonist.**

Outcome evaluation

Outcome evaluation measures the extent to which a programme achieves its immediate objectives. It focuses on outputs and outcomes, including unintended effects, to judge the programme effectiveness. It may also assess the programme process to understand how the outcomes are produced. For UNDCP, outcome evaluations often address the effectiveness of immediate project objectives and the process through which they are achieved. The time horizon for outcome evaluation is usually with the life of the programme or project.

Outcome measure

A direct or indirect observation or record that concerns a specific patient's behaviour or cognition that is relevant to their problems and to the objectives of a treatment or rehabilitation programme. Outcome measures are usually drawn from a set of domains spanning substance abuse behaviours and cognitions; physical and psychological health symptoms and conditions and various aspects of personal, social and economic functioning, including relationship difficulties, housing and accommodation problems; education, training and employment problems; and illegal activities. Commonly, outcome measures are recorded for a suitable period immediately prior to a patient commencing treatment and recorded again at one or more follow-up points and changes in scores on the pairs of measures and then attributed to the treatment provided.

Outcome monitoring

The recording, communication and application of information about the impact or benefit of treatment that is used to judge the value of the intervention and for the purpose of improving its operation and effectiveness.

Outreach[a]

A community-based activity with the overall aim of facilitating improvement in health and reduction of drug-related risk or harm for individuals and groups not effectively reached by existing services or through traditional health education channels. Outreach can be "detached", "peripatetic", or "domiciliary" or "peer". Detached outreach takes place outside of an agency or organizational setting in public places such as the streets, public transport stations, nightclubs, hotels and cafes. Peripatetic outreach focuses on organizations (for example, half-way houses, needle exchanges, youth clubs, schools and prisons) rather than individuals. Domiciliary outreach takes place in people's homes. Peer (or indigenous) outreach projects use current and former members of the target group (such as injecting drug users) as volunteers and paid staff.

Overdose

According to the WHO *Lexicon of Alcohol and Drug Terms,* "overdose" is defined as follows: the use of any drug in such an amount that acute adverse physical or mental effects are produced. Deliberate overdose is a common means of suicide and attempted suicide.

Overdose may produce transient or lasting effects, or death; the lethal dose of a particular drug varies with the individual and with circumstances.

See also: **Intoxication.**

Peer intervention

Essentially, a treatment that is delivered by a trained individual who is close in gender or age group or other socio-economic category to the target group. Peer interventions are usually, but not always, brief in duration and target individuals at risk of substance abuse problems or who have problems of moderate severity.

Peer support[a]

At one level, one of the components of a peer outreach relationship where the outreach worker provides some form of assistance to a peer. The assistance is usually ongoing rather than a single discrete episode. Examples include support provided by peer carers of people living with AIDS who may be unwell. The term "peer support group" is used to describe collectives or self-organizations of members of a community for the purpose of representing their shared interests at a socio-political level. Examples include the "Junkiebonden" in the Netherlands and other drug abuse groups which are found in many countries.

Performance indicator

A measure that is used to assess the progress of a drug supply or demand strategy.

Performance monitoring

The measurement and communication of the results of strategic plans and treatment services designed to tackle substance abuse.

See also: **Strategic plan.**

Prevalence[a]

A measure of the extent of a particular condition or illness usually expressed in terms of the numbers of cases per 10,000 people in a given population.

Prevention

An intervention designed to avoid or substantially reduce risk for the acquisition or further development of adverse health and interpersonal problems. Drug abuse prevention programmes vary widely in content and philosophy. The most effective programmes are multidimensional and contain a mixture of straight-talking education sessions about drugs and drug abuse; skills to deal with stress and personal and relationship problems; and drug resistance skills. The specific content of a programme can be specifically adapted to the nature and needs of the target population.

Primary health-care workers

The doctors, nurses, psychologists and support personnel who work from community locations and who essentially provide general health-care services to the local population.

Priority groups

Identified groups of people in a country or community that have a particular set of substance-related risks and/or problems that require treatment (for example, children and young people; people with substance abuse and psychiatric co-morbidity; and those in the criminal justice system).

Process evaluation

An evaluation to determine the degree to which programme procedures were followed according to a written programme plan: How much of the intervention was provided to whom, when, and by whom? A process evaluation can also be called a quality assurance review.

Psychoactive substance[a]

According to the WHO *Lexicon of Alcohol and Drug Terms,* "psychoactive substance" is defined as follows: a substance that, when ingested, alters mental processes, that is, thinking or emotion. That term and its equivalent, psychotropic drug, are the most neutral and descriptive terms for the whole class of substances, licit and illicit, of interest to drug policy. "Psychoactive" does not necessarily imply dependence-producing.

See also: **Psychotropic drug.**

Psychological dependence[a]

A term for a largely discredited concept but which is still used in some quarters. It refers to dependence upon a drug in the absence of the development of either tolerance or withdrawal symptoms. Most modern uses of the term "dependence" avoid a strict distinction between "psychological" and "physical" dependence. If that phenomenon exists at all, it is likely to be a characteristic of the user and not a property of the drug.

See also: **Dependence, Dependence syndrome.**

Psychosocial treatment

Interventions based on psychological principles and methods involving individual and group counselling and therapy designed to modify problematic substance-related cognitions and behaviours.

Psychotropic drug[a]

In the context of international drug control, "psychotropic substance" refers to a substance controlled by the 1971 Convention on Psychotropic Substances. According to the WHO *Lexicon of Alcohol and Drug Terms,* "psychotropic" is in its most general sense a term with the same meaning as "psychotropic", that is, affecting the mind or mental processes. Strictly speaking, a psychotropic drug is any chemical agent whose primary or significant effects are on the central nervous system. Some writers apply the term to drugs whose primary use is in the treatment of mental disorders-anxiolytic sedatives, antidepressants, antimanic agents and neuroleptics. Others use the term to refer to substances with a high abuse liability because of their effects on mood, consciousness, or both-stimulants, hallucinogens, opioids and sedatives/hypnotics (including alcohol).

Quality assurance and improvement

A systematic approach to the organization, delivery and development of treatment based on a shared staff commitment to addressing the needs of patients/clients through appropriate and good quality services.

Rapid assessment[a]

A variety of methods for rapid or focused data collection which since the early 1980s have grown out of a sense of urgency for social science input in disease control programmes. Both UNDCP and WHO have developed guidelines for conducting such assessments. Rapid assessment methods can be used as an evaluation tool or in order to generate baseline data. Methods include knowledge, attitude and behaviour surveys; community diagnosis; rapid rural analysis used in agriculture; rapid epidemiological assessments; and those rapid assessment procedures which use ethnographic methods. Rapid assessment methods may involve either quantitative or qualitative methods, but often involve both.

Rehabilitation[a]

According to the WHO *Lexicon of Alcohol and Drug Terms,* "rehabilitation" is defined as follows: in the field of substance use, the process by which an individual with a drug-related problem achieves an optimal state of health, psychological functioning and social well-being.

Rehabilitation typically follows an initial phase of treatment in which detoxification and, if required, other medical and psychiatric treatment occurs. It encompasses a variety of approaches including group therapy, specific behaviour therapies to prevent relapse, involvement with a mutual-help group, residence in a therapeutic community or half-way house, vocational training, and work experience. There is an expectation of social reintegration into the wider community.

See also: **Recovery, Treatment.**

Relapse[a]

According to the WHO *Lexicon of Alcohol and Drug Terms,* "relapse" is defined as follows: a return to drinking or other drug use after a period of abstinence, often accompanied by reinstatement of dependence symptoms. Some writers distinguish between relapse and lapse ("slip"), with the latter denoting an isolated occasion of alcohol or drug use.

The rapidity with which signs of dependence return is thought to be a key indicator of the degree of drug dependence.

See also: **Relapse prevention.**

Relapse prevention[a]

According to the WHO *Lexicon of Alcohol and Drug Terms,* "relapse prevention" is defined as follows: a set of therapeutic procedures employed in cases of alcohol or other drug problems to help individuals avoid or cope with lapses or relapses to uncontrolled substance use. The procedures may be used with treatment based on either moderation or abstinence, and in conjunction with other therapeutic approaches. Patients are taught coping strategies that can be used to avoid situations considered dangerous precipitants of relapse, and shown, through mental rehearsal and other techniques, how to minimize substance use once a relapse has occurred.

See also: **Relapse.**

Research evidence base

The extant published research literature that describes the nature and strength of clinical, social and economic benefits associated with a particular treatment modality. To say that a treatment has a "research evidence base" is to state that its benefit has been demonstrated by a number of published outcome studies. The research evidence base is generally seen as relating only to reports published in scientific peer-reviewed journals, where the quality of the research undertaken can be assured. Systematic reviews of the evidence base for a particular treatment are also published in scientific journals and by the Cochrane Collaboration. Caution needs to be exercised when considering the published research on a particular treatment—in particular when studies vary by nation, method and the populations treated.

Residential treatment

Programmes that provide ancillary residential services on the same site as treatment services. The programmes generally strive to provide an environment free of substance abuse, with an expectation for compliance in a number of activities such as detoxification, assessment, information/education, counselling, group work, and the development or recovery of social and life skills.

Risk reduction[a]

Risk reduction describes policies or programmes that focus on reducing the risk of harm from alcohol or other drug use. Risk reduction strategies have some practical advantages in that risky behaviours are usually more immediate and easier to objectively measure than harms, in particular those harms which have a low prevalence. For example, it may be more practical to measure reduced sharing of needles and other injecting equipment than indices of harm such as the incidence of HIV.

See also: **Harm reduction, Safer use.**

Risky behaviour[a]

In relation to drug use, risky behaviour refers to behaviours that place persons at risk of some drug-related harm. Although most often used in relation to behaviours, such as sharing needles or other injecting equipment (spoon, water, tourniquet, etc.) which place drug injectors at risk of transmission of blood-borne viruses such as HIV or hepatitis C, the term can be applied to any drug and to any risk of harm to livelihood, relationships, legal sanctions, or health.

Safer use[a]

Most drugs may be used in a way in which risk of adverse consequences is reduced by means of a combination of safer preparation, low dose, safer route of administration and in safer settings. For example, the risk of adverse consequences from using heroin, or the extent to which a drug use episode is life threatening, is greatly determined by whether injecting equipment is shared; whether a new batch of heroin is tested first in a small dose in case it is unusually pure; or whether it is used concomitantly with other central nervous system

depressants such as benzodiazepines and alcohol. In most cases it is possible to identify drug-using practices which reduce, though usually not eliminate, the risk of serious adverse consequences.

See also: **Harm reduction, Risk reduction.**

Screening

A rapid procedure designed to detect individuals who have a substance abuse problem.

Self-help group

Groups that offer programmes of recovery on a voluntary basis principally through a twelve-step process for personal change. Those programmes often include participation in meetings to share histories of problems, obtain help and support from other members in dealing with challenges that have led to relapses, and seeking a member who will serve as a sponsor or mentor to provide help in times of crisis. Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) make up a significant sector of the self-help groups concerned with substance dependence, while Al-anon, Alateen and Adult Children of Alcoholics (ACOA) attract family members trying to reconcile and resolve current or past personal problems associated with substance abuse in the family. Numerous other groups also operate in a similar fashion within and outside the field of substance abuse.

Service accreditation

A system within quality assurance that indicates that a treatment service or programme meets a set of organizational, operational, clinical and professional performance standards and relevant legal requirements for its operation. There are currently no internationally agreed standards for service accreditation, but a wide range of countries have developed national standards and accreditation processes.

Shared care

A formal arrangement or cooperation between one or more generic services (usually primary health care) and a specialist substance abuse treatment service for the management of patients. Shared care arrangements usually involve the transfer of a patient receiving continuing treatment from a specialist service to a generic service and vice versa.

Specialist service

A social, welfare or health-care service that has the treatment of people with substance abuse problems as its primary purpose.

Stakeholders

The set of individuals in a community with an investment or expectation in the efficient and effective operation of a treatment service or system. That can include patients, carers/family members, treatment providers, planners and those providing financial support for service costs.

Strategic framework

A formal government policy that describes the national vision and goals for tackling substance supply and demand. The strategic framework provides a summary description of the different agencies or bodies involved, how they will operate jointly and singly, the nature of resources that have been allocated and the specific actions and objectives that are sought.

Strategic plan

An overall framework prepared at a national (and usually subnational) level that characterizes the nature of substance abuse problems, the vision underpinning demand reduction and other prevention efforts, the agencies and resources to be committed to tacking the problem and the specific time-based goals and objectives sought. Effective plans place considerable value on consultation and open communication with the community and target populations. Most strategic plans are published open-access documents and can be accessed via the Internet.

Structured treatment

Structured treatment describes a programme of therapeutic care that has several components that are organized in a logical or sequential way and are based on an initial patient assessment, and personalized treatment plan. Those components may include short and longer stay residential care and community/outpatient settings and involve the provision of medical and/or psychosocial interventions and/or aftercare. Naturally, there is variation in the intensity and duration of the components and their goals and objectives.

Substance abuse[d]

A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. There may be repeated failure to fulfil major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems, and recurrent social and interpersonal problems.

[d] Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) (Washington, D.C., American Psychiatric Association, 1994).

Substance dependence[d]

A cluster of cognitive, behavioural and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal and compulsive drug-taking behaviour.

Substance use disorder[a, e]

A generic term used in international systems (DSM-IV and ICD-10) for classifying diseases for various conditions and illnesses associated with the use of any psychotropic drug. It includes both problematic and dependent drug use.

Any mental or behavioural disorder resulting from the use of one or more psychoactive substances, whether or not medically prescribed. The substances specified are alcohol, opioids, cannabinoids, sedatives or hypnotics, cocaine, other stimulants (including caffeine), hallucinogens, tobacco, and volatile solvents. The clinical states that may occur include acute intoxication, harmful use, dependence syndrome, withdrawal state, withdrawal state with delirium, psychotic disorder, late-onset psychotic disorder and amnesic syndrome.

Substitution treatment

See: **Drug substitution.**

Synthetic estimation

A set of indirect methods used to determine the prevalence of substance abuse for a specified locality using results from existing prevalence estimates and other demographic information for specified segments of the population.

Syringe exchange

See: **Needle exchange.**

Target groups[a]

Groups or categories of people who are selected for special attention by a programme or policy, for example, indigenous peoples, single mothers, persons aged 14 to 19.

Targeted programme[a]

A programme designed to reach particular high-risk groups in society, such as unemployed youth, street children and prisoners.

[e] Lexicon of Psychiatric and Mental Health Terms (Geneva, World Health Organization, 1994).

Therapeutic community[a]

A structured environment in which individuals with drug-related problems live while undergoing rehabilitation. Such communities are often specifically designed for drug-dependent people; they operate under strict rules, are run mainly by people who have recovered from dependence, and are often geographically isolated. Therapeutic communities are also used for management of patients with psychotic disorders and anti-social personalities. Therapeutic communities are characterized by a combination of "reality testing" (through confrontation of the individual's drug problem) and support for recovery from staff and peers. They are usually closely aligned with mutual-help groups such as Narcotics Anonymous.

Tolerance[a]

A term for the well established phenomenon of reduced drug effects following repeated drug administrations. Tolerance develops fastest with more frequent episodes of use and with larger amounts per occasion. It is useful to distinguish between metabolic tolerance and functional tolerance. Metabolic tolerance arises usually as a consequence of an induction of liver enzymes which result in the faster metabolism of a given drug dose, thereby reducing the level and duration of blood-drug levels. Functional tolerance refers to diminished effects of a given blood-drug level. That is thought to occur both by virtue of neuroadaptation, as well as by the user learning to anticipate and accommodate intoxicating effects.

Treatment[a]

According to WHO (*WHO Expert Committee on Drug Dependence Thirtieth Report,* Technical Report Series) the term "treatment" refers to "the process that begins when psychoactive substance abusers come into contact with a health provider or any other community service and may continue through a succession of specific interventions until the highest attainable level of health and well being is reached". More specifically, treatment may be defined "… as a comprehensive approach to the identification, assistance, ... (and) ... health care ... with regard to persons presenting problems caused by the use of any psychoactive substance".

Essentially, by providing persons, who are experiencing problems caused by their use of psychoactive substances, with a range of treatment services and opportunities which maximize their physical, mental and social abilities those persons can be assisted to attain the ultimate goal of freedom from drug dependence and to achieve full social reintegration. Treatment services and opportunities can include detoxification, substitution/maintenance therapy and/or psychosocial therapies and counselling.

Additionally, treatment aims at reducing the dependence on psychoactive substances, as well as reducing the negative health and social consequences caused by, or associated with, the use of such substances.

Treatment protocol

A document that is a complete description of the nature of the patients that are to be treated, the operational and organizational elements of the treatment to be provided, the staffing and clinical methods and procedures to be followed.

Triage

The process of priority allocation or assignment of an individual to an intervention, needed by services providing treatment for substance abuse problems.

Twelve-step group[b]

A mutual-help group organized around the twelve-step programme of Alcoholics Anonymous (AA) or a close adaptation of that programme. AA's programme of twelve steps involves admitting one is powerless over one's drinking and over one's life because of drinking, turning one's life over to a "higher power", making a moral inventory and amends for past wrongs, and offering to help other alcoholics.

Urinalysis[a]

Analysis of urine samples to detect the presence of substances a person may have ingested, or for other medical or diagnostic purposes. Different drugs can be detected in the urine for different time periods. Heroin and amphetamines can only be detected in the urine at most within a few days of last ingestion, while cannabis can be detected up to several weeks after last ingestion in persons who have been long-term heavy users. In recent years, the analysis of saliva, blood, sweat and hair strands has also become available for the detection of past drug use.

Vocational training[a]

Training in a particular field of potential employment (for example, computer skills) with the aim of helping clients to improve their chances of employment and/or a better income.

Voluntary organization

An agency whose human resources largely or wholly consist of staff who are not paid but provide their labour or services for free. They have tended to be agencies outside the government sector.

See also: **Non-governmental organization.**

Welfare net[a]

A general term to describe the constellation of social welfare, economic supports, public health and housing services which are available in a certain country, jurisdiction, or locality which aim to protect people from poor health and economic and social destruction. Usually seen as comprising health and welfare benefits, such as health care and unemployment benefit schemes, as well as government and non-government health and welfare agencies. Often used in the context of people who may have "fallen through the welfare net" in the sense that they have not been "caught" by the existing government services and schemes.

Withdrawal[a]

A term used to refer to either the individual symptoms of, or the overall state (or syndrome), which may result when a person ceases use of a particular psychoactive drug upon which they have become dependent or after a period of repeated exposure. The level of central nervous system arousal and the accompanying mood state is usually directly opposite to the direct action of the drug.

See also: **Withdrawal syndrome, Dependence syndrome.**

Withdrawal syndrome[a]

According to the WHO *Lexicon of Alcohol and Drug Terms,* "withdrawal syndrome" is defined as follows: a group of symptoms of variable severity which occur on cessation or reduction of drug use after a prolonged period of use and/or in high doses. The syndrome may be accompanied by signs of both psychological and physiological disturbance.

A withdrawal syndrome is one of the indicators of a dependence syndrome. It is also the defining characteristic of the narrower psycho-pharmacological meaning of dependence.

See also: **Withdrawal, Dependence syndrome.**

FEEDBACK FORM

Dear readers,

This *Guide* aims at offering practical, step-by-step advice for the establishment of treatment services. It is intended to be a practical "how to" resource for all those involved in the planning, delivery, monitoring and evaluation of treatment services.

Your experience in using this *Guide* is a very important source of feedback for refining it in the future. Please return this feedback form to the Demand Reduction Section, UNODC.

Thank you very much in advance for your cooperation.

Please mail to:
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Please give us your OVERALL EVALUATION of the *Guide*.

	Strongly disagree	*Disagree*	*Unsure*	*Agree*	*Strongly agree*
1. The *Guide* is clearly written.	☐	☐	☐	☐	☐
2. The language style is too technical.	☐	☐	☐	☐	☐
3. The *Guide* is well-structured.	☐	☐	☐	☐	☐
4. The format is "user-friendly".	☐	☐	☐	☐	☐
5. The material is of practical value.	☐	☐	☐	☐	☐
6. The *Guide* is relevant to practical work on treatment planning.	☐	☐	☐	☐	☐

PLEASE FEEL FREE TO ADD ANY COMMENTS THAT YOU WOULD LIKE TO SHARE WITH US.

General comments

Strengths

Weaknesses

Issues that require further clarification or elaboration/Additional material

Suggestions for making the *Guide* more practically oriented and useful

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