



UNODC

United Nations Office on Drugs and Crime



**World Health
Organization**

International Standards for the Treatment of Drug Use Disorders

Draft for Field Testing

© United Nations Office on Drugs and Crime, March 2016.

This publication has not been formally edited.

Acknowledgements

The United Nations Office on Drugs and Crime (UNODC) would like to acknowledge the following for their invaluable contribution to the process of publication of these standards:

The group of international experts for providing the relevant scientific evidence, technical advice and developing the main draft of the standards, including (in alphabetical order):

Dr. David Basangwa, Uganda; Dr. Adam Bisaga, United States; Dr. Willem Van Den Brink, Netherlands; Dr. Sandra Brown, United States; Mr. Thom Browne, United States; Dr. Kathleen Carroll, United States; Mr. Humberto Carvalho, United States; Dr. Michael Clark, United States; Dr. Steve Gust, United States; Dr. Loretta Finnegan, United States; Dr. Gabriele Fischer, Austria; Dr. Hendree Jones, United States; Dr. Martien Kooyman, Netherlands; Dr. Evgeny Krupitsky, Russia; Dr. Otto Lesch, Austria; Dr. Icro Maremmani, Italy; Dr. Douglas Marlowe, United States; Dr. Andrew Thomas McLellan, United States; Dr. Edward Nunes, United States; Dr. Isidore Obot, Nigeria; Dr. John Strang, United Kingdom; Dr. Emilis Subata, Lithuania; Dr. Marta Torrens, Spain; Dr. Roberto Tykanori Kinoshita, Brazil; Dr. Riza Sarasvita, Indonesia; Dr. Lucas George Wiessing, Netherlands.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), in particular Dr. Marica Ferri; National Institute of Drug Abuse (NIDA); Inter-American Drug Abuse Control Commission (CICAD), in particular Ms. Alexandra Hill; Substance Abuse and Mental Health Services Administration (SAMHSA); the Colombo Plan, in particular Ms. Veronica Felipe, Mr. Bian How Tay and Ms. Winona Pandan.

Dr. Vladimir Poznyak, World Health Organization (WHO) and Dr. Gilberto Gerra, UNODC, who coordinated this joint effort of UNODC and WHO in the framework of the UNODC-WHO Programme on Drug Dependence Treatment and Care.

WHO staff, in particular Dr. Nicolas Clark for his extensive support and revising the standards, Dr. Shekhar Saxena for his contribution to the standards and Mr. Cesar Leos-Toro, Consultant, for his support.

The following UNODC staff for their commitment and substantive contributions that helped bring this document to life (in alphabetical order): Ms. Anja Busse, Ms. Giovanna Campello, Dr. Igor Koutsenok, Ms. Elizabeth Mattfeld, Dr. Elizabeth Saenz, as well as consultants Ms. Christina Gamboa and Ms. Olga Parakkal.

The following staff of UNODC for their dedication and organisational support throughout all the process of developing the International Standards: Ms. Caecilia Handayani-Hassmann, Ms. Emilie Finkelstein, and Ms. Nataliya Graninger.

UNODC staff in the field offices and experts globally for providing substantive support.

Table of Contents

CHAPTER 1: INTRODUCTION.....	1
1.1 Background.....	1
1.2 Drug Use Disorders	2
1.3 New Trends in Drug Use	5
1.4 International Treatment Standards	7
CHAPTER 2: KEY PRINCIPLES AND STANDARDS FOR THE TREATMENT OF DRUG USE DISORDERS	8
CHAPTER 3: TREATMENT MODALITIES AND INTERVENTIONS	17
3.1 Community-Based Outreach.....	17
3.2 Screening, Brief Interventions, and Referral to Treatment (SBIRT).....	20
3.3 Short-Term In-Patient or Residential Treatment.....	25
3.4 Outpatient Treatment.....	33
3.5 Long-Term Residential Treatment.....	47
3.6 Recovery Management.....	57
CHAPTER 4: SPECIAL POPULATIONS.....	62
CHAPTER 5: CHARACTERISTICS OF AN EFFECTIVE SYSTEM TO DELIVER SERVICES FOR THE TREATMENT OF DRUG USE DISORDERS.....	83
REFERENCES.....	93

Chapter 1: Introduction

1.1 Background

It is estimated that a total of 250 million people, or 1 out of 20 people between the ages of 15 and 64 years, used an illicit drug in 2014 (World Drug Report, 2016). Approximately one in ten people who use illicit drugs is suffering from a form of a drug use disorder, including drug dependence. Almost half of people with drug dependence inject drugs and of them more than 10% are living with HIV, and the majority are infected with hepatitis C. Drug use disorders are a major global health problem.

Drug use disorders are a serious health issue, with a significant burden for individuals affected and their families. There are also significant costs to society including lost productivity, security challenges, crime, increased health care costs, and a myriad of negative social consequences. The social cost of illicit drug use is estimated at up to 1.7% of GDP in some countries (World Drug Report, 2016). Caring for individuals with drug use disorders places a heavy burden on public health systems of Member States and therefore improving treatment systems by making them the best they can be. This would undoubtedly benefit not only the affected individuals, but also their communities and the whole society.

After many years of medical research, it is clear that drug dependence is a complex multifactorial biological and behavioral disorder. Scientific advances are making it possible to develop treatments that help normalize brain functioning of affected individuals and support them in changing their behavior. Offering treatments based on the scientific evidence is now helping millions of affected individuals to regain control over their lives.

Unfortunately, outdated views about drug use disorders persist in many parts of the world. Stigma and discrimination that is commonly applied to drug dependent individuals and to professionals working with them have significantly compromised the implementation of quality treatment interventions in this area, undermining the development of treatment facilities, the training of health professionals and the investment in recovery programmes. Even though the evidence clearly shows that drug use disorders are best managed within a public health system, similarly to other medical problems such as HIV infection or hypertension, the inclusion of treatment of substance and drug use disorders in the health care system is still very difficult in many countries where a huge gap exists between science, policy and the clinical practice.

In some countries drug use disorders are still seen as a primarily criminal justice problem, and agencies of the Ministry of Interior, Ministry of Justice or Ministry of Defense are still responsible for affected individuals, without the supervision or engagement of the Ministry

of Health. Using only law enforcement strategies and methods is unlikely to result in sustained positive effects. Only treatment that has at its core an understanding of drug dependence as a primarily multifactorial biological and behavioral disorder, that can be treated using medical and psychological approaches, can improve chances of a recovery from the disorder and reduce (drug-)related consequences.

Currently, UNODC showed in the World Drug Report that at a global level only 1 out of 6 people in need of drug dependence treatment has access to treatment programmes; only 1 out of 11 in Latin America and 1 out of 18 in Africa. Treatment in many countries is only available in the large cities but not in rural areas. Unfortunately, in many places available treatment is often not effective, not supported by the scientific evidence, and sometimes not in line with human rights principles. This is also the case in highly developed countries where availability of evidence-based treatment programmes is often insufficient.

1.2 Drug Use Disorders

Using narcotic drugs and psychotropic substances without medical supervision, is associated with significant health risks. For this reason, the production, sale, distribution and use of these substances have been regulated under the control of the international treaties (Conventions of 1961, 1971, 1988), with the aim to avoid negative consequences that could significantly undermine health and security.

Approximately 10% of individuals who begin to use drugs will over time develop changes in their behavior and other symptoms that constitute a Drug Use Disorder (either harmful drug use or drug dependence in the ICD-10 classification system).

At the core of the drug dependence syndrome is the strong and overpowering desire to take the drug, an inability to control the consumption and the amount of drugs taken resulting in a disproportionate amount of time spending on excessive drug-related activities. Over time, the use of a drug takes on a much higher priority for a given individual, displacing other activities that once had greater value. Individuals with this disorder often lose interest in and neglect their family and social life, education, work and recreation. They may engage in high-risk behaviors and continue to use drugs despite the knowledge of recurrent social and/or interpersonal problems resulting from drug use. Finally, some drugs may produce over time a decrease in effects to the same repeated dose of a drug or tolerance, and a withdrawal syndrome - a set of characteristic adverse symptoms, when the amount of drug consumed is reduced or drug use has stopped. The desire to take the drug can persist, or easily be reactivated, even after a long period of abstinence.

At the basis of these symptoms and behaviors is the disruption of neuronal pathways in brain areas that regulate motivation and mood, experience of pleasure and well-being, memory and learning, and the ability to suppress unwanted impulses.

The scientific community now has a complex understanding of how these disruptions in brain functioning result in the development of drug use disorders. First, hereditary or genetic factors play a role in passing on the increased risk of dependence to the next generation. This genetic risk is evidenced by different responses to the initial doses of drugs seen in individuals at risk; they show more positive effects, less negative effects, and the ability to tolerate much higher doses than seen in individuals without the genetic risk factors. Nevertheless the genetic risk can be modified by early life experiences, which can have protective but also detrimental effects. Early life trauma, deprivation, and persistent stress can make the individual more vulnerable to develop abnormal effects on the brain following early drug exposure. In vulnerable individuals, the exposure to drugs triggers mechanisms of pathological reward learning and interferes with previously learned responses to other behaviors and rewards, such as social interactions or food. This new type of learned response is very stable and can persist for life, similarly to other learned behaviors such as riding a bicycle.

Previously neutral environments become strongly associated with the drug experience, when drugs are consumed, and can later independently trigger the desire for the drug and stimulate drug-seeking behavior. The desire for drugs can also be triggered by the exposure to stress or even small amounts of other intoxicants such as alcohol. Over time the memories related to drug experiences become very strong and persistent. The desire to use can become easily triggered whereas the ability to control and suppress the impulse to use becomes weaker, so that the affected individual may resume drug use despite the prior strong desire not to do so.

As a consequence, the abnormal brain functioning in affected individuals predisposes them to make decisions with disastrous consequences to their own health and well-being and also the well-being of their families and communities, including to engage in behaviors that are illegal or that they would have previously considered unethical or immoral, either to purchase drugs or under the influence of them.

Scientific advances and efforts of educating the general public are beginning to change the perceptions of drug use disorders throughout Member States and civil society. There is a greater recognition that drug use disorders are a complex health problem with psychosocial, environmental, and biological determinants, which need a multidisciplinary and comprehensive response from different institutions working together. Many policymakers and the general public are beginning to see that drug dependence is not simply a “self-acquired bad habit” but rather a result of a long series of biological and environmental factors, disadvantages and adversities, that can be prevented and treated. Risk factors in both developed and in developing countries are being recognized. Early childhood neglect and abuse, the lack of strong family supports, impaired parenting, the lack of emotional support and personal engagement of teachers, household dysfunction, social exclusion and isolation contribute to the development of mental health problems and drug dependence in many communities. In other communities, these problems are compounded by exposure to extreme poverty, degraded neighborhoods, homelessness, displacement, exploitation, violence, hunger and poor working conditions and work overload.

In addition to the symptoms of this complex disease, individuals with severe drug use disorders more often than not develop additional medical or psychiatric problems. Those who inject drugs are likely to be exposed to blood-borne infections (HIV – Human Immunodeficiency Virus, HCV – Hepatitis C Virus) and TB – Tuberculosis, to carry a high risk of cardiovascular and liver problems, to have an increased incidence of traffic and other accidents, and to more frequently experience violence. Individuals with drug dependence have a much lower life expectancy. For example, the mortality rate of people with opioid dependence is significantly higher than the rate expected in the general population and death occurs more often at a young age. Opioid dependence was estimated to account for 0.37% of global DALYs (Disability-adjusted life years) in 2010, a 73% increase on DALYs estimated in 1990 (Degenhardt et al. 2014). Overdose, HIV/AIDS, Hepatitis C, unintentional injuries (accidents and violence), cardiovascular diseases and suicide are the most frequent causes of death due to drug use. The relationship between psychiatric and substance use disorders is very complex. Often a separate psychiatric disorder exists prior to the onset of substance use, putting affected individuals at greater risk of developing drug use disorders. Psychiatric disorders may also develop secondary to the drug use disorder, due in part to biological changes in the brain resulting from chronic drug use. The risk of developing drug dependence and psychiatric complications is particularly high in children and young adults who get exposed to the effects of drugs before their brain can fully mature, a process that usually occurs during the mid-twenties.

Because drug use disorders are generally chronic in nature, the risk of relapse to drug use persist for many years, in some cases even after many years of complete abstinence from drugs. The implication of this is that therapeutic services have to be ready to work with drug use disorder patients over the long term, maintaining contact and offering monitoring for years, sometimes for the entire life. This is similar to the system of care for patients with other chronic diseases (diabetes, asthma, high blood pressure) that are prepared to deal with periods of symptom remission but also exacerbation, delivering the intensity of interventions to match the severity of the presented problem without the expectation that a condition can be completely cured after a short-term treatment episode. Recognizing the nature of chronicity and the relapsing course of drug users, ongoing drug use does not imply that the treatment is ineffective and therefore useless. On the contrary, appropriate treatment delivered repeatedly despite ongoing use or intermittent relapses in drug use is essential to guarantee an improved quality and duration of life in spite of the persistent and serious health problems while minimizing harmful effects to both the drug users and the community, and maximizing the chances of a long and healthy life.

1.3 New Trends in Drug Use

Traditionally drugs were mainly plant-derived substances such as cocaine, heroin and cannabis, consumed in the region in which they were grown or along trade routes to their final market. Increased global trade and travel is globalizing the market in plant-based substances that were previously specifically focused in different regions.

In recent decades, more synthetic psychoactive substances (NPS) including amphetamines and related stimulants synthesized in illicit laboratories have become more widely available and are being produced and consumed in every region. A significant proportion of substance use disorders due to the non-medical use of prescription drugs that are classified as controlled substances such as synthetic pain medicines, sedative hypnotics, or psychostimulants. The increase in the last 10 years in the use of strong opioids in the management of chronic pain in some parts of the world has resulted in a dramatic increase in opioid overdose deaths.

In order to avert legal efforts in controlling the distribution of dangerous psychoactive substances based on the scheduling of specific compounds, hundreds of new psychoactive substances are synthesized, distributed, and used every year with unpredictable and often dramatic adverse consequences in users. The production and trafficking of NPS, that can often be purchased via the internet, makes their monitoring and control even more difficult. Few countries have an early warning system in place to collect and share information on these new substances.

The result of these changes is that many countries are seeing a change in drug use patterns; away from more traditional plant-based substances towards synthetic compounds, prescription medicines, or other plant-based substances. While globally opioids continue to represent the major threat to public health, this is now being more closely followed by amphetamine-type stimulants (UNODC World Drug Report, 2016).

Often health care systems are struggling to respond appropriately to the emergence of new behavioral and medical problems in drug users. For example, in parts of the world where opioids were previously seldom used, health systems do not usually have the capacity to deliver medically assisted treatment of opioid use disorders, such as opioid agonist maintenance treatment. Similarly, in parts of the world where the treatment system has mainly focused on opioid use disorders, there are now large increases in the prevalence of psychostimulant use disorders and treatment systems, that have been developed to manage opioid-related disorders are not able to respond appropriately to the new type of patients, for whom evidence-based psychosocial treatment is the main effective intervention. In addition, many regions are seeing new treatment populations such as young people with poly-drug use, pregnant women, children with drug use problems, elderly drug users, people with medical comorbidities such as HIV, TB, and HCV, people with psychiatric comorbidities such as anxiety, depression, personality disorders and psychosis, people with primary prescription drug problems, and people primarily using new psychoactive substances. The resulting combination of changing patterns of substance use and changing populations of substance users results in challenges for many health care systems to adapt

in a timely, effective and efficient way, which would require urgent investment in treatment programmes and human resources.

1.4 International Treatment Standards

To assist Member States in the development of appropriate responses and evidence based services for drug use disorders, in 2009 UNODC and WHO jointly created a Global Programme on Drug Dependence Treatment and Care. The main purpose of this inter-agency programme is to disseminate good practice-examples informed by science and ethical principles in this field, guaranteeing for drug dependent people the same quality standards and opportunities that are provided by the health system for any other chronic diseases.

The International Standards for the Treatment of Drug Use Disorders (*Standards*) were prepared to support Member States in the development and expansion of treatment services that offer effective and ethical treatment. The goal of such treatment is to reverse the negative impact that persisting drug use disorders have on the individual and to help individuals achieve a recovery from the disorder as fully as possible and help them to entirely participate in society as a member of their community.

The UNODC-WHO International Standards for the Treatment of Drug Use Disorders summarize the currently available scientific evidence on the effective treatment interventions and approaches, and set out a framework for their implementation consistent with principles of health care more broadly. This document identifies major components and features of an effective drug treatment system, with a description of evidence-based treatment interventions to match the needs of people affected in different stages of the disease, in a consistent manner consistent with the treatment of any chronic disease.

In the past, UNODC and WHO developed Principles of Drug Dependence Treatment (*Principles*) which constitute an overarching policy and guidance. The *Standards* include a description of specific practices and procedures that help establish, maintain and support the *Principles*. The *Standards* provide rules or minimum requirements for clinical practice, generally accepted principles of patient management in any healthcare system.

This work builds on and recognizes the work of many other organizations (e.g. EMCDDA, CICAD, NIDA, SAMHSA) which have previously developed standards and guidelines on various aspects of drug treatment and participated in the drafting of the present *Standards* document.

It is our hope that the present *Standards* will guide policy makers and social or health practitioners worldwide in the development of policies, drug treatment services, and human resources to support therapeutic services. The *Standards* will be also helpful in evaluation and ongoing improvement of services. It is our hope that new policies and treatment systems developed with the help of these *Standards* will be a truly effective investment in the future of people affected by drug use disorders, their families, and communities.

Chapter 2: Key Principles and Standards for the Treatment of Drug Use Disorders

Drug Use Disorders can be effectively treated using a range of pharmacological and psychosocial interventions. The effectiveness of the majority of these interventions has been tested using scientific methods developed for the treatment of other medical disorders.

In the management of substance use disorders, the goals of treatment are to:

- 1) reduce drug use and cravings for drug use,
- 2) improve health, well-being and social functioning of the affected individual, and
- 3) prevent future harms by decreasing the risk of complications and relapse.

Many interventions that are commonly used in the management of substance use disorders do not meet accepted scientific standards of clinical efficacy. Such interventions may be ineffective or even harmful, or it may be that the necessary clinical trials may not have been conducted, and the effectiveness of the treatment is unknown. Resources available to work with affected individuals are limited, therefore priorities for resource allocation must be carefully evaluated against the goals of treatment.

In addition to these criteria that have a clinical effectiveness focus, the treatment of substance use disorders should meet the common standards of all health care:

1. be consistent with UN Declaration of Human Rights and existing UN Conventions,
2. promote personal autonomy,
3. promote individual and societal safety.

The International Standards for the Treatment of Drug Use Disorders define a set of requirements that must be in place before any form of outreach, treatment, rehabilitation, or recovery services may be considered safe and effective care, regardless of the treatment philosophy that is used or the setting it is used in. This is critically important, because individuals with drug use disorders deserve nothing less than ethical and science-based standards of care that are similar to the standards used in treatment of other chronic diseases.

Principle 1. Treatment must be available, accessible, attractive, and appropriate

Description: Drug use disorders can be treated effectively in the majority of cases if people have access to a wide-range of services that cover the continuum of issues that patients may face. Treatment services must match the specific requirements of the individual patient at the specific phase of their disorder. These services include outreach, screening and brief interventions, inpatient and outpatient treatment, medical and psychosocial treatment (including treatment of common comorbidities), long-term residential treatment, rehabilitation, and recovery-support services. These services should be affordable,

attractive, available in both urban and rural settings, and accessible with a wide range of open hours and a minimal waiting time. All barriers that limit the accessibility of appropriate treatment services should be minimized. Services should not only offer treatment for the drug use disorders per se, but also provide social support and protection and general medical care. The legal framework should not discourage people with drug use disorders from attending treatment programmes. The treatment environment should be friendly, culturally sensitive and focus on the specific clinical needs and the level of preparedness of each patient, thus providing an environment that encourages rather than deters individuals from attending the programme.

Standards:

- 1.1. Essential treatment services for drug use disorders should be available at different levels of health systems: from primary health care to tertiary health services with specialized treatment programmes for drug use disorders.
- 1.2. Essential treatment services include outreach services, brief psychosocial interventions, diagnostic assessment, outpatient psychosocial treatment, evidence-based pharmacological treatment, services for management of drug-induced acute clinical conditions such as overdose, withdrawal syndromes and drug-induced psychoses, inpatient services for the management of severe withdrawal, long-term residential services, treatment of common comorbidities.
- 1.3. Essential treatment services for drug use disorders should be within reach of public transport and accessible to people living in urban and rural areas.
- 1.4. Low threshold and outreach services, as part of a continuum of care, are needed to reach the 'hidden' populations most affected by drug use, often non-motivated to treatment or relapsing after a treatment programme.
- 1.5. Within a continuum of care, people with drug use disorders should have access to treatment services through multiple entry points.
- 1.6. Essential treatment services for drug use and drug-induced disorders should be available during a sufficiently wide range of opening hours to ensure access to services for individuals with employment or family responsibilities.
- 1.7. Essential treatment services should be affordable to clients from different socio-economic groups and levels of income with minimized risk of financial hardship for those requiring the services.
- 1.8. Treatment services should be gender-sensitive and tailored to the needs of women including specific child-care needs and needs in pregnancy.
- 1.9. If not otherwise accessible, affordable or available, treatment services should provide access to social support, general medical care and the management of co-morbid health conditions.
- 1.10. Treatment services for drug use disorders should be oriented towards the needs of the populations they serve, with due respect to cultural norms and involvement of service users in the service design, delivery and evaluation.
- 1.11. Information on availability and accessibility of essential treatment services for drug use disorders should be easily accessible through multiple sources of information including internet, printed materials and open access information services.

Principle 2: Ensuring ethical standards of care in treatment services

Description: Treatment of drug use disorders should be based on universal ethical healthcare standards – including the respect for human rights and the patient’s dignity. This includes responding to the right to enjoy the highest attainable standard of health and well-being, ensuring non-discrimination, and removing stigma. Treatment decisions, including when to start and stop treatment, and what kind of treatment, should be made by the individual, to the extent that they have capacity to do so. Treatment should not be forced or against the will and autonomy of the patient. The consent of the patient should be obtained before any treatment intervention. Accurate and up-to-date medical records should be maintained and the confidentiality of treatment records should be guaranteed. Registration of patients entering treatment outside the health records should not be permitted. Punitive, humiliating or degrading interventions should never be used. The individual affected should be recognized as a person suffering with a health problem and deserving treatment similar to patients with other psychiatric or medical problems.

Standards:

- 2.1 Treatment services for drug use disorders should in all cases respect the human rights and the dignity of service users, and humiliating or degrading interventions should never be used.
- 2.2 Informed consent should be obtained from a patient before initiating treatment and guarantee the option to withdraw from treatment at any time.
- 2.3 Patient data should be strictly confidential, and registration of patients entering treatment outside the health records should not be allowed. Confidentiality of patient data should be ensured and protected by legislative measures and supported by appropriate staff training and service rules and regulations.
- 2.4 Staff of treatment services should be properly trained in the provision of treatment in full compliance of ethical standards and human rights principles, and show respectful, non-stigmatizing and non-discriminatory attitudes towards service users.
- 2.5 Services procedures should be in place which require staff to adequately inform patients of treatment processes and procedures, including the right to withdraw from treatment at any time.
- 2.6 Any research conducted in treatment services involving human subjects should be subject to review of human research ethical committees, and participation of service users in the research should be strictly voluntary with informed written consent ensured in all cases.

Principle 3: Promoting treatment of drug use disorders by effective coordination between the criminal justice system and health and social services

Description: Drug use disorders should be considered primarily as health problems rather than criminal behaviors and as a general rule, drug users should be treated in the health care system rather than in the criminal justice system. Even though individuals with drug use disorders may commit crimes, these are typically low-level crimes used to finance the drug purchase, and this behavior typically stops with the effective treatment of the drug use disorder. Because of that, the criminal justice system should collaborate closely with the health and social system to encourage treatment in the health care system over criminal prosecution or imprisonment. Law enforcement, court professionals and penitentiary system officers should be appropriately trained to effectively engage with treatment and rehabilitation efforts. If prison is warranted, treatment should also be offered to prisoners with drug use disorders during their stay in prison and after their release as effective treatment will decrease the risk of reoffending following their release. Continuity of care after the release is of vital importance and should be assured or facilitated. In all justice-related cases people should be provided with treatment and care of an equal standard to treatment offered in the community.

Standards:

- 3.1 Treatment for drug use disorders should be provided predominantly in health and social-care systems, and effective coordination mechanisms with the criminal justice system should be in place to facilitate access to treatment and social services of people in contact with the criminal justice system.
- 3.2 Treatment of drug use disorders should be available to offenders with drug use disorders and, where appropriate, be a partial or complete alternative to imprisonment or other penal sanctions.
- 3.3 Treatment of drug use disorders as an alternative to incarceration or provided within criminal justice settings should be supported by appropriate legal frameworks.
- 3.4 Criminal justice settings should provide opportunities for individuals with drug use disorders to receive treatment and health care that are available in health and social care systems in a community.
- 3.5 Treatment interventions for drug use disorders should not be imposed on individuals with drug use disorders in criminal justice system against their will.
- 3.6 Essential prevention and treatment services should be accessible to individuals with drug use disorders in criminal justice settings, including prevention of transmission of blood-borne infections, pharmacological and psychosocial treatment of drug use disorders and comorbid health conditions, rehabilitation services and the linking with community health and social services in preparation for their release.
- 3.7 Appropriate training programmes for criminal justice system staff, including law enforcement and penitentiary system officers and court professionals should be in place to ensure recognition of medical and psychosocial needs associated with drug use disorders and to support treatment and rehabilitation efforts.

- 3.8 Treatment of drug use disorders in the criminal justice system should follow the same evidence-based guidelines and ethical and professional standards as in the community.
- 3.9 Continuity of treatment for drug use disorders should be ensured in all cases by effective coordination of health and social services in communities and criminal justice settings.

Principle 4: Treatment must be based on scientific evidence and respond to specific needs of individuals with drug use disorders

Description: The cumulative body of scientific knowledge on the nature of drug use disorders and their treatment should guide interventions and investments in the treatment of drug use disorders. The same high standards required for the approval and implementation of pharmacological or psychosocial interventions in other medical disciplines should be applied to the treatment of drug use disorders. As a general rule, only the pharmacological and psychosocial methods that have been demonstrated effective by science or agreed upon by the international body of experts should be applied. Where there is reason to believe that other treatment approaches may be useful, they should be provided in the context of clinical trials. The duration and the intensity (dose) of the intervention should be in line with evidence-based guidelines. Multidisciplinary teams should integrate different interventions tailored to each patient. Organization of treatment for drug use disorders should be based on a chronic care philosophy as opposed to an acute care philosophy. Severe drug use disorders are similar in their course and prognosis to other chronic diseases such as diabetes, HIV, cancer, or hypertension. A long-term model of treatment and care is most likely to promote a long and healthy life. Existing interventions should be adapted to the cultural and financial situation of the country without undermining the core elements identified by science as crucial for effective outcomes. Traditional treatment systems may be unique to a particular country or setting and may have limited evidence of their effectiveness beyond the experience of patients and their clinicians. Such systems should learn from and adopt as much as possible of the existing evidence-based interventions into their programmes and efforts should be made to formally evaluate whether such treatments are effective and/or carry acceptable risks.

Standards:

- 4.1 Resource allocation in the treatment of drug use disorders should be guided by existing evidence of the effectiveness and cost-effectiveness of prevention and treatment interventions for drug use disorders.
- 4.2 A range of evidence-based treatment interventions of different intensity should be in place at different levels of health and social systems with appropriate integration of pharmacological and psychosocial interventions.
- 4.3 Health professionals at primary health care should be trained in the identification and management of the most prevalent disorders due to drug use.
- 4.4 In the treatment of drug use disorders health professionals in primary health care should be supported by specialized services for substance use

- disorders at advanced levels of health care, particularly for the treatment of severe drug use disorders and patients with comorbidities.
- 4.5 Where possible, the organization of specialized services for drug use disorders should be based on multidisciplinary teams adequately trained in the delivery of evidence-based interventions with competencies in addiction medicine, psychiatry, clinical psychology and social work.
 - 4.6 The duration of treatment should be determined by individual needs and there should be no pre-set limits in the duration of treatment that can't be modified according to the patient's clinical needs.
 - 4.7 Training of health professionals in the identification, diagnosis and evidence-based treatment of drug use disorders should be in place at different levels of education including university curricula and programmes of continuing education.
 - 4.8 Treatment guidelines, procedures and norms should be regularly updated in accordance with accumulated evidence of effectiveness of treatment interventions, knowledge about the needs of patients and service users and results of evaluation research.
 - 4.9 Treatment services and interventions for drug use disorders should be adapted for relevance to the socio-cultural environment in which they are applied.
 - 4.10 Treatment services should attempt to measure their performance against performance standards for comparable services.
 - 4.11 The development of new treatments should be conducted through the clinical trial process and overseen by an authorized human research ethics committee.

Principle 5: Responding to the needs of specific populations

Description: Several subgroups within the larger population of individuals affected by drug use disorders require special consideration and often specialized care. Groups with specific needs include, but are not limited to: adolescents, the elderly, women, pregnant women, children, sex workers, sexual and gender minorities, ethnic and religious minorities, individuals involved with the criminal justice system and individuals that are socially marginalized. Working with those special groups requires differentiated and individualized treatment planning that considers their unique vulnerabilities and needs. For some of these subgroups, special considerations will need to be addressed directly in every setting on the treatment continuum.

In particular, children and adolescents should not be treated in the same setting as adult patients, and should be treated in a facility able to manage other issues such patients face, and should encompass broader health, learning, and social welfare context in collaboration with family, schools and social services. Similarly, women entering treatment should have special protection and services. Women with drug use disorders are more vulnerable to domestic violence and sexual abuse, and their children may also be at risk of abuse, therefore a liaison with social agencies protecting women and children is helpful. Women may require women-focused treatment in a safe single-sex setting to obtain maximum

benefit. Treatment programmes should be able to accommodate children's needs and to allow parents caring for children to receive treatment as well, and support good parenting and child care practices. Women may need training and support on issues such as sexual health and contraception.

Standards:

- 5.1 The needs of specific population groups are reflected in service provision and treatment protocols, including the needs of women, adolescents, children, pregnant women, ethnic minorities and marginalized groups such as the homeless.
- 5.2 Special services and treatment programmes should be in place for adolescents with substance use disorders to address the specific treatment needs associated with this age and to prevent contacts with patients in more advanced stages of drug use disorders. Separate settings for treatment of adolescents should be considered whenever possible.
- 5.3 Treatment services and programmes for drug use disorders should be tailored to the needs of women and pregnant women in all aspects of their design and delivery, including location, staffing, programme development, child friendliness and content.
- 5.4 Treatment services should be tailored to the needs of people with drug use disorders from minority groups, and cultural mediators and interpreters should be available whenever necessary in order to minimize cultural and language barriers.
- 5.5 A package of social assistance and support should be integrated into treatment programmes for people with drug use disorders who are homeless, or unemployed.
- 5.6 Outreach services should be in place to establish contact with people who may not seek treatment because of stigma and marginalization.

Principle 6: Ensuring good clinical governance of treatment services and programmes for drug use disorders

Description: Good quality and efficient treatment services for drug use disorders require an accountable and effective method of clinical governance. Treatment policies, programmes, procedures and coordination mechanisms should be defined in advance and clarified to all therapeutic team members, administration, and the target population. Service organization should reflect current research evidence and be responsive to the service user's needs. Treating people with drug use disorders who often have multiple psychosocial and sometimes physical impairments is challenging, both for individual staff and organizations. Staff attrition in this field is recognized and organizations should have in place a variety of measures to support their staff and encourage the provision of good quality services.

Standards:

- 6.1 Treatment policies for drug use disorders should be based on the principles of universal health coverage, consistent with the best available evidence and developed with the active involvement of key stakeholders including the target populations, community members (families), and non-governmental organizations.
- 6.2 Written service policy and treatment protocols should be available, known to all staff and guide delivery of treatment services and interventions.
- 6.3 Staff working in specialized services for drug use disorders should be adequately qualified, and receive ongoing evidence-based training, certification, support and clinical supervision. Clinical supervision, mentoring and other forms of support are needed for the prevention of burnout among staff members.
- 6.4 Policies and procedures for staff recruitment and performance monitoring should be clearly articulated and known to all.
- 6.5 A sustainable source of funding should be available at adequate levels and proper financial management and accountability mechanisms should be in place. Whenever possible, resources for ongoing staff education, for the evaluation of service quality and performance should be included in the relevant budget.
- 6.6 Services for the treatment of drug use disorders should network and link with relevant general and specialized health and social services in order to provide a continuum of comprehensive care to their patients.
- 6.7 Adequate record systems should be in place to ensure accountability and continuity of treatment and care.
- 6.8 Service programmes, rules and procedures should be periodically revised, and mechanisms of continuous feed-back, monitoring and evaluation should be developed.
- 6.9 Patterns of drug use and related health consequences and comorbidities should be regularly monitored and results made available to help the planning and governance of treatment services.

Principle 7. Treatment policies, services, and procedures should support an integrated treatment approach, and linkages to complementary services must be constantly monitored and evaluated

Description: As a response to a complex and multifaceted health problem, comprehensive treatment systems must be developed to facilitate effective treatment of drug use disorders and associated health-care problems. Where possible, a treatment system should include and coordinating teams should engage psychiatric, psychological and mental health care, social services (for housing and job skills/employment and, if necessary, legal assistance), other specialist health care (such as services for HIV, HCV, TB and other infections). The treatment system must be constantly monitored, evaluated and adapted. This requires planning and implementation of services in a logical, step-by-step sequence that insures the strength of links between (a) policy, (b) needs assessment, (c) treatment planning, (d) implementation of services, (e) monitoring of services, (f) evaluation of outcomes and (g) quality improvements.

Standards:

- 7.1 Treatment policies for drug use disorders should be formulated by relevant governmental authorities on the principles of universal health coverage, best available evidence and with active involvement of key stakeholders including the target populations, community members (families), non-governmental organizations and religious organizations.
- 7.2 Links between drug use prevention, drug dependence treatment, and prevention of health and social consequences of drug use should be established and operational.
- 7.3 Treatment planning should be based on estimates and descriptions of the nature and the extent of the drug problem, as well as of the characteristics of the population in need.
- 7.4 Roles of national, regional and local agencies in different sectors responsible for the delivery of treatment for drug use disorders and rehabilitation should be defined and mechanisms for effective coordination should be established.
- 7.5 Quality standards for drug treatment services should be established and compliance should be required for accreditation.
- 7.6 Mechanisms of clinical governance, monitoring and evaluation should be in place including clinical accountability, continuous monitoring of the patient's health and well-being, and intermittent external evaluation.
- 7.7 Information on the number, type, and distribution of services available and used within the treatment system should be monitored for planning and development purposes.

Chapter 3: Treatment Modalities and Interventions

3.1 Community-Based Outreach

3.1.1 Brief Definition and Description of the Setting

Community-based outreach services approach and engage with people who use drugs in their community who are not currently receiving treatment, because of the unavailability, inaccessibility or unacceptability of existing services. Outreach also targets individuals who are affected by the drug use of others (e.g. sexual partners, needle-sharing partners, etc.). Being based or coming from the community they serve, outreach workers are often indigenous to the local community. They are familiar with the drug use subculture or may even themselves be former or occasional drug users. Outreach workers and peer workers typically carry out a set of specific education and support strategies devised and implemented by members of that same subculture, community or group of people.

Outreach acknowledges the influence of social networks on individuals experiencing drug use disorders and recognizes that these networks are important determinants of negative health and social outcomes and utilize them to influence and promote healthy behavior. Many outreach models use a mixture of individual and network-based interventions.

3.1.2. Target population

Outreach activities primarily target individuals with harmful use of drugs and/or dependence who are not currently receiving treatment for drug use disorders.

3.1.3 Goals

The objectives of community-based outreach are to identify affected populations, engage them, provide community-based care, and if necessary to refer to more intensive treatment modalities.

Outreach work is possible in any community, including online “virtual” communities, with the main barriers being access to funding and interference with local authorities.

3.1.4 Characteristics

Given the often clandestine nature of drug using populations, outreach workers should be knowledgeable of the local communities they serve and should have access to mental health services and other supports themselves. They require adequate basic training:

- to establish trust and recognize sources of accurate information,
- in recognizing and responding to crisis situations,

- in relevant health conditions:
 - recognition and response to overdose,
 - prevention and treatment of HIV, TB, Hepatitis,
 - mental health and suicidal behavior.
- about health and social services in the community.

An outreach programme is dependent on their front-line workers, key assets that require adequate periodic training and access to mental health services and other supports themselves.

The programme itself should be flexible, adaptive, have a clear mission statement, mechanisms for monitoring and evaluation, as well as clear and relevant documentation.

3.1.5 Treatment Models and Methods

Outreach programmes vary enormously according to the local situation but typically the following ‘core services’ should be provided:

1. Information and linkage to services caring for basic needs (safety, food, shelter, hygiene and clothing)
2. Needle exchange and condom distribution
3. HIV/HCV testing and counselling
4. Hepatitis B vaccination
5. Education on drug-effects and risks involved in drug use
6. Basic assessment of substance use disorders
7. Brief Intervention to motivate change in substance use
8. Referral to treatment for substance use disorders
9. Basic counselling/social support
10. Referral to health care services as needed
11. Overdose prevention services including emergency naloxone

3.1.6 Strength of Evidence

The effectiveness of outreach programmes, which involve risk reduction interventions targeting overdose, HIV, viral hepatitis and other infections, is supported mostly by quasi-experimental and large observational studies¹.

¹ WHO

http://www.who.int/mental_health/mhgap/evidence/resource/substance_use_q6.pdf?ua=1

3.1.7 Recommended standards for outreach

Policy makers

- There is detection of intoxicated persons requiring treatment for intoxication and withdrawal syndromes in public spaces.
- Agreements between health and law enforcement personnel are in place and there is a mutual understanding of the benefits of outreach work.
- 'Core interventions' (see above) to reduce the negative health and social consequences of drug use and dependence are available.
- There is promotion of early intervention for drug related problems.
- There is promotion of early intervention among specific population subgroups (e.g., pregnant women, sex workers, youth, homeless people).
- There is promotion of voluntary seeking for the treatment of drug related problems.
- Information about assessment procedures and treatment resources is distributed to individuals who are the initial contact points for potential patients.
- Procedures exist for counselling family members, employers, and those who seek assistance in recruiting drug users into treatment.
- A record of onward referral is kept to ensure continuity of clinical care.

Programme managers

- Peer outreach workers should be officially employed.
- The work of peer outreach workers should meet accepted safety standards.
- The service should have policies for defining what constitutes safe working conditions and what to do if staff feel they are in an unsafe situation.
- Specialised care (medical, nursing, medication dispensing, psychological, psychotherapeutic) is always carried out by personnel with relevant qualifications and licences.

3.2 Screening, Brief Interventions, and Referral to Treatment (SBIRT)

3.2.1 Brief Definition and Description of the Setting

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent drug use disorders, particularly in health settings, which are not specialized in the treatment of drug use disorders (i.e. primary care, emergency care, hospitalized patients, antenatal care, social welfare services, school health services, prison health services, mental health facilities etc.). Screening and Brief Interventions (SBI) can be implemented in a rapid and cost-efficient manner that causes minimal interference with the provision of other services (WHO, 2012).

WHO mhGAP Evidence-Based Recommendations for Management of Drug Use Disorders in Non-Specialized Health Settings: Brief Psychosocial Interventions

Individuals using cannabis and psychostimulants should be offered brief intervention, when they are detected in non-specialized health care settings. Brief intervention should comprise a single session of 5-30 minutes duration, incorporating individualised feedback and advice on reducing or stopping cannabis / psychostimulant consumption, and the offer of follow-up.

People with ongoing problems related to their cannabis or psychostimulant drug use who do not respond to brief interventions should be considered for referral for specialist assessment.

WHO, 2012

3.2.2 Goals

Routine screening in non-specialized health settings can support the early identification of individuals experiencing problems related to their drug use. For people who screen positive, a brief intervention, carried out in a non-judgmental and motivational style, can be effective in altering the trajectory of people at risk of developing drug use disorders or experiencing other severe negative complications related to their drug use. Screening may also identify a smaller subset of persons with already more significant, chronic or complex substance use problems who will require a more extensive assessment and referral for formal treatment.

3.2.3 Types of clients this setting is best suited for

Systematic screening of all clients is recommended in all clinical settings with a high prevalence of drug use. This may include:

- General practice settings in economically disadvantaged areas
- Mental healthcare patients
- Hospital patients
 - Emergency room
 - Plastic surgery ward

- Orthopaedic surgery ward
- Sexual health clinics
- Hepatitis services
- Individuals in contact with social service and welfare agencies
 - Populations experiencing insecure housing conditions
 - Populations living and working on the street
 - Populations transitioning from institutions
- Patients in infectious disease clinics

In other settings, opportunistic screening may be based on specific complaints which can be associated with drug use or other features of the client that increase the possibility of drug use.

Brief interventions are suitable for people with harmful drug use but not for people who are drug-dependent, who need referral to more comprehensive treatment.

3.2.4 Treatment Models and Methods used

3.2.4.1 Screening

Screening tools can be grouped in two categories:

- Self-report tools (interviews, self-report questionnaires) and
- Biological markers (breathalyzer, blood alcohol levels, saliva or urine testing, serum drug testing).

Self-report tools have the advantages of being physically non-invasive and inexpensive. A good self-report screening tool should be brief, easy to administer and to interpret, address alcohol and other drugs, have an adequate clinical sensitivity and specificity for identifying people who need a brief intervention or referral for treatment.

The accuracy of self-report can be enhanced when the patient is given the assurance of confidentiality, when the patient is interviewed in a setting that encourages honest reporting and when the patient is asked clearly worded and objective questions.

The **ASSIST** (Alcohol, Smoking and Substance Involvement Screening Test) is an evidence-based screening tool developed and recommended by the World Health Organization. It consists of 8 questions asking about alcohol, tobacco and drug use (including injecting drug use). The questions give information about hazardous, harmful or dependent use. It has been especially developed for a primary care setting and is recommended in either an interview or self-completed format (WHO, 2010).

Biological markers may be useful when a patient is not able to respond to an in-person interview, but information is required to attain a screening result (i.e. an unconscious patient in intensive care). However, for conscious patients it is preferable to use a self-report screening tool.

3.2.4.2 Brief Intervention

A brief intervention is a structured therapy of short duration (typically 5-30 minutes) with the aim of assisting an individual to cease or reduce the use of a psychoactive substances or (less commonly) to deal with other life issues. It is designed in particular for general practitioners and other primary health care workers (WHO, 1994).

Following a client-centered and strength-based approach patients are empowered and motivated to take responsibility and change their substance use behavior. If available and necessary, brief intervention may be extended for one or two sessions to help patients develop the skills and resources to change, or for a follow-up to assess if further treatment is required.

Several basic steps should be followed for an effective brief intervention. Initially the practitioner will introduce the issue of drug use in the context of the patient's health and wellbeing, in context of the challenge that brought them to this current situation. Since the patient is placed at the center of the discussion, strategies such as summarizing and reflection are used to provide feedback. Patients are asked to talk about change and to set realistic goals. At the end of the session, practitioners summarize and provide positive feedback to empower patients to take responsibility for changing their behavior.

The components of effective brief interventions can be summarized in the FRAMES framework (Miller and Rollnick, 2002):

- **F**eedback is given to the individual about personal risk or impairment
- **R**esponsibility for change is placed on the individual
- **A**dvice to change is given by the provider
- **M**enu of alternative self-help or treatment options is offered
- **E**mpathic style is used in counselling
- **S**elf-efficacy or optimistic empowerment is engendered

WHO recommends the following 9 step approach to brief interventions following the ASSIST screening:

1. Asking clients if they are interested in seeing their ASSIST questionnaire scores.
2. Providing personalised feedback to clients about their scores using the ASSIST feedback report card.
3. Giving advice about how to reduce risk associated with substance use.
4. Allowing clients to take ultimate responsibility for their choices.
5. Asking clients how concerned they are by their scores.
6. Weighing up the good things about using the substance against the less good things about using the substance.
7. Summarize and reflect on clients' statements about their substance use with emphasis on the 'less good things'.
8. Asking clients how concerned they are by the 'less good things'.
9. Giving clients take-home materials to bolster the brief intervention.

3.2.4.3 Referral to Treatment

Persons who are screened and subsequently assessed as having a clinically significant substance use disorder or a serious co-occurring condition should be referred immediately for treatment to the most appropriate facility or practice. Referrals may be facilitated by techniques such as making the appointment at the treatment center together with the patient present, using ‘patient navigators’ who accompany the patient to the treatment center, and following up with the patient regarding their enrollment in the treatment programme. The most efficient referral to treatment is achieved by initiating and providing drug treatment at the setting where SBIRT is delivered.

3.2.5 Criteria for programme completion and indicators of effectiveness

Performance metrics for SBIRT can include rates of screenings completed by each trained person within the facility, the proportion of those who screened positive (unusually high or low numbers of positive screens may indicate a problem), the proportion of patients with positive screens who received at least one brief motivational intervention session, the proportion of patients with more serious screening results who received formal assessment and referral to treatment, and proportion of patients referred to treatment who initiated treatment.

3.2.6 Rating the Strength of Evidence

There is evidence from a small number of Randomized Clinical Trials (RCTs) that screening and brief intervention is effective in reducing drug use, in people who are not drug dependent².

3.2.7 Recommendations

- Health care facilities with a high prevalence should systematically screen all patients for substance use disorders.
- Patients in all health care settings should be screened for drug-use disorders when there is a clinical suspicion of drug use.
- All health care personnel should be trained in screening, brief intervention and referral to treatment.

² WHO

http://www.who.int/mental_health/mhgap/evidence/resource/substance_use_q1.pdf?ua=1

Staffing

- The provider has a system laid out that ensures that the method for selecting, hiring and training staff corresponds to valid legal norms and established internal rules.
- The organisation has rules defined that the staff follows in cases where valid legislation is too general.
- The structure and management of the organisation is defined, making competences for individual positions clear.
- The provider has specified the structure and staffing needs, as well as corresponding job profiles and staff qualifications, taking into account the needs and current number of service users for service organisation. The composition and additions to the team correspond to these needs.
- Prevention of work risks has been secured.
- Cases where a patient's rights have been violated by an employee and the corresponding measures that were taken are documented in personnel records.
- Specialised care (medical, psychological, psychotherapeutic, social, educational etc.) is always carried out by personnel with relevant qualifications and licences.

3.3 Short-Term In-Patient or Residential Treatment

3.3.1 Brief definition and description of the setting

The short-term inpatient (or residential) treatment setting is an environment in which 24 hour care is available at an intensity which is capable of managing the symptoms and potential complications likely to occur in the days and initial weeks following the cessation of drug use, including the drug withdrawal syndrome.

Short-term inpatient treatment provides an opportunity to cease drug use with minimal discomfort and risk to health and offers both a temporary reprieve from the environmental stressors in a person's life, and an opportunity to receive some psychosocial support, which may become the start of an ongoing treatment process. The length of stay varies from 1 to 4 weeks according to the local practices and the clinical situation. Given that the drug withdrawal syndrome and its treatment can pose significant health risks, short-term residential treatment requires a higher degree of medical supervision than long-term residential treatment, which follows the acute withdrawal phase (see chapter 3.5).

3.3.2 Goals

The goals of short-term residential treatment are to facilitate the initial cessation of drug use and to motivate patients to continue some further treatment after the short-term residential treatment. This ongoing treatment may be psychological (i.e. a structured psychological support such as CBT, MET, CRA or CM), social (i.e. employment of housing programmes), or pharmacological (such as naltrexone for opioid dependence, or methadone or buprenorphine maintenance treatment).

Medically assisted detoxification can also be accomplished on an outpatient basis, which is less resource intensive, but the rates of completion of detoxification are lower (WHO, 2009). The risk of relapse is high following any form of detoxification, which can result in an increased risk of overdose post treatment, particularly in opioid users.

3.3.3 Target population

The typical target population are people with drug dependence likely to experience significant withdrawal symptoms upon cessation of their drug use. Short-term residential treatment can also be used to commence opioid maintenance treatment.

Any person likely to experience a severe withdrawal syndrome following cessation of drug use, and people for whom their current drug use is causing a significant risk of harm are most in need.

The following criteria should be considered when deciding whether a short-term residential treatment or another treatment setting is applicable:

- Type of drug being used,
- Likelihood of withdrawal syndrome,
- Severity of drug dependence,
- Related health and social problems,
- Co-occurring medical and psychiatric problems,
- Sedative and opioid withdrawal can be severe, and is highly likely for people using high doses over extended periods of time.

3.3.4 Treatment models and methods used

Achieving the therapeutic goals of short-term residential treatment typically requires a combination of interventions such as psycho-education on drug-effects, motivational counseling, pharmacotherapy and support through drug withdrawal. Other interventions which can be initiated are introduction to behavioral therapy, orientation to self-help groups, social services, and appropriate referrals for follow-up care after discharge. The specific types and the duration of these interventions differ depending upon the nature, complexity and patterns of drug use, as well as the presence of co-occurring medical and psychiatric problems.

Treatment activities

Short-term residential treatment programmes for drug use disorders should include the following activities:

- Comprehensive medical and psychosocial assessment
- Treatment plan which best addresses individual needs
- Medication-assisted detoxification if indicated
- Initiation of maintenance medication if indicated
- Strategy to foster patients' motivation for change
- Contact with individuals that are of significance in patient's social network to engage them in the treatment plan
- Initiation of behavioral treatment strategies for the treatment of drug use disorders
- Initiation of treatment for co-occurring medical and psychiatric disorders, if time and resources permit
- Ongoing evaluation of patient's progress in treatment, and continuous clinical assessment that is built into the programme
- Discharge planning with relapse prevention and continuing care strategies for the period after residential treatment, including maintenance medication if indicated, an appropriate level of psychosocial treatment, and ongoing treatment for co-occurring medical and psychiatric problems.

Either prior to admission, preferably, or on admission to short-term residential treatment a comprehensive medical and psychosocial evaluation of every patient should be conducted to determine the unique needs and the treatment plan for each patient. This should include medical and psychiatric history, and both physical and mental status examinations. It may also be valuable to conduct some laboratory investigations, including urine drug screen, and testing for HIV and hepatitis.

An evidence-based assessment tool such as the Addiction Severity Index (ASI), which evaluates severity of drug use problems and associated problems (medical, psychiatric, family, etc.) can be administered by a trained staff member. When the patient is not in acute withdrawal, a structured interview for psychiatric disorders such as the MINI, SCID, or CIDI-SAM may be considered and are particularly useful for both establishing drug use disorders and identifying co-occurring psychiatric disorders.

Immediately after admission to short-term residential treatment, patients should be monitored multiple times per day regarding withdrawal symptoms, and any acute medical or psychiatric problems. Once these acute problems have stabilized, daily monitoring should focus on both medical and psychiatric status, as well as the motivation and development of goals and plans for treatment after discharge.

3.3.5 Treatment of withdrawal

The treatment of withdrawal, also called detoxification, is typically the foremost concern if a patient has had a protracted, and severe recent history of opioid, alcohol, benzodiazepine or barbiturate use. In these cases, there are established withdrawal protocols usually employing pharmacotherapy combined with rest, nutrition and motivational counseling. Unrecognized and untreated withdrawal is likely to drive a patient out of treatment. Thus, staff of short-term residential treatment programmes need to be knowledgeable about the various withdrawal syndromes, and be prepared to be psychologically supportive, motivating the patient to get through the withdrawal phase, and able to prescribe effective medication treatments for withdrawal.

Short-term residential treatment services need to be either capable of the medical management of the severe symptoms of withdrawal syndrome, or have the ability to transfer such patients to a medical hospital.

Opioid withdrawal syndrome

Pharmacological treatment of opioid withdrawal includes either short-term treatment with methadone and buprenorphine, or alpha-2 adrenergic agonists (clonidine or lofexidine). If neither of these are available, reducing doses of weak opioids can be used, as well as medications to treat the specific symptoms that arise (sedatives for anxiety and insomnia, analgesics for muscle pains, anti-diarrhoeals, and anti-emetics). Nevertheless, people with opioid dependence generally have better outcomes with long-term opioid agonist treatment,

as they are at increased risk of overdose following detoxification alone. If available, people with opioid dependence and their families should be given naloxone to take home in case of an opioid overdose, and trained in the management of opioid overdose.

Sedative-hypnotic withdrawal syndrome

Patients admitted to a short-term residential treatment programme should be asked about alcohol and sedative use, monitored for the emergence of withdrawal symptoms, or treated prophylactically if deemed high-risk (heavy or regular use, or history of past withdrawal episodes).

Sedative-hypnotic withdrawal can be effectively treated with long-acting benzodiazepines starting at a dose sufficient to relieve withdrawal and tapering slowly over a period of days or weeks. Patients need to be monitored for the emergence of severe manifestations of alcohol or sedative-hypnotic withdrawal, including seizures, cardiovascular instability and delirium. It should be ensured that the treatment is not simply prolonging sedative-hypnotic use.

Stimulant withdrawal syndrome

Stimulant withdrawal (the "crash") is less well defined than syndromes of withdrawal from central nervous system depressant substances; depression is prominent and is accompanied by malaise, inertia, and instability.

Cannabis withdrawal syndrome

A cannabis withdrawal syndrome can occur in heavy users, typified by insomnia, headaches, depressed mood and irritability.

Pharmacological treatment of stimulant and cannabis withdrawal depends on symptom emergence.

3.3.6 Treatment of co-occurring psychiatric and medical problems

Psychiatric disorders, including depression, anxiety, post-traumatic stress disorder, schizophrenia or other psychotic disorders, are associated with drug use disorders and may interfere with engagement in treatment. Psychiatric symptoms, including depression, anxiety, and psychosis, may be caused or exacerbated by the use of different drugs and may resolve when drug use is stopped.

A critical first step in the accurate evaluation of psychiatric symptoms among drug users is to distinguish independent disorders from disorders that are substance-induced and will resolve with abstinence.

Short-term residential treatment can provide an opportunity to observe whether psychiatric symptoms are resolved when abstinence from substances is achieved, and to initiate

medical or psychosocial treatment for disorders that persist after cessation of substance use.

A comprehensive assessment of the patient should be administered on entry into any treatment programme that is as comprehensive as possible and includes a medical history, presence of chronic and acute diseases and related pharmaceutical therapies, as well as a routine documentation of infectious diseases including HIV, Tuberculosis, Hepatitis etc.

Any acute medical conditions seen on admission may need to be managed prior to any further treatment or care. These can include: confusion, excessive sedation, hallucinations, seizures or fever. Depending on local conditions, mechanisms for treating opioid dependence should be combined, if necessary, with treatment for TB, HIV and hepatitis, to ensure continuity of anti-infective agents. A short-term residential treatment programme may not have medical expertise, or the time to initiate such treatment, but consultation and referral to appropriate services should be available.

Hepatitis B is common in many drug use populations, particularly (but not exclusively) to those who inject drugs. Short-term residential treatment can be an opportunity to vaccinate against hepatitis B. Depending on the length of the treatment, an accelerated vaccination schedule, consisting of 2 or 3 doses, may be administered to people who have not had a complete course of hepatitis B vaccination before, and without necessarily testing serology beforehand (WHO, 2012).

Chronic pain is another common problem which may contribute to the motivation to use illicit drugs, particularly opioids, and to the risk of relapse. Referral for further evaluation of the source of the pain and specific management strategies should be arranged.

3.3.7 Follow-up treatment

Entry and engagement with short-term residential treatment is often an important first step in treating drug-use disorders. Nevertheless maintenance of sustainable healthy behaviours are of particular importance after patients leave treatment as the risk of relapse and overdose increases significantly immediately after discharge.

An effective follow-up treatment plan should include strategies for patients to successfully transition to the next level of care and maximize the chances to maintain medical and psychological health. Health and social care professionals should work together to provide patients with the necessary resources and consider the following treatment dimension when planning a discharge from residential to outpatient treatment or to a long-term residential programme:

Availability of social supports

Social networks are influential to patterns of drug consumption and good social support can help patients to recover and maintain abstinence. Patients should be educated and made

aware of the different factors that contribute to their harmful drug use and equipped with different strategies to create and maintain an environment that promotes health.

Long-term medication treatment

For opioid dependence, treatment plans usually include long term maintenance on medication (methadone maintenance, buprenorphine maintenance, or extended-release naltrexone). Opioid agonists (methadone and buprenorphine) reduce drug use, crime and the risk of dying from opioid dependence by approximately two thirds. The opioid antagonist naltrexone has been shown to be more effective than placebo. Ideally, medication should be started during in-patient treatment and continued after discharge at an outpatient medication maintenance programme.

Follow-up care

Psychosocial care for substance use disorders needs to continue after short-term residential treatment. For patients with more severe substance use disorders and the lack of social support, referral to long term residential treatment is indicated after short-term residential treatment. For patients with lower severity and better social supports, outpatient treatment can be an advisable next treatment modality. Support to navigate the social care system should be present to access vocational training, stable housing, etc. as needed.

3.3.8 Criteria for programme completion and indicators of effectiveness

Successful completion of short-term residential treatment can be evaluated for each patient on the basis of several dimensions including:

- Resolution of withdrawal symptoms
- Understanding of the substance use disorder and related problems
- Motivation to engage in follow-up treatment after discharge in either long-term residential treatment or outpatient treatment
- Improvement in physical and mental health, and initiation of treatment and/or discharge plans to handle such problems over the long term
- Improvement in craving for drugs and beginning development of skills to control over triggers (thoughts, emotions, and behaviors) that lead to drug use

The effectiveness of a short-term residential treatment programme can be evaluated by process indicators (i.e. what services are delivered or what goals are met by patients during the treatment stay), or objective measures of patients' long term outcome after discharge. One objective outcome measure would be the proportion of patients who engage in follow-up treatment after discharge. Another outcome indicator would be abstinence and other markers of recovery at long-term (e.g. 6-month) follow-up. This type of long-term indicator is rarely implemented in routine care, as it requires tracking and long term follow-up of patients.

3.3.9 Rating the strength of evidence

- There is evidence from Randomized Clinical Trials (RCTs) that methadone, buprenorphine, clonidine and lofexidine are effective in supporting detoxification from opioid dependence.
- There is evidence from a small number of RCTs indicating that long term agonist treatments are more effective than detoxification for opioid dependence.
- There is evidence from RCTs that psychosocial support improves the outcomes of detoxification in opioid dependence.
- There is one RCT which compared inpatient to outpatient detoxification for opioid withdrawal, which found twice the rates of successful completion with inpatient treatment³.

3.3.10 Recommendations

- The treatments provided are regularly reviewed and modified by staff in conjunction with the patient to ensure appropriate management
- Clearly defined protocols exist for prescribing medications and other interventions appropriate to the specific needs of patients
- The protocols are firmly based on research findings wherever possible. If that is not possible, they are in line with recognized good clinical practice
- The range of relevant treatment options available is described to the patient
- On-site or off-site laboratory and other diagnostic facilities are available
- Access to self-help and other support groups is available
- Whether or not the goal of treatment is abstinence, measures are taken to reduce the harm of continued drug use (health diet, use of sterile injection equipment)
- When a procedure with known risks is under consideration a careful risk/benefit evaluation is carried out resulting in selection of the least risk producing criteria
- A mechanism exists to ensure continuity of patient care
- There is a regular assessment of the effectiveness of the services (i.e., programme evaluation)
- Links exist between the dependence treatment programmes and other services which facilitate interventions with children and other family members of patients who have suffered psychologically or socially
- Emergency support or transport in case of life threatening complications of drug use or withdrawal is available
- There are defined criteria for the expulsion of patients due to violation of treatment service rules, violence, continued non-prescribed drug use, etc.
- There are defined criteria for the management of specific risk situations (e.g., intoxication, suicide risk)

³ WHO

http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf

Staffing

- The provider has a system laid out that ensures that the method for selecting, hiring and training staff corresponds to valid legal norms and established internal rules.
- The organisation has rules defined that the staff follows in cases where valid legislation is too general.
- The structure and management of the organisation is defined, making competences for individual positions clear.
- The provider has specified the structure and staffing needs, as well as corresponding job profiles and staff qualifications, taking into account the needs and current number of service users for service organisation. The composition and additions to the team correspond to these needs.
- Prevention of work risks has been secured.
- Cases where a patient's rights have been violated by an employee and the corresponding measures that were taken are documented in personnel records.
- Specialised care (medical, psychological, psychotherapeutic, social, educational etc.) is always carried out by personnel with relevant qualifications and licences.

3.4 Outpatient Treatment

3.4.1 Brief Definition and Description of the Setting

The outpatient treatment setting for the treatment of substance use disorders cares for people who do not reside in the treatment facility, who live at home instead and visit the treatment facility only for treatment interventions. Outpatient services vary considerably in terms of their components and intensity. Typically outpatient drug treatment is either carried out by health and social services specializing in the treatment of substance use disorders, or within the context of mental health treatment more broadly.

The range of treatment offered in the outpatient setting include:

- psychological interventions
- social support
- pharmacological interventions

3.4.2 Target Population

Outpatient treatment in its different modalities can cater for a broad range of individuals, but some modalities such as psychological therapies are more appropriate for individuals who have sufficient social support and resources at home and in their communities, and who are able to be sober enough to benefit from such treatment.

3.4.3 Goals

The primary goals of outpatient treatment are to help patients to stop or reduce drug use; to minimize medical, psychiatric and social problems associated with drug use; to reduce the risks of relapse and to improve their well-being and social functioning, as part of a long-term recovery process.

3.4.4 Characteristics

Outpatient treatment services and programmes vary considerably depending on the services' level of intensity and interventions they offer.

High-Intensity Interventions

Programmes such as intensive day treatment require frequent interactions with patients (i.e. daily, or several hours on one or more days). Components and activities of these service settings include:

- Comprehensive medical and psychosocial assessment on admission
- Treatment plan which best addresses individual needs
- Treatment is voluntary, with patient participation in treatment decisions

- Medication-assisted detoxification, if indicated
- Initiation of maintenance medication if indicated
- Contact with family and significant others of the social network to engage them in the ongoing treatment
- Behavioral and psychosocial treatment for substance use disorder and co-occurring psychiatric disorders
- Pharmacological treatment for co-occurring medical and psychiatric disorders
- Treatment contract which clearly outlines all treatment procedures, services and other policies and regulations as well as programme's expectations of the patient
- Ongoing evaluation of patient's progress in treatment, and continuous clinical assessment that is built into the programme
- Relapse prevention and discharge strategies for continuous care after residential treatment, including maintenance medication if indicated, an appropriate level of psychosocial treatment, and ongoing treatment for co-occurring medical and psychiatric problems
- Intensive social support including accommodation and employment

Mid to Low-Intensity Interventions

Lower intensity interventions involve weekly group support sessions, individual psychological treatment, health and drug education, and lower intensity social support.

In the course of outpatient treatment, associated health care professionals may regularly assess drug and alcohol use, and physical and mental health status of patients. Routine cooperation with allied care services is essential and should include integration of outpatient treatment with medical services for HIV, viral hepatitis, TB and sexually transmitted infections.

Routine cooperation with social support and other agencies, including education, employment, welfare, support sources for disabled, housing, social networking or legal assistance should also be present.

3.4.5 Models and Methods

Treatment objectives can be best accomplished by using a combination of pharmacological and psychosocial interventions. Ideally, outpatient treatment programmes for drug use disorders offer a comprehensive range of services to manage various problems affecting patients across several life domains.

3.4.6 Evidence-based psychosocial and behavioral interventions

Psychosocial interventions should be used in outpatient treatment programmes to address motivational, behavioral, psychological, social, and environmental factors related to substance use and have been shown to reduce drug use, promote abstinence and prevent relapse. Psychosocial interventions can also be used to increase adherence to treatment

and medications. For different drug use disorders, the evidence from clinical trials supports the effectiveness of cognitive behavioral therapy (CBT), motivational interviewing (MI), community reinforcement approach (CRA), motivational enhancement therapy (MET), family therapy (FT) modalities, contingency management (CM), insight oriented treatments, 12-step group facilitation, housing and employment support among others.

Cognitive Behavioral Therapy (CBT)

CBT is based on the understanding that behavioral patterns and cognitive processes around drug use are learned and can be modified. During treatment patients are introduced to new coping skills and cognitive strategies to replace the maladaptive behavioral and thinking patterns. CBT therapy sessions are structured with specific goals to be accomplished at each session and focused on immediate problems faced by the drug user. CBT can be used as a short-term approach that can be adapted to a wide range of patients and a variety of settings and both individual and group treatment sessions. CBT can be combined with a range of other psychosocial and pharmacological treatments.

Contingency management (CM)

CM involves giving patients concrete non-monetary rewards to reinforce positive behaviors such as abstinence, treatment attendance, compliance with medication, or their own particular treatment goals. An objective measure of an agreed positive outcome (typically supervised urine collection and toxicology testing) with immediate feedback are necessary for CM effectiveness. Test results provide an indicator of treatment progress and these may be discussed in confidential therapy sessions to promote better understanding of the patient condition. A CM approach is often used as a part of treatment that focuses on promoting new behaviors that are competing with drug use and can be combined with CBT.

Patients treated with CM often show greater initial reductions in drug use than in other treatments, although there are questions about the persistency of these effects unless CM is combined with other treatment approaches. CM has been found to be particularly useful in treatment of patients with amphetamine and cocaine use disorder helping to reduce treatment dropout and to decrease drug use. Other studies found that CM using vouchers for the reward of high performance in the treatment were effective in increasing the level of employment for drug users in treatment. Although many of the research trials use monetary reinforcement, the use of contingency management should be adapted to the culture and population with input from patients.

Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET)

Motivational Interviewing is collaborative, evocative, and recognizes the autonomy of the patient. The clinician assumes an advisory, rather than an authoritative role, and seeks to understand what the patient values – this process builds empathy and fosters a therapeutic alliance from which it may be possible to promote behavioral modifications. In this process the patient may realize that their drug use behavior is inconsistent with the things that are important to them. MI is also promising as an approach to reduce high-risk behaviors such as unprotected sex and sharing needles. MI can be delivered in one or two sessions for less

severe forms of drug use, or the approach can be extended (where it is called MET) over 6 or more sessions for more severe drug use disorders.

Involvement of family members and concerned significant others

Family-oriented treatment approaches have been found effective to improve engagement with treatment, reduce drug use, and improve participation in aftercare when compared to care focused on the individual patient. Family-oriented approaches are particularly useful in educating patients and their families about the nature of drug use disorders and the process of recovery.

Effective family-oriented approaches identified include: Behavioral Couples Therapy, Brief Strategic Family Therapy, Multisystemic Therapy and Multidimensional Family Therapy (MDFT).

MDFT appears to be particularly effective in treating cannabis dependence in adolescence. Couples therapy has been examined more in the context of alcohol dependence treatment, but may also play a role in drug dependence treatment.

Working with the family can also be helpful when the patient refuses to be involved in treatment using approaches such as Unilateral Family Therapy or Community Reinforcement and Family Training.

WHO Recommendations:

Psychosocial interventions including contingency management, and cognitive behavioural therapy (CBT) and family therapy can be offered for the treatment of **psychostimulant dependence**.

Psychosocial interventions based on cognitive behavioural therapy or motivational enhancement therapy (MET) or family therapy can be offered for the **management of cannabis dependence**.

Behavioural interventions for children and adolescents, and caregiver skills training, may be offered for the treatment of behavioural disorders.

Psychosocial interventions including cognitive behavioural therapy (CBT), couples therapy, psychodynamic therapy, behavioural therapies, social network therapy, contingency management and motivational interventions, and twelve-step facilitation can be offered for the treatment of **alcohol dependence**.

(mhGAP, 2015)

3.4.7 Evidence-based pharmacological interventions

Medications can be very helpful in managing/treating a variety of drug use disorder aspects such as intoxication, overdose, withdrawal, dependence and psychiatric problems related to drug use. Pharmacological interventions should be administered alongside psychosocial interventions.

3.4.8 Pharmacological Treatment

3.4.8.1 Pharmacological Treatment of Opioid Use Disorders

Opioid Overdose

Opioid overdose can be identified by a combination of three symptoms: 1) pinpoint pupils, 2) unconsciousness, and 3) respiratory depression. The opioid antagonist naloxone can completely reverse the effects of opioid overdose within minutes and is a lifesaving treatment. With a long history of clinical success and extremely rare adverse effects, Naloxone should therefore be available in all health-care facilities that may be called upon to respond to opioid overdose.

Naloxone can be injected intramuscularly, subcutaneously, intravenously, or can also be administered intranasally. Improvised intranasal devices made by adding an atomiser to a syringe containing naloxone have been shown to be effective in clinical trials, although sometimes a second dose was needed. Commercial intranasal formulations are more concentrated than those for injection, as the nasal mucosa has a limit to the amount of liquid it can absorb at one time. The doses used for intranasal administration may need to be higher than that used intramuscularly.

In addition to the administration of naloxone, the treatment of opioid overdose includes attempting to rouse the person, to call an ambulance, resuscitation techniques such as rescue breathing, and to stay with the person until they are fully recovered.

Naloxone and resuscitation training should be distributed to patients, family members and other people likely to witness an opioid overdose.

WHO Recommendations (2014)
Naloxone should be available in all health-care facilities that may be called upon to respond to opioid overdose.
Use of a range of treatment options for opioid dependence include psychosocial support, opioid maintenance treatments such as methadone and buprenorphine, supported detoxification and treatment with opioid antagonists such as naltrexone.
Naloxone should be made available to people likely to witness an opioid overdose, as well as training in the management of opioid overdose.

Opioid Detoxification

The main goal of detoxification is to stabilise a patient's physical and psychological health while managing the symptoms of withdrawal on cessation or reduction of drug use. Detoxification is necessary before starting subsequent treatment, however, this is a particularly vulnerable time for patients as recent periods of abstinence are major risk factors for fatal opioid overdose due to a reduction in tolerance and inaccurate judgment with respect to dosage. Where available, reducing daily supervised doses of methadone and buprenorphine over 1-2 weeks can be used safely and effectively for opioid detoxification. Otherwise, low doses of clonidine or lofexidine, or a gradual reduction of weaker opioid medications can be used to, along with specific medications, treat the symptoms of opioid

withdrawal as they emerge (i.e anti-emetics, anti-diarrhoeals, analgaesics, sedatives). Clinicians should only prescribe sedating medications for short periods and closely monitor treatment response as the risk of tolerance and medication misuse may develop for some medications with longer use. The effectiveness of treatment is greater when psychosocial assistance is made available during withdrawal management.

WHO Recommendations	
<p>Standard Recommendations For the management of opioid withdrawal, tapered doses of opioid agonists (methadone or buprenorphine) should preferably be used, although alpha-2 adrenergic agonists may also be used.</p> <p>Clinicians should not routinely use the combination of opioid antagonists and minimal sedation in the management of opioid withdrawal.</p> <p>Psychosocial services should be routinely offered in combination with pharmacological treatment of opioid withdrawal.</p>	<p>Strong Recommendations Clinicians should not use the combination of opioid antagonists with heavy sedation in the management of opioid withdrawal.</p>

Opioid Dependence

Opioid dependence generally has a chronic and relapsing course and therefore a long-term relapse-prevention treatment should be implemented for individuals who stop the use of opioids. Relapse-prevention treatment should include a combination of pharmacological treatment and psychosocial intervention. The outcome of treatment that includes only psychosocial approaches is inferior to treatment that also includes appropriate medication.

The two main pharmacological therapeutic strategies to address opioid dependence are:

1. Opioid Agonist Maintenance Treatment (OAMT) with long acting opioids (methadone or buprenorphine).
2. Detoxification followed by relapse-prevention treatment using opioid antagonist (naltrexone).

Opioid Agonist Maintenance Treatment (OAMT)

WHO Opioid agonist maintenance treatment recommendations.

Standard Recommendations

Average buprenorphine maintenance doses should be at least 8 mg per day.

Take-away doses may be provided for patients when the benefits of reduced frequency of attendance are considered to outweigh the risk of diversion, subject to regular review.

Strong Recommendations

For opioid agonist maintenance treatment, most patients should be advised to use methadone in adequate doses in preference to buprenorphine.

During methadone induction, the initial daily dose should depend on the level of neuroadaptation; it should generally not be more than 20 mg, and certainly not more than 30mg.

On average, methadone maintenance doses should be in the range of 60–120 mg per day.

Methadone and buprenorphine doses should be directly supervised in the early phase of treatment.

Psychosocial support should be offered routinely in association with pharmacological treatment for opioid dependence.

The primary aim of Opioid Agonist Maintenance Treatment (OAMT) is to reduce the use of illicit opioids and manage abstinence by preventing withdrawal symptoms, reducing drug craving, and decreasing effects of additional opioids if they are consumed.

Methadone Maintenance Treatment

Compared to treatment without medication, methadone-treated patients show marked reductions in heroin and other drug use, have lower mortality, fewer medical complications, lower rates of HIV and hepatitis transmission, decreased criminal activity, and have improved social and occupational functioning.

Methadone should be commenced following the general rule 'start low, go slow'. The initial dose should generally be 20mg or less, depending on the level of opioid tolerance, allowing a high margin of safety to minimize the risk of methadone overdose. Small additional doses can be given, if necessary, up to 30mg. Once inducted safely, the goal is to achieve an optimal dose for longer-term maintenance to prevent craving and the use of illicit opioids. The initial dose should be gradually adjusted upwards to reach the optimal dose which eliminates opioid cravings while producing neither sedation nor euphoria and allows patients optimal functioning in all areas of their life. The dose should be adjusted upwards if there is ongoing heroin use and downwards if there is any sedation, or if the person is ready to cease treatment.

Typically, effective methadone maintenance doses range from 60 to 120mg/day and depend on individual factors such as the ability to metabolize medication and metabolic interferences by other medications that can change the blood level of methadone (i.e. HIV or TB medications, psychiatric, or cardiac medications).

In order to maintain adequate plasma levels and avoid opioid withdrawal it is important that methadone is administered daily and that patients are regularly monitored for adherence to the medication regime. At the start of treatment methadone should be administered under supervision. Once the patient is stabilized, take home doses can be introduced according to local laws and an individual risk-benefit assessment.

As methadone is an opioid, some people may try to illicitly sell their prescribed methadone. This can be reduced, among other measures, by diluting the supervised dose and by diluting the take home dose of methadone to a point where it is less likely to be injectable.

WHO Recommendations for use of methadone in maintenance treatment

Pharmacological treatment options should consist of both methadone and buprenorphine for opioid agonist maintenance and opioid withdrawal, alpha-2 adrenergic agonists for opioid withdrawal, naltrexone for relapse prevention, and naloxone for the treatment of overdose.

The initial methadone dose should be 20mg or less, depending on the level of opioid tolerance, allowing a high margin of safety to reduce inadvertent overdose.

The dosage should be then quickly adjusted upwards if there are ongoing opioid withdrawal symptoms and downwards if there is any sedation.

A gradual increase to the point where illicit opioid use ceases; this is likely to be in the range of 60–120 mg methadone per day.

Patients should be monitored with clinical assessment and drug testing.

Psychosocial assistance should be offered to all patients.

Methadone use should be supervised initially.

The degree of supervision should be individually tailored, and in accordance with local regulations; it should balance the benefits of reduced dosing frequency in stable patients with the risks of injection and diversion of methadone to the illicit drug market.

Buprenorphine and buprenorphine/naloxone combination

Aims and principles of buprenorphine maintenance treatment are similar to those of methadone maintenance treatment: prevent craving and the use of illicit opioids. When initiating treatment with buprenorphine, the first dose should be administered with a range of 2-4mg at least 8-12 hours after the last use of opioid or when symptoms of opioid withdrawal occur. In contrast with the premise for methadone induction ('start low, go slow'), buprenorphine induction should proceed rapidly once the first dose has been shown to be well tolerated as the risk of toxicity is low due its partial agonist action.

Effective maintenance doses for buprenorphine range from 8 to 24 mg per day not surpassing a maximum daily dose of 32mg. Alternate-day dosing, using double the daily dose, may be considered in patients who require supervised dosing and do not require an alternate daily dose of more than 32mg. Compared to methadone, buprenorphine interacts less with other commonly administered medications. As with methadone, it is recommended that buprenorphine doses should be administered under supervision until the patient is

stable and then take home doses can be introduced according to local laws and an individual risk-benefit assessment.

To reduce the attractiveness of people injecting or selling the buprenorphine tablets, buprenorphine also exists in a buprenorphine-naloxone combination. This combination makes it less attractive to opioid users and they may experience withdrawal symptoms if they inject it. Since the sublingual formulation can take up to 15 minutes to fully dissolve in the mouth, a film formulation has also been developed which solidifies in contact with water and makes injecting much more difficult.

When managing people who are dependent on strong prescription opioids (i.e. morphine-like), physicians can switch to a long acting opioid (such as methadone and buprenorphine) which can be taken once daily, with supervised dispensing if necessary, either for maintenance treatment or for detoxification.

WHO, 2009

Opioid antagonist treatment with naltrexone

Treatment with the long acting opioid antagonist naltrexone can only be initiated following detoxification in individuals who have not used opioids for one week or more (e.g., typically those leaving residential treatment). Naltrexone is used to prevent relapse; it blocks the effects of opioids for 1-2 days. Unless the patients are sufficiently well motivated, the rates of treatment drop out can be high.

Naltrexone can be useful to patients who:

- 1) do not have access to treatment with agonists,
- 2) have high motivation for abstinence from all opioids,
- 3) are unable to take agonist treatment due to adverse effects, or
- 4) have been successful on agonist treatment but want to discontinue agonists treatment and be additionally protected against relapse.

Naltrexone is available as an oral tablet which can be taken daily (50 mg/day) or three times a week (100-150 mg each dose) to maintain blocking blood levels of the medication. Naltrexone is also available in extended-release depot injection preparation (given as injection or as an implant) that can maintain blocking levels of the medication for 3-6 weeks after a single dose. A number of naltrexone implant formulations are in circulation which report even longer duration of opioid blocking.

WHO Recommendation for Opioid Antagonist treatment with naltrexone.

For opioid-dependent patients not commencing opioid agonist maintenance treatment, antagonist pharmacotherapy using naltrexone should be considered following the completion of opioid withdrawal.

WHO, 2009

3.4.8.2 Pharmacological Treatment of Psychostimulant Use Disorders

Psychostimulants such as amphetamines and cocaine are one of the most frequently used and problematic illicit substances in many parts of the world. To date there is no medication proved consistently efficacious for the treatment of psychostimulant use disorders. At present, medications are primarily used to manage co-occurring psychiatric disorders and withdrawal symptoms.

If a stimulant withdrawal syndrome is observed, symptomatic medications can be used to treat withdrawal symptoms as required (i.e. anti-emetics, anti-diarrhoeals, analgesics, sedatives). However clinicians should prescribe these medications for short periods of time only and closely monitor the treatment response as the risk of tolerance and medication misuse may develop with a longer use.

Antipsychotic and sedative medications may be used to manage psychotic symptoms resulting from acute psychostimulant intoxication. As more than half of the patients with a psychostimulant use disorder have a co-occurring major psychiatric disorder, (e.g. major depressive disorder, bipolar disorder, or schizophrenia), appropriate psychotropic medications play a major role in the treatment of psychostimulant use disorders. Frequently patients with a psychostimulant use disorder also have another substance use disorder, (e.g. alcohol or opioid dependence) which should be treated using pharmacological as well as psychosocial approaches.

WHO Recommendation for treatment of psychostimulant dependence

Dexamphetamine should not be offered for the treatment of stimulant use disorders in non-specialized settings.

mhGAP, 2012

Pharmacological Treatment of Cannabis Use Disorders

To date there is no approved pharmacological treatment of cannabis use disorders and psychosocial treatment remains the primary approach. If a cannabis withdrawal syndrome is observed, symptomatic medications can be used to treat withdrawal symptoms as required (i.e. anti-emetics, anti-diarrhoeals, analgaesics, sedatives), however clinicians should prescribe these medications for short periods of time only and closely monitor the treatment response as the risk of tolerance and medication misuse may develop with a longer use.

Pharmacotherapy of comorbid mental disorders

Many patients with drug use disorders also experience comorbid mental disorders such as depression, post-traumatic stress disorder, mania or psychosis.

Soon after cessation of drug use many patients experience psychiatric symptoms such as anxiety or insomnia which may be treated with symptomatic medications. However, sedative-hypnotic medications such as benzodiazepines should be used with caution as a first line of treatment as they have a high dependence potential. Rather, alternative

medications such as sedating antidepressants or low-dose neuroleptics should be considered in addition to psychosocial and behavioral treatment.

3.4.9 Recovery Management and Social Support

Recovery management combines a variety of activities that promote and strengthen internal and external resources to help patients manage voluntarily and actively drug-related problems and their recurrence. Some of these activities may be already present in the context of a patient's home, neighborhood and community while others need to be developed. The following factors and activities increase social reintegration and improve chances of stable remission and recovery from substance use disorders:

- Strengthening individual's resilience, self-efficacy and self-confidence to manage daily challenges and stress while maintaining commitment to recovery and avoiding relapse to substance use
- A supportive social network (i.e. partner, family members and friends) that can monitor the stability of recovery, abstinence from drugs and compliance with treatment
- Stable accommodation
- Meaningful work with appreciation in the work-place that replaces stigma and discrimination
- Engagement with individuals and social networks of friends and workmates that have abstinence-oriented norms and are supportive of recovery goals
- Political, humanitarian or spiritual involvement that provides a way to attribute meaning to life's stressors and develop a stronger purpose in life
- Social participation and integration in educational and vocational pursuits, including volunteering or community involvement
- Remediation of legal and financial problems
- Active involvement in self-help, religious or other support groups

3.4.10 Rating of the strength of evidence

- There is a large number of Randomized Clinical Trials (RCTs) comparing different approaches to psychosocial support, however most are underpowered to demonstrate a difference. A small number of trials shows that some approaches are better than waitlist, that some approaches are better than some other approaches, and that some approaches are equivalent to other approaches which have shown to be effective (see WHO mhGAP review for details).
- There is evidence from RCTs that psychosocial support combined with Opioid Agonist Maintenance Treatment (OAMT) is better than OAMT alone⁴.

⁴ WHO

http://www.who.int/mental_health/mhgap/evidence/resource/substance_use_q5.pdf?ua=1

http://www.who.int/mental_health/mhgap/evidence/substance_abuse/q4/en/

- There is strong evidence from RCTs on the benefits of methadone and buprenorphine maintenance, and of the effectiveness of methadone and buprenorphine for detoxification⁵.
- There is weak evidence for the benefits of oral naltrexone for opioid dependence⁶.

3.4.11 Recommendations for outpatient treatment services

Information about 24-hour emergency facilities is provided to patients and their relatives who are being treated on an outpatient basis.

Outpatient Opioid Disorder Management

- Opioid withdrawal services should integrate treatment of withdrawal with other ongoing treatment options.
- Essential pharmacological treatment options should consist of opioid agonist maintenance treatment and services for the management of opioid withdrawal. At a minimum, this would include either methadone or buprenorphine for opioid agonist maintenance and outpatient withdrawal management.
- Pharmacological treatment options should consist of both methadone and buprenorphine for opioid agonist maintenance and opioid withdrawal, alpha-2 adrenergic agonists for opioid withdrawal, naltrexone for relapse prevention, and naloxone for the treatment of overdose.
- Take-home doses can be recommended when the dose and social situation are stable, and when there is a low risk of diversion for illegitimate purposes.
- Involuntary discharge from treatment is justified to ensure the safety of staff and other patients, but noncompliance with the programme rules alone should not generally be a reason for involuntary discharge. Before involuntary discharge, reasonable measures to improve the situation should have been taken, including re-evaluation of the treatment approach used.
- Laboratory or other facilities are available for the monitoring of progress and compliance with the treatment being administered.
- There are defined criteria for the management of specific risk situations (e.g., intoxication, suicide risk).

Assessment and Choice of Treatment

- The choice of treatment for an individual should be based on a detailed assessment of the treatment needs, the appropriateness of treatment to meet those needs (assessment of appropriateness should be evidence based), the patient acceptance and the treatment availability.

http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf

⁵ WHO

http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf

⁶ WHO

http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf

- Voluntary testing for HIV and common infectious diseases should be available as part of an individual assessment, accompanied by counselling before and after testing.
- Ideally, all patients should be tested at initial assessment for recent drug use.
- Treatment plans should take a long-term perspective.
- Opioid withdrawal should be planned in conjunction with ongoing treatment.

Range of Services Offered

- Pharmacological treatment options should consist of both methadone and buprenorphine for opioid agonist maintenance and opioid withdrawal, alpha-2 adrenergic agonists for opioid withdrawal, naltrexone for relapse prevention, and naloxone for the treatment of overdose.
- A variety of structured psychosocial interventions should be available, according to the needs of the patients. Such interventions may include - but are not limited to - different forms of counselling and psychotherapy, and assistance with social needs such as housing, employment, education, welfare and legal problems.
- Onsite psychosocial and psychiatric treatment should be provided for patients with psychiatric comorbidities.

Treatment for Comorbid Medical Conditions

- Where there are significant numbers of opioid dependent patients with either HIV, hepatitis or TB, treatment of opioid dependence should be integrated with medical services for these conditions.
- For patients with TB, hepatitis or HIV and opioid dependence, opioid agonists should be administered in conjunction with medical treatment; there is no need to wait for abstinence from opioids to commence either anti-TB medication, treatment for hepatitis or antiretroviral medication.
- Treatment services should offer hepatitis B vaccination to all opioid-dependent patients.
- There should be intermittent or ongoing evaluation of both the process and outcomes of the treatment provided.

Staffing

- The provider has a system laid out that ensures that the method for selecting, hiring and training staff corresponds to valid legal norms and established internal rules.
- The organisation has rules defined that the staff follows in cases where valid legislation is too general.
- The structure and management of the organisation is defined, making competences for individual positions clear.
- The provider has specified the structure and staffing needs, as well as corresponding job profiles and staff qualifications, taking into account the needs and current number of service users for service organisation. The composition and additions to the team correspond to these needs.
- Prevention of work risks has been secured.
- Cases where a patient's rights have been violated by an employee and the corresponding measures that were taken are documented in personnel records.

- Specialised care (medical, psychological, psychotherapeutic, social, educational etc.) is always carried out by personnel with relevant qualifications and licences.

Discharge, Aftercare, and Referral

- There are defined criteria for the expulsion of patients due to violation of treatment service rules, violence, continued non-prescribed drug use, etc.
- Involuntary discharge from treatment is justified to ensure the safety of staff and other patients, but noncompliance with the programme rules alone should not generally be a reason for involuntary discharge. Before involuntary discharge, reasonable measures to improve the situation should have been taken, including re-evaluation of the treatment approach used.
- There are defined criteria for the management of specific risk situations (e.g., intoxication, suicide risk).
- Care plans are explored which map out alternative pathways which might be followed in the event of partial or complete failure of the original plan, or expulsion from drug treatment services.

3.5 Long-Term Residential Treatment

3.5.1 Brief definition and description of the setting

Residential treatment for drug use disorders exists in a variety of forms, having developed independently in a variety of settings. Residential treatment which intends to promote therapeutic change must be distinguished from supported accommodation that primarily functions as a housing intervention that is not providing active treatment.

Long-term residential treatment can take place in a hospital environment, typically a psychiatric hospital, or in a therapeutic community (TC). A hybrid of therapy and community living, therapeutic communities have been developed from programmes of drug-free communal living with a mutual-support philosophy. Other models of long-term residential treatment have been developed to deal more specifically with co-occurring mental health disorders, and have characteristics of psychiatric and medical clinics with integrated psychotherapy, family therapy and pharmacological interventions.

Staying long-term in a residential setting allows patients to be removed from the chaotic and stressful environment that might have contributed to their drug use. In a therapeutic environment that is free of drugs, and usually also free of alcohol, patients are no longer exposed to the usual cues that trigger drug seeking behavior and may find it easier to maintain abstinence and work towards recovery.

Not every setting in which people with drug use disorders live together in an attempt to create a supportive environment for each other necessarily qualifies as a health care facility. However once a facility makes claims about providing health care benefits, once it accepts funding for therapeutic purposes, then by definition it is a health care facility, and as such, it would be expected to meet the standards of such health care facilities. The unique characteristic of the therapeutic community is that while it has the standards of a health care facility, it also maintains the less formal beneficial aspects of community living.

TCs use the programme's entire community, including other residents, staff, and the social context, as active components of the treatment. The environment is "drug free" meaning that residents agree not to bring or use drugs (including alcohol) while residing in the community.

Although traditional models of long-term residential treatment include only psychosocial treatment methods, modern approaches may involve the use of medications to decrease drug cravings and manage comorbid psychiatric symptoms.

The primary focus of treatment is on learning skills to control cravings and on developing new interpersonal skills, personal accountability, responsibility, and improving self-esteem. Long-term residential treatment programmes have rules and activities designed to help residents examine dysfunctional ways of thinking and behaving and assist them to adopt

new and more effective ways to interact with others. Comprehensive services including vocational skills, employment training, and treatment for mental health disorders may be provided in the residential setting.

The intensive and supportive caregiving that patients experience in residential treatment represent an appropriate response to the personal history often characterized by poor parental care, emotional neglect, physical or sexual abuse, trauma, interpersonal violence and social exclusion. Additionally, the structured activities and the rules of the residential programme help patients develop better impulse control and delay gratification while learning skills to deal with frustration and to cope with stress. Taking on concrete commitments helps develop personal accountability and evaluate personal progress with measurable achievements.

While the model of a therapeutic community is one of the oldest models of treatment of substance use disorders, and while it is well accepted in many countries, it is a model which has been difficult to test in clinical trials. The Cochrane review on Therapeutic Communities, for example, found evidence to support their efficacy only in the prison setting, and there is no specific WHO guidance on therapeutic communities. Without commenting on the effectiveness of the therapeutic community approach compared to other treatment modalities, this chapter will outline the standards expected of a long-term residential treatment, including therapeutic communities.

3.5.2 Target population

Patients who are unlikely to maintain abstinence outside of a structured environment to improve their life quality, or to participate in health and social integration. Long-term residential programmes are best suited for individuals who require intensive and continuing treatment to address the whole person, with particular focus on managing complex psychological and social problems associated with drug use disorders, and initiating changes in multiple life domains to facilitate transition to the process of recovery.

Residential treatment services are typically indicated for individuals:

- experiencing severe drug-related problems that affect their education, employment and social integration process,
- with a history of unsuccessful treatment, who do not respond to pharmacological and psychosocial treatment in outpatient or short-term in-patient facilities,
- affected by severe co-occurring mental health disorders that affect their health and security outside of structured environments (who usually require hospitalization),
- with limited personal resources,
- with social and family problems and limited social supports,
- who are socially isolated or marginalized,
- with difficulties in interrupting their affiliation to criminal groups and drug dealing networks,

- who recognize the need and are prepared to significantly change life-style and acquire new skills.

3.5.3 Goals

The primary goals of long-term residential treatment for patients are:

- to reduce the risk of a return to active drug use
- to treat psychiatric and substance/ drug use disorders using medication and psychosocial therapy
- to develop skills to cope with cravings and life stressors without drugs
- to improve personal health and the family and work environment and social functioning
- to develop effective interpersonal relationships with other patients and staff while acquiring new social skills, gaining self-confidence and receiving appreciation for positive behaviors
- to develop interpersonal and communication skills to build a network of friends who are abstinent
- to acquire a healthier lifestyle e.g. good nutrition, a stable sleep/wake routine, routine health monitoring and adherence to treatment
- to complete their education and develop vocational skills to progressively become able to regain control over their life once they return to the general community

3.5.4 Treatment approaches

Long-term treatment programmes may differ in their applied approaches. Treatment may begin with a detoxification period, or this may occur prior to admission. Usually in TCs treatment consists of a mixture of group and individual interventions, with community members sharing the tasks of daily living also as a form of therapy. Interventions offered vary significantly and can be based on the 12-step approach or alcoholics anonymous, structured psychosocial approaches such as CBT, or a less well-defined approach of the collective wisdom of the group. While residents are generally supportive of each other, most communities provide a limited scope for provision of critical feedback.

3.5.5 Treatment Methods

Assessment

An initial meeting allows the staff to become familiar with the prospective resident, and the prospective resident to become familiar with the residential programme. It is the first step in the development of a therapeutic alliance. During this meeting, prospective residents usually decide whether or not to enter the programme, and the programme decides whether or not to accept the prospective resident. An initial phone-based interview may be used prior to the in-person assessment.

Residential treatment programmes should conduct a comprehensive psychosocial and medical assessment of every patient entering the programme to determine individual needs

and consider patients' suitability for the specific treatment programme. Patients with significant mental and physical health problems may need a treatment setting which provides the appropriate level of medical and psychiatric care.

Following a patient's consent, individual needs and medications should be discussed with referring agencies and with patients' medical practitioners, including a plan for detoxification, if needed.

Treatment plans should be developed based on comprehensive assessments, which should include standardized instruments and procedures such as the Addiction Severity Index (ASI) or a Composite International Diagnostic Interview Substance Abuse Module (CIDI-SAM).

The following areas are important for the assessment:

- Previous short and long-term treatment and perception of previous treatment
- General health, including current health concerns, physical, sensory, or cognitive disabilities
- Mental health, including trauma and abuse history (physical, emotional and sexual), violence and suicide risk, current psychological and interpersonal functioning
- Current living conditions, including safe accommodation and housing, support system at home
- Family life, including relationships with family of origin, intimate relationships, and dependent children
- Friendships, including network of peer relationships, positive or negative influences, and people supporting long-term sobriety
- Education and work, including school and work history, vocational training level and needs, income (legal and illegal)
- Legal problems, including criminal activity and links to drug use
- Leisure activities and hobbies

The long-term period and the residential setting create an opportunity for thorough evaluation. It also allows evaluation after an initial period of abstinence for drugs, which assures that the evaluation is not affected by effects of drug intoxication or withdrawal and that patients fully understand the nature of treatment and are able to fully consent to it. Living with peers and the staff together allows the evaluation of temperamental and personality traits which can be very useful for individualizing the treatment.

Every programme should have a written intake policy to assure that admission to the programme is voluntary and confirmed with the written consent of the patient. Such a policy should clearly describe the eligibility and exclusion criteria. In addition, programmes should have a written intake/orientation procedure, which is used for all incoming residents. During the intake procedure, new residents should be well informed and receive written information about the programme including its objectives, the treatment methods used, and the programme rules. Patients should be informed about their obligations, their rights and the details regarding privacy, non-discrimination, and confidentiality. Patients should be informed about the role of the staff, the underlying philosophy, and the rules concerning communication with people outside the programme and visitors. Finally administrative

details (i.e. the programme costs and payment methods) should be discussed. Intake policies and procedures should be well known by the staff.

Non-acceptance to a programme

If a potential resident is not accepted to a programme, a comprehensive explanation of the reasons should be given verbally and be provided in written form to the rejected person and, if possible (and without breaching patient confidentiality), to the referring agency. If a person is not accepted, an appropriate referral must be made. The evaluation staff must be aware of appropriate alternative services for referrals with the help of a pre-established network of services.

Treatment Engagement

Higher levels of treatment engagement can influence treatment outcomes positively. Variables that foster treatment retention include:

- Level of motivation before treatment
- Level of drug or alcohol consumption before treatment
- Number of arrests before treatment
- Strength of the therapeutic relationship
- Perceived helpfulness of the treatment service and usefulness of the treatment
- Empathy of the staff
- Inclusion of relapse prevention training

During the first three weeks and in particular during the first days of treatment, the risk of dropout and relapse is highest. Therefore it is important that residents receive individualized attention focused on enhancing motivation to remain in treatment. Especially during this period many residents may continue to experience psychological distress related to protracted withdrawal (insomnia, anxiety, irritability, drug cravings), be ambivalent about giving up drugs and may find it difficult to adapt to the rules of the programme. Information sessions should cover themes such as: the programme's philosophy and expectations as well as its approach to treatment and recovery, programme's retention and health outcomes, and frequently encountered concerns that residents have during early phases of treatment.

To address wavering motivation and ambivalence about the treatment programme staff should:

- Provide a friendly and welcoming atmosphere
- Establish a therapeutic alliance built on trust early in the process
- Respond quickly to requests for treatment to maximize treatment engagement
- Focus on the client's immediate concerns, not those of the programme
- Provide more intensive support during the first 72 hours in treatment through closer observation, increased general interaction and the use of a "buddy system" (pairing of new resident with an established resident)
- Be caring and respectful in all aspects of the treatment programme, as confrontation often results in anger and early drop out

- Give objective feedback about the problems and processes of change in order to foster credibility and trustworthiness
- Develop motivational strategies that focus on the individual patient
- Develop realistic and personalized treatment goals that reflect the client's stage of change and that are flexible enough to shift as the client progresses
- Create an awareness of the heterogeneity of clients, particularly in the group treatment process
- Identify multiple strategies for clients with multiple problems
- Intervene early to reduce confusion and to clarify expectations and roles
- Manage clients to provide individualized, holistic and ongoing support
- Develop skills to manage relationships after discharge

Therapeutic Interventions

At a minimum, long-term residential treatment (mainly those based on the therapeutic community model) should provide drug and alcohol free environments, a variety of regular group meetings (e.g., morning meetings, non-confrontational groups, special groups for female residents, peer evaluation groups), and individual psychosocial support if needed. Hospital-based residential programmes should provide medical and psychiatric care, individual and group therapy and interventions involving family members.

Long-term residential programmes may include a broad range of therapeutic modalities such as individual and group psychosocial intervention, life skills training, vocational and educational training and recreational activities. Evidence-based interventions that are routinely used in outpatient treatment can be adapted and used in long-term residential treatment as well. Specific psychosocial treatment methods that may be utilized include: Cognitive-behavioral Therapy, Motivational Enhancement Therapy, and Social Skills Training. Structured Relapse Prevention programmes are essential in preparation for re-integrating residents into the community. Therapeutic interventions such as art and creative therapy, movement therapy, meditations, relaxation and physical activity (i.e. exercise and group sports) can help patients discover and develop new free time and recreational activities, which can support recovery if continued after returning to the community.

As employment is essential to reintegration and recovery, residents are commonly prepared for work with education, vocational services and job training. Vocational services include job counseling, job interview coaching, resume writing and job application/placement services. Job training allows residents to learn skills and develop confidence. Work and educational activities, are therapeutic interventions combined with other methods to prepare residents to re-enter the community.

Like in any other treatment setting, harsh verbal confrontation or shaming techniques, punitive or restrictive techniques (including physical restraints), approaches such as counter-conditioning or shock therapy, and any other intervention that compromises individual safety or dignity should be avoided.

Length of Treatment

A sufficient duration and intensity of treatment increases the chance that any behavioral change will be consolidated and internalized, and that residents will be sufficiently prepared to live a drug-free life in their communities. The duration of treatment necessary to reach this point varies for each resident, however residents who stay at least 3 months in treatment usually have better outcomes.

3.5.6 Specific programme requirements

Programmes offering long-term residential treatment for people with drug use disorders should include the following components:

- Comprehensive medical and psychosocial assessment on admission
- Treatment plan which best addresses individual needs
- Programme rules that cover clear procedures for admission, discharge and consequences for negative behavior
- Treatment contract which clearly outlines all treatment procedures, services and other policies and regulations as well as programme's expectations of the patient
- Ongoing evaluation of patient's progress in treatment, and continuous clinical assessment that is built into the programme
- Relapse prevention and discharge strategies for continuous care after residential treatment
- A clear structure of activities and responsibilities

Documentation

Written or electronic records of all assessments should be confidentially kept in a secure location, only available to the staff directly involved in the treatment. Proper documentation should include at minimum:

- Signed consent to treatment and agreement on programme rules
- Signed confidentiality and ethics policy
- Appropriate treatment and management plans for each resident
- Regular updates with details of treatment, progress and any changes to the original goals
- A completion summary at the end of the programme (informing the resident of its contents)

Staffing

Some degree of medical supervision is required for therapeutic communities and other long-term residential treatment services. According to the size of the therapeutic community, usually a team of trained professionals and volunteers is necessary for the delivery of optimal care.

Medical doctors, including psychiatrists if possible, should be on call or available for a certain number of hours every week. In residential treatment facilities of co-occurring mental health disorders, medical care services need to be present on site during the day and be “on call” availability during the night. Counsellors, nurses and social workers should be present at the programme’s site at all times.

Individuals who are themselves in recovery from drug use disorders and who work as staff can be valuable role models for residents. Preferably they should have working experience outside a treatment programme and follow a professional training as a counselor or group worker. For professionals starting to work in a TC it is advisable to spend time in a TC before or immediately after being hired. A strict code of ethics for staff should apply. Staff should refrain from humiliating or degrading measures and advocating personal beliefs. Optimally, an external board provides oversight to assure that TC directors and staff do not abuse their power.

Safety requirements

All residential treatment programmes must provide a safe environment to staff and residents to assure a psychologically and physically safe living and learning environment.

The physical environment and appearance of the programme facility is of great importance, as residents may stay for several months. The facility should not look like a prison or a hospital but as a home. Absence of alcohol and drugs should be required and assured. However, psychoactive medications used under medical supervision to treat psychiatric or substance/ drug use disorders, such as methylphenidate, antidepressants, methadone or buprenorphine, should not be discontinued unless it is medically indicated. Procedures for the dispensing and administering of prescribed medication should be in place.

Behaviours which are not acceptable and may result in the removal from the programme include the use of drugs or alcohol, violence, theft and sexual activities between residents. Urine toxicology screening on a regular basis, on returning to the community from temporary leave and when drug use is suspected, can help to ensure a drug-free environment. Procedures to report and deal with unsafe incidents such as physical or sexual abuse should be in place. Also for responding to breaches of programme rules and values, clear procedures with differing levels of response reflecting the specific circumstances should be installed. Contact with visitors should be monitored or supervised, and restricted if necessary, particularly in the early stages of treatment.

3.5.7 Criteria for programme completion and indicators of effectiveness

During treatment, residents are regularly monitored and periodically evaluated with the goal of providing the resident with feedback about their progress towards treatment goals and programme completion.

The evaluation of treatment success and readiness for discharge should be on the basis of several dimensions including:

- Improvement of physical and mental health
- Understanding of factors and triggers that may contribute to drug use and relapse as well as demonstration of skills to recognize them and manage drug cravings
- Improvement of social functioning and willingness to move away from drug using networks towards social networks which value abstinence and recovery
- Development of new hobbies and interests that can be continued after discharge
- Motivation to continue treatment and recovery maintenance following discharge
- Ability and motivation to engage in work and to contribute to the community

Some long-term residential treatment programmes offer a transitional or re-entry treatment phase to prepare residents for discharge from the programme. During this phase residents may gradually spend more time outside the community (pursuing school or work) while still residing in the programme. This period of increased contact with the wider community while maintaining safety, stability, and support provided by programme services gives residents the opportunity to practice newly acquired skills, to maintain abstinence, to develop new relationships and supportive friendship networks and, where appropriate, to re-establish relations with their immediate families.

3.5.8 Rating of the Strength of Evidence

There is a lack of rigorous controlled studies evaluating the effectiveness of long-term residential treatment and specifically the therapeutic community (TC) model. A recent Cochrane review found no evidence to say if the TC model is more or less effective than other treatment approaches, except for TCs in prisons, which were found to be more effective⁷ than routine medical and psychiatric care in prison.

⁷ Smith LA, Gates S, Foxcroft D. Therapeutic communities for substance related disorder. Cochrane Database of Systematic Reviews 2006, Issue 1.

3.5.9 Recommendations

Therapeutic Community Standards

- The community has a planned therapeutic programme
- There is a structured and consistent daily schedule of group activities
- All members have a written care plan
- The community prepares members for independent living in the wider community
- The community has a clear chain of clinical accountability
- There are clearly defined privileges with a rationale and process for allocating them
- The community takes responsibility for improving and maintaining patient members' physical health
- Where patients are offered a pharmacological therapy, there is a written policy and adequate clinical oversight
- Registered care homes should meet national minimum standards

Staffing

- The provider has a system laid out that ensures that the method for selecting, hiring and training staff corresponds to valid legal norms and established internal rules.
- The organisation has rules defined that the staff follows in cases where valid legislation is too general.
- The structure and management of the organisation is defined, making competences for individual positions clear.
- The provider has specified the structure and staffing needs, as well as corresponding job profiles and staff qualifications, taking into account the needs and current number of service users for service organisation. The composition and additions to the team correspond to these needs.
- Prevention of work risks has been secured.
- Cases where a patient's rights have been violated by an employee and the corresponding measures that were taken are documented in personnel records.
- Specialised care (medical, psychological, psychotherapeutic, social, educational etc.) is always carried out by personnel with relevant qualifications and licences.

Discharge

- There are defined criteria for the expulsion of patients due to violation of treatment service rules, violence, continued non-prescribed drug use, etc.
- There are defined criteria for the management of specific risk situations (e.g., intoxication, suicide risk)
- Discharge is based on a consideration of patient recovery status
- Attention is paid to further treatment and support (e.g., family, social) which may be required, based on patient's diagnoses, goals, and resources
- Care plans are explored which map out alternative pathways which might be followed in the event of partial or complete failure of the original plan, or expulsion from drug treatment services

3.6 Recovery Management

3.6.1 Brief Definition and Description of the Setting

Recovery management, also known as “aftercare”, “continuing care” or social support, describes a long-term recovery-oriented model that follows stabilization of abstinence achieved during outpatient or residential treatment. It focuses on reducing the risk of relapse to drug use by comprehensively supporting social functioning, well-being, as well as social reintegration into community and society. Recovery management helps to stabilize and strengthen recovery following a life course perspective. By building on the strength and resilience of patients the focus is moved to the patient, which increases their sense of personal responsibility for managing their drug use disorder.

Longitudinal studies have repeatedly demonstrated that the treatment of drug use disorders is associated with major reductions in substance use, drug-related problems, and costs to society. However, post-discharge relapse and eventual re-admission are very common, so that the majority of patients admitted to treatment have received treatment before. The risk of relapse appears to decrease not until 4 to 5 years of successful abstinence. A sustainable recovery however is possible, and up to 40% of patients with drug use disorders achieve it.

Ideally, long-term residential and intensive outpatient care should both be followed by a step down to a less intensive level of care that continues long-term. This is opposed to repeated brief episodes of care following each relapse that lack continuity. Recovery-oriented continuing care is an approach to long-term management of patients within the network of community-based supports and services. Professionally directed recovery management, like the management of other chronic health disorders, shifts the focus of care from one of “admit, treat, and discharge” to a sustained health management partnership. In this model, the traditional discharge process is replaced with post-stabilization monitoring, recovery education, recovery and coaching, active linkage to communities of recovery, recovery community resource development, and early re-intervention when needed.

The focus on long-term management as opposed to single-episode treatment is supported by the evidence that drug dependence is best understood and managed as a chronic and relapsing disorder rather than an acute illness or episode, similar to diseases like hypertension, asthma and diabetes. Therefore medical and psychosocial interventions should be available for individuals affected by drug use disorders over a lifetime, with intensity matching the severity of symptoms. Recovery management approaches should include long-term pharmacological, psychosocial, and environmental interventions targeted at reductions in substance use and criminal behavior as well as improvements in physical and mental health, and social functioning.

3.6.2 Goals

The primary goal of recovery management is to maintain benefits obtained in earlier treatment. After being able to maintain abstinence and control compulsive drug-seeking behavior, during intensive treatment stages, recovery-oriented care aims to support the development and consolidation of personal and social assets that are necessary to cope with external circumstances and maintain a healthy lifestyle. This includes ongoing pursuit of personal and social recovery as a part of living a drug-free life, improvement of self-care for physical and psychological well-being, reclaiming personal dignity, self-worth, and spiritual growth.

Recovery can be supported by regular contact with treatment (including medication and regular therapy) and/or maintaining engagement with a broader recovery community such as mutual-support groups. Recovery-oriented care supports the development of skills to manage daily stress related to homelessness or the maintenance of housing, unemployment or workplace problems, social isolation or unsatisfactory interpersonal relationships. In particular, patients need support prior to and during crises and conflicts to help control dysfunctional and emotionally intensive reactions. Through all these elements recovery oriented treatment supports a focus on reducing stressful stimuli that may provoke the recurrence of compulsive drug seeking. In general, recovery-oriented care assists patients in improving and stabilizing a good quality of life and opportunities for social reintegration in the community.

In addition, the resurgence of psychiatric symptoms that have been “masked” by drug use must be anticipated and identified during early recovery. This allows for the appropriate provision of treatment and care, including pharmacological and psychosocial interventions.

3.6.3 Types of patients this treatment modality is best suited for

After initial treatment of drug use disorders the majority of patients need some degree of long-term recovery management, at an intensity matching the needs of each individual. Patients with a history of multiple relapse episodes, physical and mental health disorders, poor family and community support, financial, legal and/or housing problems, are in special need of recovery management. Patients with high disorder complexity, in particular those with an early onset of drug use disorders and global impairment of functioning, low effective life skills and limited coping mechanisms for stress, are in need of more intensive recovery management programmes. It is important that patients with a high vulnerability for relapse are connected with appropriate and personalized components of recovery management before discharge from long-term residential or intensive outpatient treatment.

3.6.4 Treatment Models and Methods

Continuing Care and Recovery Management (RM) offers to patients the opportunity to maintain ongoing contact with the health care system, social services and treatment

facilities. Commonly a counsellor would coordinate the case management, meet the patient frequently, provide positive support, encourage engagement in the community and help to manage stressful situations which arise. A counsellor helps the patient to connect with other professionals who can be helpful in the process of social reintegration. In response to specific needs, a counsellor refers patients in particular to social workers and psychologists, medical practitioners, sex and reproductive health professionals and legal services officers.

Principles of recovery management

The recovery management approach is characterized by:

Focus on increasing strengths rather than reducing deficits. Recovery-oriented approaches seek to identify, support and develop skills, talents, resources, and interests instead of emphasizing needs, deficits, and pathologies.

Flexible rather than fixed programmes. Recovery management programmes must respond to patient changes through modifications made over time, offering choice by providing a flexible range of support and services to meet needs of the individual patient.

Consideration for patient's autonomy. Recovery management is a self-directed approach that encourages and supports the making of informed choices about their life and the treatment. The importance of incorporating patients' choices has been stressed in other areas of medicine, especially in the management of chronic diseases, and was found to increase individual's responsibility for their recovery.

Participation of community. As opposed to overcoming dependence in isolation recovery management tries to involve family members, friends, and the community to strengthen social aspects of recovery. Others are encouraged to play a role in the recovery process and resources of the community are used such as professional and non-professional organizations, faith-based organizations and schools.

Treatment Activities

Recovery management combines a variety of activities that promote and strengthen internal and external resources to help patients manage voluntarily and actively drug-related problems and their recurrence. Some of these activities may be already present in the context of a patient's home, neighborhood and community while others need to be developed. The following factors and activities increase social reintegration and improve chances of stable remission and recovery from substance use disorders:

- Strengthening individual's resilience, self-efficacy and self-confidence to manage daily challenges and stress while maintaining commitment to recovery and avoiding relapse to substance use
- A supportive social network (i.e. partner, family members and friends) that can monitor the stability of recovery, abstinence from drugs and compliance with treatment

- Engagement with individuals and social networks of friends and workmates that have abstinence-oriented norms and are supportive of recovery goals
- Meaningful and appreciated work that replaces stigma and discrimination
- Social participation and integration in educational and vocational pursuits, including volunteering or community involvement
- Active involvement in self-help, religious or other support groups
- Political, humanitarian or spiritual involvement that provides a way to achieve a stronger purpose in life
- Stable accommodation
- Remediation of legal and financial problems

Specific Requirements

Treatment plans should be developed with the help of a team of professionals with patients being involved. Treatment plans should be individualized and consistent with the management of other chronic illnesses. In contrast to intensive care programmes, treatment plans in recovery-oriented care expand their focus from primarily medical care to social care including other professionals (e.g., social workers, psychologists, peer counsellors, and potentially also tribal elders, religious leaders, and other community leaders), as well as friends and supportive family members.

Recovery management treatment plans usually involves a regular monitoring or follow-up evaluations that can be done by a counsellor, psychologist as well as specialist or a primary care physician. Such recovery checkups, done in person or by phone, can promote sustained recovery and prevent relapse. During the checkup, the counsellor may ask the patient to provide an update on their work performance, living conditions, coping mechanisms with stress, or maintaining healthy relationships. With recovery checkups, that may include voluntary toxicology testing, patients can be screened for relapse while living in the community and if needed receive early re-intervention.

3.6.5 Criteria for programme completion and indicators of effectiveness

As the recovery management approach adopts a “life course” perspective, it is open-ended and may continue for an entire lifetime. Terms of “discharge” or “graduation” used in more traditional treatment models are therefore not utilized. It embraces the chronic disease management approach that aims to help individuals effectively manage their own health problems with the goal of improving their well-being.

The success of recovery management programmes should be evaluated with respect to its capacity to reduce relapse rate (controlling drug use and avoiding associated harms) and improve physical and psychological health, well-being, social functioning and reintegration. Structured instrument that evaluate global functioning such as the Addiction Severity Index can be used to assess the progress in multiple dimensions of health and functioning while

other instruments can assess the “recovery capital”, which is the amount of internal and external resources that can be used to initiate and sustain recovery.

3.6.6 Rating the strength of evidence

Recovery Management is a new and evolving conceptualization of long-term treatment of drug use disorders that does not stop after a single treatment episode, or after a short-term aftercare programme. It is more a treatment approach than a specific intervention and has not been compared to other treatment approaches through Randomized Clinical Trials (RCTs).

Chapter 4: Special Populations

4.1 Treatment of pregnant women

4.1.1 Treatment Principles

Women with drug use disorders who are pregnant represent a unique population in special need of treatment for two reasons. First, pregnant women with drug use disorders present a challenge to health service providers, because drug use may impact both the mother and the fetus – and, because treatment may also adversely affect both members of the dyad. There are medical and ethical challenges that come with providing treatment for drug use disorders to a dyad, in comparison to a mother and a child separately. Second, the majority of pregnant women with a drug use disorder have few if any parenting skills, and may lack basic knowledge about child development and childrearing. Moreover, once the baby has been delivered, the child may need medical and other comprehensive services, given the possibility of having experienced adverse fetal circumstances. On the other hand, the opportunity to provide treatment for substance use disorders to pregnant women has tremendous potential for positive life-improving changes for the mother and the fetus and the mother and the child if the child is provided services too. Thus, there are often two ‘dyads’ that are involved in treatment of pregnant women with substance use disorder – the mother-fetus dyad, and the mother-child dyad.

Issues for pregnant women with drug use disorders mirror the issues for drug-using adults. Several of these issues, such as the lack of formal education or likely legal involvement, are common to men, women and pregnant women. In contrast stigma, shame and the lack of positive and supportive relationships are issues which may have a more adverse impact on women, which are key reasons why women often do not seek, enter or engage in treatment. Women are more likely than men to have experienced child abuse and/or neglect, undergone repeated exposure to interpersonal violence, be economically dependent on others for survival, have not been able to access formal educational or vocational opportunities, and have limited parenting skills and resources. With pregnancy the above mentioned issues may become even more prominent and present barriers to treatment entry, engagement and outcomes. Unlike other individuals who use drugs, pregnant women are exposing their fetus to potential harmful substances. The vast majority of these women are conflicted, ashamed, and guilt-ridden about what they often see as their inability to ‘control’ their substance-using behavior.

The World Health Organization has recently stressed the unique needs of treatment services for pregnant women with drug use disorders. Pregnant women with drug use disorders have the same rights for treatment as non-pregnant persons and pregnant women without substance use disorders and should not be ejected from treatment nor prevented from receiving treatment because of pregnancy. Treating women for drug use disorders is not more complicated than treating other populations of patients. Women with a drug use disorder should not be forced to have involuntary abortions and sterilizations. Moreover,

treatment programmes must have procedures and safeguards in place to prevent detention and forced treatment of pregnant women. Finally, women have better long-term outcomes when they receive treatments that focus on the issues more commonly found in women with drug use disorders compared to treatments that lack such a women-centred focus.

4.1.2 Treatment Methods

Screening and Intake

Services that provide treatment to pregnant women with drug use disorders and their children typically have a screening and intake procedure that allows for determination of suitability for entry into the programme. At minimum, screening should assess three risk factors: urgent medical attention, detoxification and prevention of harm to self and/or others. Any one or more of these three risk factors might indicate that a pregnant woman may be referred or transferred to a more specialized medical or psychiatric unit to manage these risks, at least on a short-term basis, prior to entry into the treatment programme. Pregnant women's needs and whether these fit with the services provided by the programme should be considered the first step in establishing a patient-provider relationship and a chance to build rapport.

A written policy regarding screening and intake procedures should exist and include the following elements:

- Description of the screening procedures and intake measures and/or interviews. To the extent possible, all intake measures and interviews should be validated in pregnant women with substance use disorders.
- Staff training requirements to conduct intake and screening.
- Policy regarding eligibility for admission to the programme and procedures for non-admission including information about alternative services for pregnant women.

All clinical information should be kept in a safe and secure location, and entered into patient's program records.

Assessment

Clinical assessment occurs on entering the programme examining the pregnant woman's life in detail for 3 purposes: accurate diagnosis, appropriate treatment placement, and development of appropriate treatment goals. The primary purpose of an assessment is to evaluate current life circumstances and gather information regarding physical and psychological health, substance use, family support and social history so that a treatment plan can be developed that matches her strengths and needs. Pregnancy specific information such as the due date, past pregnancies and plans to deliver are also important. An assessment should utilize multiple sources of information to obtain a complete history of the woman. There should be an initial assessment and then it should be seen as a fluid process, and assessment should be periodically planned to occur during treatment. Given changes in physical, psychological and social functioning, it is critical to assess a woman

throughout treatment, and as she enters recovery. How frequently such assessment should be undertaken would depend on the clinical course of treatment and the occurrence of any setbacks in the treatment progress. Standards for assessment are similar to those standards for screening and intake as described above.

Treatment Planning

A pregnant woman with a drug use disorder should not be seen as a passive patient who is only informed of her health status. Rather, she should be actively participating in treatment decisions that affect not only herself but also her child.

Treatment Approaches

Treatment approaches for pregnant women with drug use disorders depend in large part on the drug(s) that are used, and the amount of such use. In certain circumstances a brief intervention that focuses on education and risk review and is provided by a primary care provider or obstetrician may be appropriate. However, given the potential risks to the fetus, such interventions need to be limited to very selective cases with only problematic substance use or mild drug use disorder. As such, most treatment programmes for substance-using pregnant women utilize more traditional treatment approaches.

There are two distinct dimensions that can be used to organize such treatment programmes: Setting and Type of Intervention. On one end of the treatment setting continuum are outpatient treatment programmes; on the other, full-time residential programmes. Treatment interventions include pharmacotherapy and psychosocial interventions.

Special considerations for pharmacological treatments during pregnancy

Pharmacological considerations are especially important for women with opioid use disorder where medication assisted treatment is essential. Women should not be denied treatment with opioid agonist medication only because of pregnancy. Opioid medication choices should be made on a patient by patient basis considering individual characteristics. Both methadone and buprenorphine are effective treatments with favorable risk to benefit ratio but their effects are not always comparable in every patient. Research evidence shows that buprenorphine exposure in utero leads to less severe neonatal abstinence syndromes (NAS) than methadone. However, NAS is an easily identifiable and treatable condition that is only one aspect of the complete risk and benefit ratio decision to consider for a woman and her physician when making medication decisions during pregnancy.

Both methadone and buprenorphine effectively reduce opioid use and allow patients to further benefit from psychosocial treatment. Medication dose should be re-assessed periodically during pregnancy for adjustments, usually upward, in order to maintain therapeutic medication plasma levels and thereby minimize the risk of opioid withdrawal and craving and reduce or eliminate drug use and maintain abstinence.

If a woman becomes pregnant while on either methadone or buprenorphine, treatment should be continued on the same medication, especially when treatment response is good.

Medical withdrawal from opioid agonist during pregnancy is not recommended. Withdrawal is associated with high rates of treatment dropout and relapse with associated risk to the woman and the fetus, and opioid withdrawal increases the risk of miscarriage.

Comprehensive Treatment

A comprehensive women-centered treatment approach consists of treating the whole person and the mother-child dyad. This includes trauma-informed group and individual treatment, childcare, transportation, medical care, obstetric and gynecology care, psychiatry, parenting education, early intervention, vocational rehabilitation, housing, and legal aid. Providing these services is necessary but not sufficient to make a treatment women-centered. Women-centered treatment programmes for drug-using pregnant women need to be sensitive and deal with the following specific biological as well as cultural, social, and environmental factors related to drug use and treatment in women in order to optimize the outcome of treatment.

Other consideration in the treatment of women with drug use disorders include:

- Significant interpersonal relationships and family history play an integral role in the initiation of drug use
- Stigma deters treatment entry for women
- Women often enter treatment for drug use disorders from a wider array of referral sources
- Women are more likely to encounter obstacles in seeking and during treatment as a result of caregiver roles, gender expectations, and socioeconomic hardships. These barriers may result in a delayed treatment entrance at a more severe stage of the disorder with additional medical and psychiatric pathology
- Women are more likely to engage in help-seeking behavior and in attending treatment after admission
- Pregnant women may require adjustment of medication dosages
- Women may require women-focused treatment in a safe single-sex setting to obtain maximum benefit
- Women may need training and support on issues such as sexual health, contraception, parenting and child care
- Women and children are more vulnerable to risk of domestic violence and sexual abuse, therefore a liaison with social agencies protecting children and women is helpful
- Treatment services should be able to accommodate children to allow mothers to receive treatment

Delivery Protocol

Programmes that include delivery services for pregnant women with drug use disorders should have a written delivery protocol that specifies potential issues with both delivery and patient management. At a minimum, discussion of where delivery will be conducted, who will be notified, what provisions she and her child need and how she will get these provisions should be included. Appropriate pain management procedures must also be in place. Many women with opioid use disorders are actually more sensitive to pain than women without such disorders. Untreated pain can trigger drug use relapse and other adverse outcomes for the mother and the infant if the mother is not able to care for the child.

Postnatal Treatment Protocol

All programmes that provide services to pregnant women with drug use disorders should have a postnatal treatment protocol in place. Women should not be discharged from treatment due to pregnancy or postpartum status alone. Methods to support the mother-infant dyad, including at least basic parenting skills, should be also outlined.

Breastfeeding

Although every effort should be made to encourage breastfeeding in drug-using mothers, the decision about breastfeeding should be evaluated on a case-by-case basis. Breastfeeding may be contraindicated in the case of HIV-positive mothers and for mothers with other medical conditions who take certain psychotropic medications. Other contraindications or precautions regarding breastfeeding occur in the case of maternal use of inhalants, methamphetamines, stimulants, tranquilizers, and alcohol.

Specific guidelines on this issue have been published to help physicians make the best recommendation. The need for a case-by-case approach to breastfeeding in the case of substance-using mothers is based on an assessment of the mother's understanding of the impact of the substance secreted in breast milk as well as her substance use practices. It is suggested to reach clear, written agreements with mothers about their breastfeeding practices.

4.1.3 Specific requirements for the programme

Staff Training

Any staff member who has direct contact with patients (secretaries, office managers) must be knowledgeable and sensitive to the issues pregnant women face. Staff should be trained on what to do when a woman goes into labor: who to contact, how to react, where to go for medical help. Unlike other individuals who use drugs, pregnant women are exposing their fetus to potential harmful substances. The vast majority of these women are conflicted, ashamed, and guilt-ridden about what they often see as their inability to 'control' their drug-using behavior. Staff need to be aware of these feelings and concerns and be prepared to respond appropriately in a supportive way. Shaming and stigmatizing women for drug use during pregnancy is not an effective treatment method for preventing drug exposure to the fetus or improving the health of the mother.

Documentation

Regardless of the type of setting or intensity of care provided, proper documentation of the treatment of pregnant women with drug use disorders should include all of the elements specified for the general population of patients with drug use disorders, i.e. treatment contract, individualized treatment and management plan, and a treatment completion summary. Services providing care to pregnant women with drug use disorders need to properly keep records of all medical, psychiatric, and treatment services to assure close coordination between various care services and the implementation of all recommended care.

4.2 Treatment of Newborn Infants Passively Exposed to Opioids in utero

Introduction

The number of neonates born following intrauterine chronic exposure to opiates and other substances is difficult to determine. Factors contributing to this imprecision include lack of measurement and alterations in drug-taking patterns over time, and geography. The outcome of newborn infants is enhanced if comprehensive medical, psychosocial and medication assisted treatment is provided for their mothers. When these services are not provided, the newborn infant is at risk for prematurity, Intrauterine Growth Restriction (IUGR), neonatal sepsis, stillbirth, perinatal asphyxia, poor mother–infant attachment, deprivation, neglect, Failure to Thrive, and Sudden Infant Death Syndrome (SIDS). One of the major conditions that may exist in 50–80% of in-utero opioid-exposed newborns is Neonatal Abstinence Syndrome (NAS). NAS is defined as transient alterations in the central nervous system (e.g., irritability, high pitched cry, tremors, hypertonia, hyperreflexia, sleep disturbances), gastrointestinal system (e.g., regurgitation, loose stools, increase sucking reflex, dysrhythmic sucking and swallowing, poor intake with weight loss), respiratory system (e.g., nasal stuffiness, tachypnea), and the autonomic nervous system (e.g., sneezing, yawning), that manifest in the days and weeks following birth in babies exposed to opioids or other sedatives in utero. Newborn babies develop NAS from maternal use of illicit opioids purchased on the street or from prescribed medication given by the mother's physician for her medical condition including methadone or buprenorphine used to treat her opioid use disorder.

Treatment of Neonatal Abstinence Syndrome (NAS)

Treatment of NAS should include non-pharmacological interventions followed by medication treatment (when needed) after proper and consistent assessment. Supportive measures include: rooming-in, breastfeeding, offering a pacifier (non-nutritive sucking), swaddling snugly with hands available for sucking without overdressing, and skin to skin contact with the mother. Newborns naso-pharynx should be aspirated and feeding should include frequent offerings (every 2hrs) of small amounts (if poor feeding persists) without overfeeding with positioning right side-lying to reduce aspiration if vomiting or regurgitation are prominent symptoms of NAS.

Initiation of pharmacological treatment of NAS should not be delayed. The most commonly used medications for NAS due to opioid exposure are oral morphine or methadone according to body weight and score. With neonatal abstinence from other substances (e.g. barbiturates, ethanol, and sedative hypnotics) generally phenobarbital is administered. The goal of medication is to alleviate the symptoms of abstinence and calm the baby so that the usual functions of eating, sleeping and elimination are normal. The medication dose should be promptly escalated when needed, preferably in response to the frequent assessments of NAS severity using validated instruments, and similarly promptly reduced as NAS symptoms decrease.

Staff Training

All health care staff caring for infants should be trained to identify the signs and symptoms of NAS as well as the neonatal conditions that may present in similar ways as NAS (e.g., septicemia, encephalitis, meningitis, post-anoxic CNS irritation, hypoglycemia, hypocalcemia, and cerebral hemorrhage).

Documentation

Any assessment for NAS should be recorded as should the medication and non-medication interventions provided to minimize NAS.

4.3 Children and Adolescents with Substance Use Disorders

4.3.1 Treatment Principles

Types of children and adolescents who may present to treatment

Children and adolescents around the world comprise a large majority of the victims of neglect and physical, sexual and emotional abuse. Children are used in war, terrorism, are subjected to many forms of violence, are kept illiterate, trafficked for profit, and used in the drug trade. Children suffer deprivation, poverty, famine, gender-based discrimination, displacement and various mental and physical health conditions. Children are victimized at each point of the drug trade industry, they are used in the growing, manufacturing, selling, buying, and in distribution. Children whose families grow drug-producing plants are exposed to toxic residues and second and third-hand smoke. Children living in countries of conflict are made vulnerable to dire risks in multiple ways. Child soldiers have easy access to drugs to keep them awake, make them fight, and perform other terrorizing behaviors as well as deal with trauma of violence. For them, drug use is used as a way to find temporary solace in an unsafe and unpredictable world.

Issues to Consider when Treating Children and Adolescents

Substance use disorders are critical paediatric illnesses. The earlier substance use starts, the greater the risk for more rapid progression to heavy use and use disorders. Children who use drugs are unlikely to identify it as a problem for themselves or others in their lives; however, drug use – both licit and illicit – can harm the development of a child. Moreover, such children will very likely be in need of substance use and mental health treatment services in the future.

Children may reside with their families but may also live on the streets, being orphaned or rejected from their family, may be conscripted into the military, or live in correctional system institutions. As a result, treatment circumstances and settings for these latter two groups of children may be quite different than traditional outpatient or residential treatment, and may involve more outreach and drop-in centers than is typically found in treatment of substance use disorders of adults. Adolescents may be brought to treatment by their parents who are concerned about recent drug use.

Research on the treatment for this population is limited and although there is encouraging evidence that psychosocial treatment is effective in older children, guidance regarding treatment for younger children has often been based on research findings from treatments provided to adults or adolescents. However, such an approach to treat children with drug use disorders may present unanticipated problems such as different response to medications in children in contrast to adults. Finally, many psychosocial treatments used with children need to be tailored to the level of cognitive development and life experiences of the children.

Other issues to consider when providing treatment for substance use disorders in children and adolescents include:

- Children and adolescent drug users have unique treatment needs related to their immature brain and cognitive functioning and limited coping skills related to incomplete psychosocial development;
- Adolescents have high levels of risk-taking and novelty seeking and are very responsive to peer pressure;
- Adolescents with drug use problems have high prevalence of comorbid psychiatric disorders and family dysfunctions which need to be a focus of treatment;
- Children and adolescents may be less likely than adults to see the value of talking about their problems, they are more concrete in their thinking, less developed in their language skills, and may be less introspective than adults;
- Behavioral treatment interventions must be adapted taking into account the limited cognitive abilities of children and adolescents;
- Children and adolescents may have different motivations than adults to participate in treatment and to share common treatment goals with a treatment provider.

Adolescence is an important developmental period and adolescent brains are especially vulnerable to drug use disorders. Given the neurotoxic effects of drugs or alcohol on developing brain, substance use needs to be identified and addressed as early as possible. Adolescents can also benefit from interventions for substance use even if they are not dependent on any specific substance. Disrupting exposure to the substance as soon as possible may help minimize the risks for subsequent physical and/or psychological damage. Routine medical, school, or other health-related visits provide opportunities for asking adolescents about substance use and adolescents will respond honestly if they do not perceive immediate negative consequences for being honest. Legal, school, and family pressure can be important forces to have adolescents enter, stay in, and complete treatment.

Treatment of drug use disorders should be tailored to the unique needs of the adolescent and address the needs of the whole person, not only the drug use. Violence, child abuse, and risk of suicide need to be identified and addressed early in treatment. Monitoring substance use is key to treatment of adolescents, where the goal is to provide the needed support and additional structure while their brains are developing. In treatment, adolescents need more and different support than adults do. Given the onset of sexual involvement and higher rates of sexual abuse among adolescents with drug dependence, testing adolescents for sexually transmitted diseases such as HIV, as well as Hepatitis B and C, is an important part of drug treatment. Treatment should also include strategies such as: social skills training, vocational training, family-based interventions, sexual health interventions including prevention of unwanted pregnancy and sexually-transmitted diseases.

Treatments should attempt to integrate other areas of social involvement of adolescents such as school, sports, hobbies and recognize the importance of positive peer relationships.

Treatment of adolescents should promote positive parental involvement where appropriate. Access to child welfare agencies must be available.

Drug use disorder and mental health treatment services should accommodate the unique characteristics and be flexible in identifying and addressing the needs of children and adolescents within a framework that best protects a child from harm and meets their individual health needs.

4.3.2 Treatment Methods

Outreach Services

The goal of outreach programmes is to identify children who might be in need of health-related services, and provide such services to the extent possible, given the constraints under which a child might be living (e.g., on the streets, incarcerated). Thus, outreach staff intend to target children known to be at risk, and then to serve as a conduit for necessary services. These services would be intended to address any of a variety of problems, including health-related and mental-health-related treatment services. In outreach cases, screening may be conducted by interview on the part of the outreach staff, and its goal is to collect sufficient information to determine the need for referral and treatment in multiple areas known to be problematic for children in such circumstances where contact is made (e.g., street) and to be an active agent in arranging for such treatment. The cause and extent of the problem are secondary to simply initiating treatment.

Screening and Assessment

Traditional inpatient and outpatient programmes that provide treatment to children will typically have screening and intake procedures that determine suitability of the child for entry into the programme. Thus, screening for three risk factors, at a minimum, is necessary as part of the admissions process: intoxication, threat for self-harm and/or harm to others and abuse (emotional, sexual and/or physical). Any one or more of the problems might suggest that a child be admitted to a more suitable in-patient treatment. An assessment evaluates a child's current life circumstances and gathers information regarding the physical, psychological, family, and social history to determine specific treatment needs, so that a treatment plan can be developed that matches the strengths and needs. Standards use in screening and assessment of children should be no different than those used for other patient populations.

Treatment Planning

Children with drug use disorders need to be considered as part of a treatment team that focuses both on the physical and psychological well-being. A child should not be viewed as a patient to be passively informed of her/his health status, rather, the child should be seen, along with the caregiver, as actively participating in treatment decisions. Additionally, early on in the planning process, decisions should be made regarding transitioning back to the community.

Treatment Approaches

Treatment approaches for children with drug use disorders depend in large part on the substance(s) that are used. As with other patient population, treatment should involve psychosocial interventions in combination with medication when appropriate. However, there is little research regarding the efficacy of these pharmacotherapies in the treatment of adolescents and even less with child substance use disorders and therefore none of the medication are approved for use in this population. There is some support for the use of opioid agonists, such as methadone and buprenorphine, in adolescents when they are considered able to consent to such treatment and it should be used for adolescents with severe opioid dependence with high risk for continuing drug use. The consent to any treatment of minors should be provided also by parents in compliance with national legislations. Adolescents with a short duration of opioid use disorder who have a significant family and social support may respond to opioid withdrawal with or without naltrexone as a relapse prevention strategy. Appropriate pharmacotherapy should also be used to treat co-occurring psychiatric disorders as a part of integrated treatment plan that also involves psychosocial treatments.

Psychosocial approaches for the treatment of drug use disorders in children and adolescents should cover a wide range of their lives as possible using an individualized approach that takes into account their vulnerabilities and strengths. Examples of treatment approaches for substance use disorders in children and adolescents include the life skills approach, family-based interventions (e.g., brief strategic family therapy, family behavior therapy or multisystemic family therapy) and basic education. Adolescents will benefit from training in self-control, social skills, and decision making.

Gender-specific Issues in the Treatment of Adolescents

Recognition of gender differences should be included as an integral part of treatment in adolescents. Boys typically prefer mixed-gender groups, while girls prefer girls-only groups, reflective of differences in both the socialization and substance use histories of girls and boys. Given the much higher rates of physical abuse, sexual abuse and the exchange of sex for drugs among girls than boys, at least part of a treatment programme should be gender-specific. In girls, treatment may focus on unique vulnerabilities of girls such as depression and a history of physical and sexual abuse, while in boys treatment may focus on impulse control issues, disruptions in the school and the community, and a history of learning and behavioral problems however many of these issues will need to be addressed in all children.

4.4 Treatment of People with Drug Use Disorders in Contact with the Criminal Justice System

4.4.1 Brief definition and description of the setting

Over 10 million people are incarcerated worldwide (approximately 146 per 100,000 inhabitants) and in most countries, the majority of these individuals have a history of drug use. Also, a large percentage of individuals with drug use disorders who are not currently incarcerated report having been incarcerated at least once.

It should be noted that with regard to offences of possession for personal consumption the international drug control conventions⁸ foresee the provision of measures such as treatment, education, aftercare, rehabilitation or social reintegration, including as complete alternatives to conviction or punishment.⁹ In addition to the international drug control conventions, States have a range of standards and norms related to the application of non-custodial measures, which they should draw upon.¹⁰

Persons with drug use disorders who come into contact with the criminal justice system can be offered drug treatment services, which at the same time possibly also addresses an essential factor in reoffending risk. By making sure that people with drug use disorders in contact with the criminal justice system have access to evidence-based treatment and care services, significant decreases in drug use disorders, and directly related criminal activity, are likely to occur and positive public health outcomes would be expected (e.g. decreased spread of Hepatitis C, HIV). Left untreated, individuals who have an extensive drug use and related criminal history are more likely to continue their activities, thus posing an ongoing threat to public health and security.

Treatment of people with drug use disorders in contact with the criminal justice system may – depending on the offence – take place as an alternative to conviction or punishment or in addition (e.g. in prison). Treatment as an alternative to conviction or punishment takes place under a variety of conditions, such as probation or parole, diversion and drug treatment court programmes, or police referral to treatment, as appropriate. In closed settings, such as prisons and pretrial places of detention, the criminal justice system addresses persons that to a large extent may benefit from access to effective drug dependence treatment services, as appropriate.

⁸ The international drug control conventions are the 1961 Single Convention on Narcotic Drugs as amended by its 1972 Protocol (1961 Convention); the 1971 Convention on Psychotropic Substances (1971 Convention); and the 1988 United Nations Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988 Convention).

⁹ See article 36(1)(b) of the 1961 Convention, article 22(1)(b) of the 1971 Convention, and article 3(4) of the 1988 Convention.

¹⁰ See, notably, the United Nations Standard Minimum Rules for Non-custodial Measures, General Assembly resolution 45/110, annex (the Tokyo Rules); and the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders, General Assembly resolution 65/229, annex (the “Bangkok rules”).

Providing drug treatment and rehabilitation services in the context of the criminal justice system must be based on the same principles as for any field of medical practice. In addition, the fundamental principles listed below will be relevant based on the specific context.

4.4.2 Goals

Evidence-based approaches, including interventions based on an assessment of an individual's risk of recidivism, can be effective in breaking the drug use and crime cycle. An important aspect of selecting these interventions is to provide individuals with the most appropriate type and intensity of services. Providing low intensity treatment services to those who have serious drug-related problems typically fails to result in the desired outcomes. Similarly, providing high intensity treatment services to those with less serious drug-related problems can also be problematic, and can occasionally make the situation worse by exposing the individual to people with higher risk patterns of drug use. Matching individuals to intervention services and the tailoring of services to specific risks and needs should be based on matching the intensity of the individual's problems to the type and intensity of the services that are provided.

4.4.3 Types of clients

Evidence-based treatment and care needs to be available to all people with drug use disorders independent of their legal status. Considering people who use drugs and those with differing degrees of severity of drug use disorders without any criminal behavior not as criminal offenders but primarily as suffering from a health disorder eases their access to health and social services.

Interaction with the criminal justice system can be turned into an opportunity to encourage the voluntary participation in treatment services for people with drug use disorders. It is therefore critically important to screen for individuals in need of drug treatment services and continuing care also in the context of the criminal justice system. With the exception of cases where the criminal justice system directly employs treatment specialists, it is sensible for clinically trained treatment professionals to first provide an assessment, while the criminal justice system would facilitate referral to the treatment service in the first place. Depending on the severity of the disorder, some people with drug use disorders who come into contact with the criminal justice system may require only a brief interaction with a treatment service, other cases will require long-term treatment.

When individuals with drug use disorders have committed criminal offences, those offences may be related to the drug use disorders, such as to finance a drug purchase. The most effective intervention for such patients is the treatment of their drug use disorder; and the criminal behavior usually stops when the patient stops illicitly using drugs. In this situation, the offer of effective drug treatment is the best public health and public security response for individuals with a drug use disorder and related criminal offenses. The continued need for criminal justice sanctions, as applicable, may depend on the outcome of this treatment.

In other cases, the criminal offence itself may be unrelated to drug use; and the person may not meet the diagnostic criteria of drug dependence. In this situation, while schemes of treatment as an alternative may be less applicable, still any person using drugs or with a drug use disorders in contact with the criminal justice system would benefit from healthcare or social interventions as part or in conjunction with other applicable measures.

4.4.4 Treatment models and methods

Fundamental principles

Assessment of drug use disorders should be done by someone with clinical training

Assessment of drug use disorders needs to be conducted by trained personnel with a health background. The key issues to be resolved in the assessment are:

- Is the person in need of any acute treatment, such as for drug withdrawal or psychosis?
- Does the pattern of drug use fit the pattern of either harmful use or dependence?
- Is the person interested in receiving treatment for drug use disorders?
- What kind of treatments have they received in the past?
- What range of treatment interventions are likely to be effective?
- Of these treatment interventions, which would the person be interested in pursuing?
- Are there concomitant medical problems (including psychiatric issues) that need to be taken into consideration?

Justice and health authorities would jointly be able to evaluate if treatment could be applied as an alternative to conviction or punishment and which options are available and would best match the person under consideration taking into account both the offence committed and the healthcare needs.

Screening and Assessment is the key to treatment matching

Matching patients to treatment options has been shown to be a difficult science. A pragmatic approach would take into consideration the pattern of drug use and the degree of dependence, with non-dependence normally starting with brief psychosocial interventions with the full range of longer term treatment options for dependent drug use. Medication-assisted treatment options, such as methadone and buprenorphine, are limited to opioid dependence. Antagonist treatment of opioid dependence such as with naltrexone, is often limited to highly motivated individuals with limited psychiatric comorbidity. Significant medical or psychiatric comorbidity requires a treatment setting where these issues can also be addressed. Past treatment performance can be a good guide to future treatment success.

A clinician may after their initial discussion propose a range of treatment alternatives that are feasible, in line with the needs of the client, and with which the client is prepared to engage. Based on this list, and the availability of different treatment programmes, the court

may make one or more proposals to the offender,¹¹ who then either agrees or disagrees, indicating a preferred option.

Because much of the information used in the screening and assessment process is based on self-reporting, it is critical that collateral sources of information (e.g., drug test results) may also be obtained when making treatment placement decisions.

Risk for Re-Offending Principle

The most effective programmes are those that appropriately match the type of intervention to the individual patient. It is well established that programmes providing only sanctions or services and that are not based on the risk profile of the individual have little to no impact on outcomes; and in some cases, these services are associated with poorer outcomes than the untreated comparison groups. As a result of these findings, many criminal justice systems have decided to reserve the most intensive treatment options for individuals with the highest levels of recidivism risk. Likewise, allocation of treatment resources should be more heavily invested in intensive services for individuals with higher recidivism risk. In most cases, those with a low risk for recidivism are likely to remain low risk, regardless of whether treatment services are provided.

Need Principle

The Need Principle states that services for individuals in contact with the criminal justice system should focus on “criminogenic” needs, address behaviors and attitudes that are associated with recidivism, and focus on people, who are amenable to change as a result of targeted treatment services. Specifically, services should target changes in antisocial attitudes, feelings, and personal associations. Helping individuals improve self-management skills and gain prosocial skills have been shown to lead to better outcomes. Conversely, traditional treatment approaches that target general psychosocial constructs, such as trying to improve self-esteem without addressing the antisocial aspects of the personality, should not be a cornerstone of service delivery.

The research in this area has shown that there are four general categories of criminogenic needs to be addressed: 1) the history of antisocial behavior, 2) antisocial personality patterns, 3) antisocial cognition, and 4) antisocial associations, with four additional areas that warrant consideration, namely substance use, family, school or work, and leisure and recreation.

¹¹ As in the Tokyo Rules, persons in contact with the criminal justice system are referred to as “offenders”, irrespective of whether they are suspected, accused or sentenced.

Responsivity Principle

Based on a comprehensive assessment of the individual (including an assessment of his or her learning style, level of motivation, gender, and ethnicity), a tailored treatment approach should be developed. For example, many individuals in the criminal justice system do not respond well to traditional didactic treatment approaches, therefore treatment services need to strive to include more visual-spatial approaches when delivering treatment content. Approaches exclusively based on a punitive approach, as well as those that lack structure, should be avoided.

Equity of services

The basic premise of the provision of health services in relation to the criminal justice system is that health services should be similar in type and scope to what is available at the community level. The decisions of criminal justice officials should not deprive a person of the right to access the needed health care and services.

Linkage to services at the community level

In addition to equity in services inside and outside prisons, there should be a linkage between the criminal justice system and community-based services to avoid interruption of services and to ensure a sustained quality and continuity of care.

The structure of the treatment services

Most programmes begin by providing individuals with highly structured treatment services, including a stringent toxicology monitoring, and over time reduce the intensity of services, as progress is made. Effective programmes implement a range of incentives and, to a lesser degree, sanctions to help shape the individual's behavior. Rewarding positive behaviors, such as providing the individual with a certificate of completion, helps to reinforce continued positive behavior. The use of negative reinforcement need to be used far less frequently and administered in a timely and objective manner when used (e.g., immediate increase in the frequency of urine testing after a positive result is obtained).

A wide network of services needs to be provided

Given the multiple problems encountered by individuals with drug use disorders in contact with the criminal justice system, it is important that treatment programmes through their networks can adequately address additional needs of patients such as housing, employment, legal, financial, and family problems.

A continuum of treatment that includes aftercare is necessary to sustain recovery

To assure that the patient will not re-offend and not incur in illicit drug use, treatment should continue beyond the primary treatment episode (aftercare). Sustaining treatment benefits requires a continuum of care that is designed to assist an individual in transitioning from corrections-based services to community-based services. Without the continuation of services, treatment gains typically are diminished or lost. Unfortunately, there are many obstacles to providing ongoing care, such as: 1) lack of coordination between criminal justice practitioners and treatment providers, 2) absence of incentives and sanctions for individuals

to continue treatment following unsupervised release from prison settings, i.e. after having served their sentence, 3) lack of community-based treatment programmes, and 4) the fact that treatment providers often are inexperienced in treating individuals involved in the criminal justice system.

Treatment as an alternative to imprisonment

After years of increasing prison population, alternatives to incarceration should be explored as a means to reduce the prison population. One approach has been to identify individuals with drug use disorders fulfilling specified eligibility criteria and provide them with intensive court or community supervision as an alternative to imprisonment. This often includes requiring community-based treatment as a condition of supervision. This approach enlarges the sentencing options available to courts, and may contribute to keeping families and communities together. Non-incarceration approaches for appropriate cases of drug-related offences of a minor nature are specifically allowed under the international drug control conventions.

Drug treatment courts

Drug treatment courts are one approach to providing alternatives to incarceration for individuals who have serious drug-related problems. As a specialized branch of courts, a drug court is created within existing jurisdictions to oversee court-supervised treatment and community supervision. The structure and processes of a drug court may vary, but most require participants to complete random urine tests, attend treatment counselling, meet regularly with probation or court officers, and often participate in self-help groups.

Drug courts aim to provide supportive environments where judges will reward, and sometimes praise, individuals for successful programme participation, while limiting “punishment” to those who do not comply. In some cases, the drug treatment court option is only available after a guilty plea; and therefore treatment may not always be immediately available for those in need. In most drug treatment court programmes, individuals who successfully complete the programme can avoid either part or the entirety of a sentence of imprisonment, and, in many cases, certain convictions (such as for drug consumption) can be removed from their record.

Community corrections

Community corrections is another alternative to imprisonment for individuals, who have serious drug use problems. Terms of supervision are placed on the individual with the threat that a violation could result in incarceration. In addition to taking random drug tests, being subject to home inspections, and not incurring in illicit drug use, supervision requirements may include participation in treatment services. For the most serious offenders, there may

be more intensive supervision, for example upon probation, which includes more frequent monitoring by law enforcement practitioners as well as more frequent required meetings. The use of “day reporting” is another option in which individuals must report to a location, such as a probation office, on a frequent (usually daily) basis. In some jurisdictions, there are treatment options dedicated to those under such intensive supervision, and day reporting supervision. Alternatively, “halfway houses” are provided when there is a need for intermediate housing during the transition from prison to the community. Individuals are required to remain within the halfway house when not at work, at court, or seeking medical treatment. Halfway houses typically provide 12-step (self-help) support groups and, in some cases, provide treatment options dedicated for those residing within the halfway house.

Supervised community treatment

Supervised community treatment refers to services provided to persons under court or community supervision. As described above, this can include drug treatment courts as well as different types of community supervision instead of imprisonment. In many cases, the offences committed by persons with drug use disorders may not give rise to imprisonment, and allow for individuals to be placed directly under community supervision, with a requirement that they receive probation or court supervised treatment services. Persons under community supervision have continued access to alcohol and drugs in the community, and therefore are at risk of continued illicit drug use. Remaining in the community can help maintain positive family relationships and address negative relationships.

Treatment interventions

In general, treatment interventions should be the same as those options available to the general population (as described in prior chapters), with recognition for the unique situation of individuals with drug use disorders facing imprisonment. Treatment interventions must always be voluntary and based on the informed consent from the patient. All persons who access services, including individuals under the supervision of the criminal justice system, should have the right to refuse treatment, even if this entails other custodial or non-custodial measures.

- 1) Medication-assisted detoxification is often the first stage of treatment. If a correctional agency does not have in-house detoxification available, it is imperative that the individual be referred to outside medical services. Forcing individuals to go through withdrawal without medical attention is not only unethical; it can be dangerous to the person’s health and safety.
- 2) Outpatient treatment can include periods of more intensive treatment followed by periods of less intensive treatment. This method of a “step down” in treatment intensity is particularly suited for those receiving intensive treatment services in prison and who upon return to the community still need treatment services though at lower levels of intensity. Decreasing intensity over time should be based on whether or not an individual is meeting the goals of treatment.

- 3) Residential treatment can be provided in dedicated units within a prison. Such programmes are particularly valuable when targeting specific high-risk populations, such as young offenders, women, and people with psychiatric disorders. Having a dedicated residential environment minimizes exposure to people, especially in the general prison population, who might victimize the individual undergoing treatment. This dedicated space also helps target the issues pertinent to the subgroup (e.g., addressing trauma among victimized women).

Clients in residential programmes are expected to cooperate with each other and collaborate on daily chores like preparing meals and doing laundry. By modeling and teaching problem-solving, communication skills, goal setting, and working together, this can be a highly-effective comprehensive treatment approach for those individuals with a history of problematic drug use. This approach, however, should not stand alone; residential treatment should be followed by the offer of ongoing services after the residential treatment programme is completed.

- 4) Therapeutic community (TC) is a model of residential treatment that can be adapted to a prison population and has been found to be effective in randomized controlled trials (Smith et al., 2006). Prison-based TC programmes should be located in a separate unit of the prison with the structure and services similar to comparable programmes outside the prison setting. Participation in this treatment should be voluntary, with inmates from the general prison population eligible to apply for admission. Some interventions that have been used in the TC have not been found to be effective in reducing recidivism or non-medical drug use and should be avoided, including ineffective approaches that typically incorporate a highly regimented, military-style schedule combined with confrontation, discipline, and behavior modification.
- 5) Self-help groups provide critical support for individuals in recovery from alcohol or drug problems. Self-help groups (NA or AA) exist across many settings, including in prison and in the community. Because many are religious-based and may reject the use of medication-assisted treatment, it is important that these factors are considered before recommending or requiring an individual to participate in specific self-help groups.
- 6) Pharmacotherapy can be among the most important elements of treatment for some substance use disorders. For example, methadone and buprenorphine are the standard of care in opioid use disorder, while other approaches such as detoxification followed by naltrexone can be effective in preventing relapse. Decisions to incorporate medication-assisted treatment as part of an overall treatment approach needs to be considered on an individual basis. Facing criminal charges should not be the sole justification for recommending medication-assisted treatment.

Note: To reduce the risk of opioid overdose after discharge from prison, persons with a history of opioid use, as well as their families and friends should be equipped with naloxone along with instructions/training on its use in the case of an opioid overdose.

4.4.5 Specific requirements for treatment in prison settings

Providing the best possible treatment for people in prison settings presents an array of complex issues, including logistical questions such as who should provide treatment, where it must be provided, and when it should be provided.

One of the more complex issues relates to the appropriate staffing of treatment programmes. In some prisons, in-house staff members are trained to provide treatment services, while in other prisons, outside treatment providers are contracted to deliver services. These staffing decisions should be made with the aim of achieving the best outcomes at the lowest possible costs. In general, though, outcomes for patients will depend on the quality of services provided rather than on the affiliation of staff members.

Ideally, those participating in treatment should be isolated from other incarcerated individuals in order to maintain a prosocial environment. Having individuals who are in recovery return to the general prison population can easily undermine the gains achieved while in treatment, given the negative climate that often exists within the general prison setting. When stand-alone treatment environments are not possible or available, efforts to minimize exposure to external risk factors should be made (e.g., such as having separate dining and recreation times). The amount of time remaining on a person's sentence must also impact treatment decisions because an individual may be in the middle of treatment at the time of release. Agencies need to consider the amount of time an individual will be incarcerated and then require completion of assigned treatment services prior to release or ensure for the necessary continued treatment after release.

Chapter 5: Characteristics of an Effective System to Deliver Services for the Treatment of Drug Use Disorders

Introduction

An effective national system for the treatment of drug use disorders requires a coordinated and integrated response of many actors to deliver policies and interventions based on scientific evidence in multiple settings and targeting different groups at different stages with regard to the severity of their drug use disorder. The public health system is best placed to take the lead in the provision of effective treatment services for people affected by drug use disorders, often in close coordination with social care services and other community services. Treatment services should be:

- available
- accessible
- affordable
- evidence-based
- diversified

The availability of treatment services refers to the physical presence of services capable of treating patients with drug use disorders.

The accessibility of treatment services refers to their reach or physical accessibility for the whole population. Treatment services must be located conveniently and in geographic proximity of public transport (including rural and urban areas). In addition, access should not be hindered because of attitudes towards certain population groups or other factors.

The affordability of treatment services refers to patients and the treatment system. Treatment services should be affordable for patients from different socio-economic groups and levels of income. At the same time treatment systems need to be affordable for the health and social system in order to be sustainable.

The evidence-based approach of treatment services guarantees the quality of treatment services. Given the overall limitations in funding available for the treatment of drug use disorders, treatment interventions should be based on scientific evidence and follow evidence-based guidelines.

Treatment services should be diversified and offer different treatment approaches. Not one approach fits for all disorders and its various stages. Therefore a diverse range of interventions should be in place in various settings to address the needs of patients with drug use disorders adequately. As recovery remains the ultimate goal of all treatment and care services, sustained recovery management services should be an integral part of it.

Treatment system organization model

Drug use disorders can be described on a spectrum from lower to higher severity and complexity. The ICD-10 (WHO, 2011) differentiates in the section on Mental and behavioral disorders due to psychoactive substance use (F10-F19) between acute intoxication, harmful use and dependence syndrome. Thorley (1980) differentiates in his model of drug use in a similar way between intoxication, regular or excessive use and dependence (Figure 1). Per the 2015 World Drug Report of UNODC, out of a total of 246 million people - slightly over 5 per cent of those aged 15 to 64 years worldwide – who used an illicit drug, some 27 million are people with drug use disorders and almost half of whom are people who inject drugs (PWID)(UNODC, 2015).

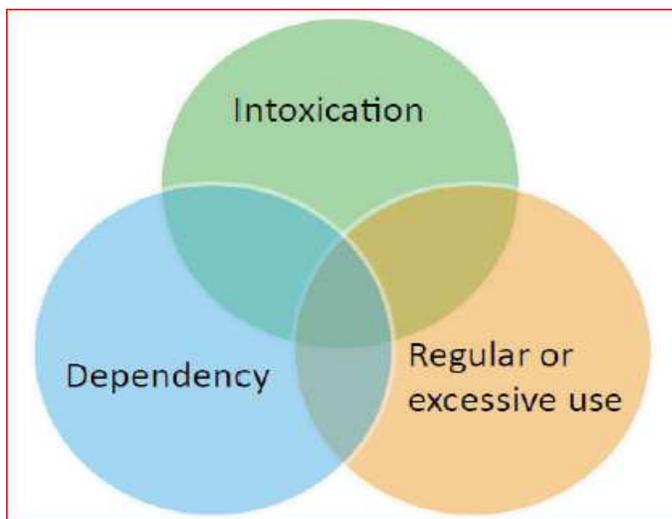


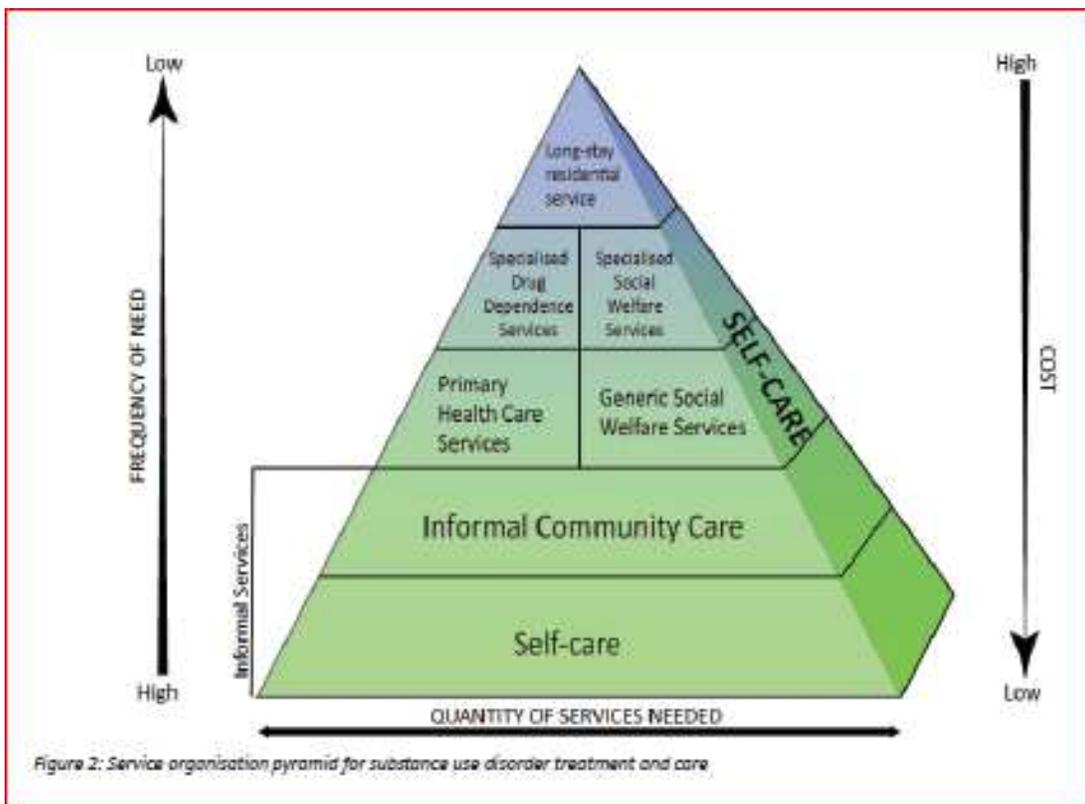
Figure 1 Thorley's model of drug use

When developing a comprehensive treatment system that wisely allocates available resources and responds best to patient's needs, the key public health principle to apply is offering the least invasive intervention possible with the highest level of effectiveness and the lowest cost possible. This principle is important when designing or reviewing a treatment system taking into account the treatment standards described in this document.

From a public budget perspective evidence-based treatment of drug use disorders is a smart investment, as the costs to treat drug use disorders are lower compared to the costs of untreated drug dependence (UNODC/WHO, 2009). The rate of savings to investments can exceed a ratio of 12:1 through reductions in drug-related crime and costs of criminal justice, law enforcement and healthcare (NIDA, 2012).

Overall, the intensity and level of specialization of services should be corresponding to the needs and the severity of the substance/ drug use disorders of patients. A patient who has taken drugs only once needs for example a different type of intervention and intensity of support than a patient with a long history of drug use and other related health and social problems.

Investments of public funds should therefore be made according to the frequency of treatment services needed. As shown in the service organization pyramid (Figure 2), most treatment services are required at levels of lower intensity, which can prevent people from developing more complex drug use disorders if delivered. As services at levels of lower intensity are more required and usually less specialized and less costly, treatment systems designed in line with the service delivery pyramid are more cost-effective, given that services offered are based on scientific evidence. However, investments are often made to a very high degree in highly intensive and highly costly treatment services at the top of the pyramid, which leads to a situation where people with low severity end up in highly intensive treatment services without having the necessity. When the severity of the disorder does not match with the intensity of the treatment, outcomes are minimized and resources inefficiently



distributed, which is not a good investment of public funds.

Figure 1 Service organization pyramid

As drug treatment services at the outpatient level are in general less interruptive for patients and less costly for the health system, they are recommendable from a public health perspective as long as outpatient treatment is conform to the severity of the substance/ drug use disorder and the needs of the patient.

World Drug Report data show that a big gap exists globally between the number of people who want or could benefit from treatment for drug use disorders and the number of people who actually receive services (UNODC, 2015). The non-existence of services at the lower threshold and lower intensity (such as brief interventions at the primary health care level) may also lead to the inaccessibility of low-threshold services, so that people who use drugs only get in contact with the health system when they already developed severe drug use disorders instead of having received less intensive (and less costly) support in earlier stages of their disorder. Data shows that individuals are rarely screened by primary care practitioners (Ernst et al, 2007). However, providing screenings and initial services in primary healthcare settings is feasible and helps identify, support and refer people with drug use problems, therefore contributing to reduce health-care costs.

Suggested interventions at different service levels

Service level	Possible interventions
Informal community care	Outreach Self-help groups Informal support through friends and family
Primary health care services	Screening, brief interventions, basic health care, referral Continued support to people in treatment/contact with a specialized treatment service Basic health services including first aid, wound management
Generic social welfare	Housing/shelter Food Unconditional social support Ensuring access to more specialized health and social services as needed
Specialized drug dependence treatment	Assessment Case management Treatment planning Detoxification Psychosocial interventions Medication-assisted treatment

	Relapse prevention Recovery management services
Specialised health care services	Mental health treatment Internal medicine Dental treatment Treatment of HIV and Hep C
Specialized social welfare services	Family support and reintegration Vocational training/Education programmes Income generation/micro-credits Leisure time planning Recovery management services
Long term residential service	Housing Vocational training Protected environment Life skills training Ongoing therapeutic support Recovery management services

An important decision when involved in the planning of a functional and sustainable drug dependence treatment system is related to the allocation of resources and the services offered at different levels of the health and social system. Treatment systems should be designed using available data on drug demand and supply at various levels as an important guidance (UNODC, 2003). The non-availability of data or systematic data collection systems should not be an obstacle for the implementation and delivery of drug dependence treatment and care services. Especially, because some of the indicators, such as the Treatment Demand Indicator (“service utilization for drug problems”), can only be effectively collected if drug treatment services are in place that can collect patient level data.

The development of a functional national drug information system needs support from partners at all levels and different sectors, as it involves not only a technical component but also a participatory process to agree on governing policies of a national drug information system and a national drug observatory. A step by step guide on this process is available for reference (EMCDDA, 2010).

Treatment service organization model: One-stop-shop approach for the treatment and care of drug use disorders

Given the diverse and multiple needs of people with drug use disorders, ideally a wide range of medical and social services should be provided in one facility or programme, which can be described as a “one-stop-shop” (Figure 3). Such an integrated service provision without barriers in accessibility includes the full range of care services and provides drug users with a comprehensive drug dependence treatment (Rapp et al, 2006).



Figure 3 One-stop-shop approach

Treatment service organization model: Community-based approach for the treatment and care of drug disorders

If treatment programmes cannot integrate all services (like the one-stop-shop approach) a coordinated comprehensive continuum of care, including various components of the care system, should be developed. This approach positions clinical services as a core element but offers many auxiliary services at the municipality/community level, which share a perspective and work in close coordination with established referral mechanisms. In order to ensure access, low-threshold entry level services (e.g., outreach, drop-in) with defined referral mechanisms to clinical treatment services and accompanying social services should be in place.

In a community-based treatment network (Figure 4) broad partnerships exist not only between different services from the public health and public social sector but also with other community stakeholders. To coordinate all services provided it is beneficial to develop a locally effective community-based treatment approach that utilizes all resources already

available in the community. Community-based treatment services offer a multifactorial and multi-sectorial approach to manage drug-related problems and health issues. Such an approach encourages the use of a variety of paths to treatment, recovery and increased quality of life. Partners in a community-based network of services need to work in close collaboration and coordination to provide the best possible support through effective referral and case management strategies in order to guarantee a continuum of care. Community-based treatment networks provide a range of low-threshold entry points and ease access to different treatment and care services.

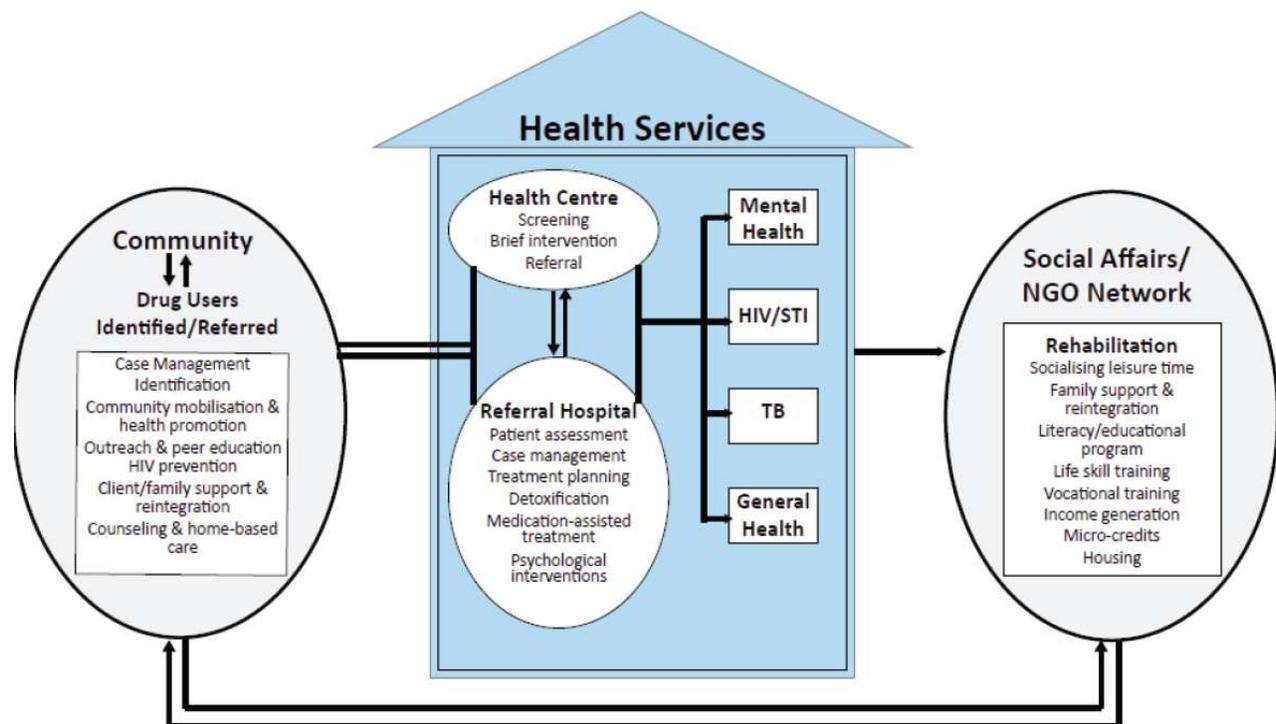


Figure 4 Model of community based treatment

Key principles of community-based drug dependence treatment and care include:

- Continuum of care from outreach, basic support and reduction in the harms related to drug use to social reintegration, with no “wrong door” for entry into the system
- Close collaboration between civil society, law enforcement and health sector
- Minimal disruption of social links and employment
- Integrated into existing health and social services
- Delivery of services in the community – as accessible as possible to drug users
- Involvement and building on community resources, including families
- Participation of people who are affected by drug use and dependence, families and the community-at-large in service planning and delivery
- Provision of evidence-based interventions
- Informed and voluntary participation in treatment
- Comprehensive approach with a recovery perspective that takes into account various needs (health, family, education, employment, housing)

- Acceptance that relapse is part of the treatment process and that individuals can re-access treatment services
- Respect for human rights and dignity, including confidentiality

Health services such as primary health care services, specialized drug treatment services, hospitals and clinics and social services are key partners in a community-based treatment and care network. In addition, broader partnerships should also be formed with other community stakeholders such as

- Civil society/NGOs (e.g., providing outreach services, vocational training, aftercare activities)
- Police (e.g., screening, referring to health system)
- Criminal justice system (e.g., providing treatment in prison, arranging follow-up services in the community)
- Professional organizations (e.g., providing legal support)
- Trade and services establishments (e.g., creating vocational opportunities)
- Organized groups of drug users and people in recovery
- Organized groups who identify themselves based on gender and ethnicity
- Educational and research institutions
- Youth organizations and youth leaders
- Religious organizations (e.g., offering places for overnight stays)
- Religious and community leaders
- Neighborhood associations
- Family members

To ensure that patients are linked and referred to appropriate services that suit their needs, case management is an essential component. Case managers work together with patients, members of the treatment team, and services or organizations to select the best combination of interventions and support. Case manager also provide a continuous assessment of the treatment progress. In this way case management ensures that the network of referral and other support services remains accessible and that resources are utilized efficiently. The following chart depicts a functioning case management system from the perspective of people who use drugs and enter the treatment system. There is “no wrong door” for entry into the system, as different treatment services are connected and collaborate, so that patients can be referred to the service facility which corresponds to the severity of their disorder and their individual needs.

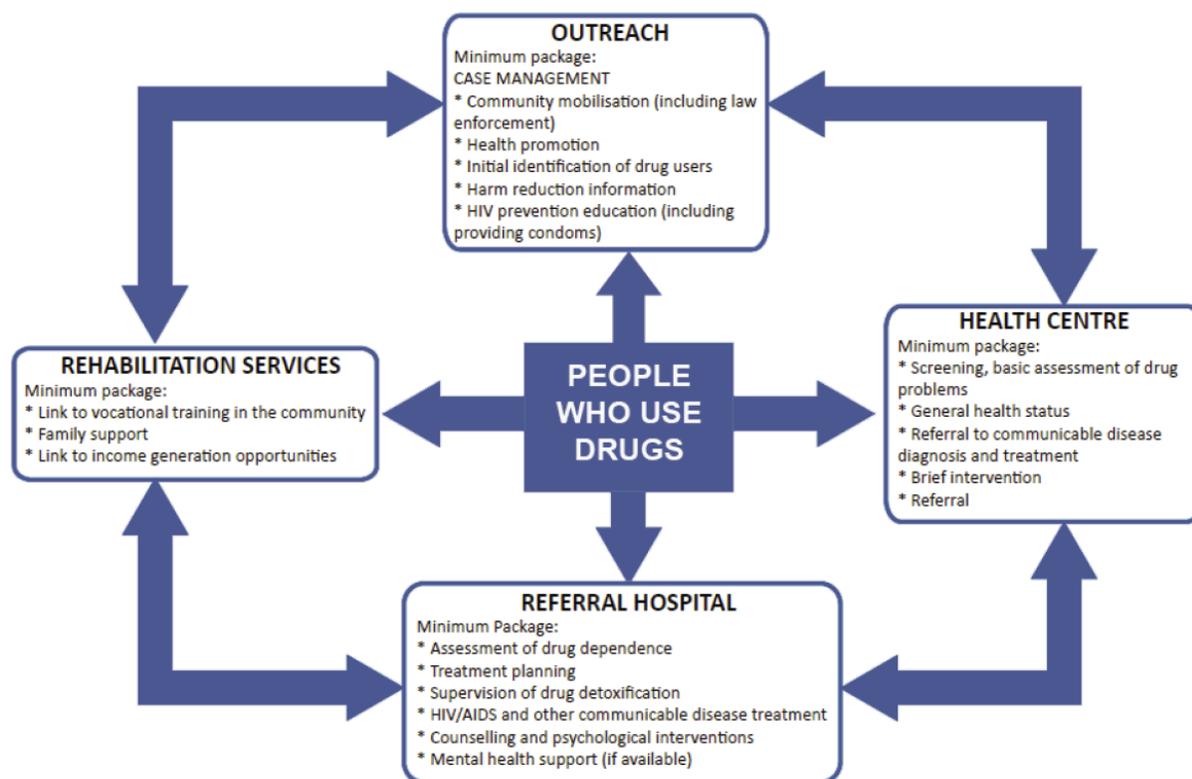


Figure 5 Model of case-management and treatment and care for people who use drugs and are affected by drug use disorders

UNODC has published a good practice document on community-based drug dependence treatment (UNODC, 2008) and a guidance note (UNODC, 2014) on the same topic, which provide examples from around the world and detailed practical guidance on the elements of a community-based treatment network.

The continued treatment service model: Sustained Recovery Management

Recovery is considered to be “[...] a continuum process and experience through which individuals, families, and communities utilize internal and external resources to address substance use disorders, actively manage their continued vulnerability to such disorders, and develop a healthy, productive and meaningful life” (Adapted from W. White, 2007). Recovery should be an ultimate goal at every stage of the treatment continuum, at every stage of the disorder and across a variety of settings (Table “Suggested interventions at different service levels”), from outreach, basic support and reduction in the harms related to drug use and to social reintegration. A continuity of services needs to be ensured in order to support people with drug use disorders and emphasize the need for rehabilitation, reintegration and the recovery itself. Such services that can be called “sustained recovery management services” might be already integrated in a functional community-based drug dependence treatment and care network. The utilization of the existing services will be lower as individuals progress towards a sustained recovery. Such services (like any other drug dependence treatment service outside of life-endangering emergency situations) should be voluntary and have the aim to be the least disruptive for the person in recovery. Despite

recovery being the ultimate goal of treatment, it is important to recognize that drug dependence is a chronic disorder and that it is likely that patients relapse and reuse the network of treatment services again.

Recovery services can be implemented in a range of settings and stages of the disorder and include for example resolving of legal issues, income generating activities, peer recovery support, social support, aftercare, half-way houses, vocational training, or other. In the UNODC (2008) good practice document on sustained recovery management, eight domains of recovery capital have been defined as a suggestion for areas and interventions to be considered on a continuing basis (Figure 5).



Figure 5 Essential supports for achieving rehabilitation and social reintegration

Recommendations/Summary

- In a treatment system resources should be invested where they are most needed. A focus should be on low-threshold and easily accessible treatment and care services as a first step.
- All treatment services provided should be affordable and evidence-based and delivered with recovery as the ultimate goal integrating sustained recovery management into all treatment and care services.
- Available data should be used when designing and implementing a drug dependence treatment system. However, the non-availability of data should not be an obstacle for the implementation and delivery of drug dependence treatment and care services.
- A one-stop-shop approach (a full range of care services available in one facility or programme) or an integrated network of health and social services in the community are models to deliver an accessible and diversified continuum of care for drug use disorders.

References

EMCDDA (2010). Building a national drugs observatory: a joint handbook.

Ernst D, Miller WR, Rollnick S (2007). Treating substance abuse in primary care: a demonstration project. *International Journal of Integrated Care*, vol. 7

NIDA (2012). Principles of drug dependence treatment. A Research based Guide. Third Edition). NIH Publication No. 12–4180

Rapp RC et al. (2006) Treatment barriers identified by substance abusers assessed at a centralized intake unit. *J Subst Abuse Treat.* 2006 Apr; 30(3): 227–235.

Smith LA, Gates S, Foxcroft D. Therapeutic communities for substance related disorder. *Cochrane Database of Systematic Reviews* 2006, Issue 1. Art. No.: CD005338. DOI: 10.1002/14651858.CD005338.pub2

UNODC (2003). Developing an Integrated Drug Information System. Toolkit Module 1. United Nations. New York

UNODC (2008). Drug Dependence Treatment: Community Based Treatment. Good Practice Document.

UNODC (2008). Drug Dependence Treatment: Sustained Recovery Management. Good Practice Document.

UNODC (2014) Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in Southeast Asia.

UNODC (2015). World Drug Report 2015 (United Nations publication, Sales No. E.15.XI.6).

UNODC/WHO (2009). Principles of Drug Dependence Treatment. Discussion Paper.

Weisner C. et al.(2001). Integrating primary medical care with addiction treatment: a randomized controlled trial. *Journal of the American Medical Association*, vol. 286, No. 14, pp. 1715-1723.

World Health Organization (2009) Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. WHO, Geneva

World Health Organization (2010), *The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) Manual for use in primary care* WHO, Geneva.

World Health Organization (2009-2015). MhGAP Evidence Resource Centre. Available online at: http://www.who.int/mental_health/mhgap/evidence/en/

World Health Organization (2011). International Classification of Diseases and Related Health Problems. 10th Revision.

World Health Organization (2012), Guidance on Prevention of viral Hepatitis B and C among people who inject drugs. WHO, Geneva.

World Health Organization. (2014). Guidelines for the identification and management of substance use and substance use disorders in pregnancy. WHO, Geneva. Retrieved November 24, 2014., from http://apps.who.int/iris/bitstream/10665/107130/1/9789241548731_eng.pdf

WHO (2015) Community management of opioid overdose. WHO, Geneva