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## **Commission on Narcotic Drugs**

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### **Preparations for the special session of the General**

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## **International Standards for the Treatment of Drug Use Disorders — Draft for Field Testing**

The International Standards for the Treatment of Drug Use Disorders (Standards) were prepared by UNODC and WHO 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 them achieve as full recovery from the disorder as possible and to become a productive member of their society.

The Standards were developed in the framework of the UNODC-WHO Programme on Drug Dependence Treatment and Care and are built on existing publications. They provide United Nations Member States with a practical and comprehensive technical tool that will help to guide policy development; plan, organize and manage drug treatment services within and beyond the health system; develop the capacity of human resources; and evaluate service and system level interventions. The Standards will be made available to the Commission for its consideration at its fifty-ninth session.

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**UNODC**

United Nations Office on Drugs and Crime



**World Health  
Organization**

# INTERNATIONAL STANDARDS FOR THE TREATMENT OF DRUG USE DISORDERS

***DRAFT FOR FIELD TESTING  
March 2016***

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# Chapter 1: Introduction

## 1.1 Background

It is estimated that a total of 246 million people, or 1 out of 20 people between the ages of 15 and 64 years, used an illicit drug in 2013. Approximately one in ten people who use illicit drugs is suffering from a drug use disorder. Almost half of people with drug dependence inject drugs and of them more than 10% are living with HIV. 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 and lawlessness, increased health care costs, and a myriad of negative social consequences. Caring for individuals with drug use disorders places a heavy burden on public health systems of member states and therefore improving treatment systems, making them the best they can be, would undoubtedly benefit not only the affected individuals, but also their communities and the whole society.

Because of many inaccurate interpretations prevailing in the past, drug dependence has been considered a social problem; a moral failure; a character pathology; a guilty behavior to be punished; or a simple result of the inappropriate exposure to dependence-producing drugs. This simplistic and ideological approach was proposed before we had a scientific understanding of the brain mechanisms that play the central role in the development and persistence of the behavioral signs and symptoms of drug use disorders. After many years of medical research, we now have a very good understanding of drug dependence as a complex multifactorial biological and behavioral disorder. These scientific advances are making possible for us 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 and initiate a productive life in recovery.

Unfortunately, the outdated views of 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 programs. 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 addiction treatment 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 many parts of the world the older view of addiction persists in the form of agencies other than Ministry of Health still being responsible for affected individuals. Managing individuals with drug use disorders by agencies of the Ministry of Interior, Ministry of Justice or Ministry of Defense, without the supervision or engagement of the Ministry of Health, is unlikely to lead to long-lasting beneficial outcomes. Only treatment that has at its core understanding of drug dependence as primarily a behavioral disorder, that can be treated using medical and psychological approaches, can improve chances of a recovery from the disorder. Using only law enforcement strategies and methods is unlikely to result in sustained positive effects.

Currently, UNODC data reported in the World Drug Report show that at a global level only 1 out of 6 people in need of drug dependence treatment has access to treatment programs; 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 the territory, particularly in rural areas. Unfortunately, in many places available treatment is often not effective, not supported by the scientific evidence, and sometimes is not in line with human rights principles and is not voluntary. This is also true in otherwise highly developed countries where availability of evidence-based treatment programs is often insufficient.

## **1.2 Drug Use Disorders**

Using narcotic drugs and psychotropic substances without medical supervision, for non-medical purposes may be dangerous. 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 Drug Use Disorder in DSM5 diagnostic system or Drug Dependence and Harmful Use of a substance in the ICD-10 system.

At the core of drug dependence syndrome is the strong and overpowering desire to take the drug and an inability to control the amount of drug taken with resulting use of excessive amounts and spending excessive amount of time on drug-related activities. The desire to take the drug can persist, or be easily reactivated even after a period of abstinence and lead to the resumption of a regular use despite a strong wish otherwise and a frequent desire to stop use. 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 family and social life, education, work and recreation. They continue to use despite recurrent social or interpersonal problems, engage in high-risk behaviors, and continue use despite knowledge of persistent 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, or a withdrawal syndrome - a set of characteristic aversive symptoms, when the amount of drug taken is reduced or drug use has stopped.

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

We now have a complex understanding of how these disruptions in brain functioning result in the development of drug use disorders. The 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 the different response to the initial doses of the drug seen in individuals at risk; more positive effects, less negative effects, and the ability to tolerate much higher doses than seen in individuals without the genetic risk factors. The genetic risk can be modified by the early life experiences, which can have protective but also detrimental effect. 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, exposure to drugs triggers mechanisms of pathological reward learning and interferes with previously learned responses to other rewards such as seeking food or social interactions. This new type of learned responses is very stable and can persist for life, similarly to other learned behaviors such as riding a bicycle. When drug is present, previously neutral environments become strongly associated with the drug experience and can later independently trigger desire for the drug and stimulate drug-seeking behavior. Desire for drug 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 and the desire to use can become easily triggered, but the ability to control and suppress the impulse to use becomes weaker and the affected individual will resume drug use despite the prior strong desire not to use.

Unfortunately, the abnormal brain functioning in affected individuals has a profound effect on their lives, causing to make decisions with disastrous consequences to their health and the well-being of their families and to engage in criminal and immoral acts despite their previous high moral and ethical standards. The unlawful behavior observed in most individuals with drug use disorders is used primarily to finance the drug purchase. The freedom to make the right choices is seriously impaired in affected individuals though they can still make the choice to seek out treatment, to be compliant with recommendations, and to start making positive changes in their lives.

Scientific advances and efforts of educating the general public are beginning to change the perceptions of drug addiction 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 a



“self-acquired bad habit” but rather a result of a long series of biological and environmental factors, disadvantages and adversities, one that can be prevented and treated. Risks affecting the vulnerable populations in both developed and in developing countries are being recognized. Early childhood neglect and abuse, lack of strong family supports, impaired parenting, lack of emotional support and personal engagement of teachers, household dysfunction, social exclusion and isolation contribute to the development of drug dependence and mental health problems in developed countries. In developing countries, those same factors are further complicated by exposure to extreme poverty, degraded neighborhoods, displacement, exploitation, violence, hunger and work overload, contributing to the risk of drug use disorders.

In addition to the symptoms of this complex disease, individuals with drug use disorders, more often than not, develop additional medical or psychiatric problems. They are likely to be exposed to blood born infections (HIV, HC) and TB, to carry a high risk of cardiovascular and liver problems, to have increased incidence of traffic accidents, and to more frequently experience violence. For example, in opioid users the rate of mortality is 6.5 times the rate expected in the general population and death occurs most often at a young age, with an average of 44 years of potential life lost for each fatality. Overdose, unintentional injuries (accidents and violence), and suicide are the most frequent causes of death. The relationship between psychiatric and substance use disorders is very complex. Often the psychiatric disorder exists prior to the onset of substance use, putting affected individuals at greater risk of developing drug use disorders. Psychiatric disorder may also develop secondary to the drug use disorder, due 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, which happens during the mid-twenties. Individuals with drug use disorder have much lower life expectancy.

Drug use disorders are generally chronic in nature as the brain abnormalities underlying the symptoms are relatively stable, similar to other skills and behaviors that developed through the process of learning (e.g., riding a bicycle). Because of that the risk of symptom recurrence, such as relapse to drug use, persist for many years, in some cases even after many years of complete abstinence from drugs. This necessitates that therapeutic services for individuals with drug use disorder have to be ready to work with the patient 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 presenting problem without the expectation that a condition can be completely cured after a short-term treatment episode. Recognizing the chronicity and the relapsing course of the disorder that may occur even despite the treatment, should not imply that the treatment is ineffective and therefore useless. On the contrary, appropriate treatment delivered repeatedly despite recurrence of symptoms is essential to guarantee an improved quality and duration of life in spite of the persistent and serious health problem while maximizing chances of long-term recovery and symptom-free life.

### 1.3 New Trends in Drug Use

Traditionally drugs of abuse included plant-derived substances such as cocaine, heroin and cannabis. More recently amphetamine and related stimulants synthesized in illicit laboratories become widely available and the most recent trend is the diversion, illicit distribution and abuse of prescription drugs that are classified as controlled substances such as synthetic pain medicines, sedative hypnotics, or psychostimulants. Those medicines have legitimate use under the medical supervision but their use can quickly become problematic if used inappropriately.

In order to avert legal efforts at controlling distribution of psychoactive substances, hundreds of new psychoactive substances (NPS) are synthesized, distributed, and abused every year with unpredictable and often dramatic adverse consequences in users. The production and trafficking of NPS that can be purchased via the internet makes monitoring and control even more difficult. Very few countries have in place an early warning system to collect and share information on these new substances. Concurrently, the mechanism of control relies on national legislations, typically with a long term process necessary to schedule new drugs under the Conventions international control. This expansion of NPS will continue to place an added burden on the already challenged healthcare systems.

Because of the emergence of NPS and changes in the distribution routes of the traditional drugs of abuse in many countries and parts of the world, health institutions are poorly prepared and less able to respond appropriately to the emergence of new behavioural and medical problems in drug users. For example, in parts of the world where opioids were previously used, there are now large increases in prevalence of psychostimulant use disorders and treatment system developed to manage opioid-related problems disorder is not able to respond appropriately to the new type of patients. Similarly, the trend toward poly-drug use among the young consumers, combining “traditional” drugs, prescription drugs, alcohol and new psychoactive substances, has evidenced an even more dramatic picture that requires urgent investment treatment programs 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 created a large scale joint Global Program for Drug Dependence Treatment and Care. The main purpose of this inter-agency program is to disseminate good practice 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 disease.

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 them achieve as full recovery from the disorder as possible and to become a productive member of their society.

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. This document identifies major components and features of an effective drug treatment system, with a description of evidence-based treatment interventions to match needs of the people affected in different stages of the disease.

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

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 present *Standards* document.

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

## 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. These interventions have been developed with the support of scientific evidence and their effectiveness has been tested using scientific standards used in developing treatments for other medical disorders. The goals of treatment are to: 1) reduce the intensity of drug use desire and drug use, 2) improve functioning and well-being of the affected individual, and 3) prevent future harms by decreasing the risk of complications and reoccurrence.

Many interventions that are commonly used in working with affected individuals do not meet standards of scientific evidence of effective treatment. Such interventions are ineffective or can even be harmful. This distinction between effective and ineffective intervention has important financial implications. In many countries, resources available to work with affected individuals are limited, therefore priorities for resource allocation must be carefully evaluated. The scientific standard can be used to make an important differentiation between interventions that are worth supporting and those that are not. That means the determination which activities should be developed and prioritized for funding from public resources and which activities should not be funded because they do not meet the minimum standard for effective treatment.

The three questions listed below can lend assistance to these important funding determinations:

1. Is there evidence that proposed activity results or contribute to the reduction of compulsive drug use (symptom reduction) or reduces the risk of returning to drug use in someone who has succeeded in stopping use of drugs?
2. Is there evidence that such activity results or contribute to improvements in physical, psychological and/or social functioning and well-being?
3. Is there evidence that such activity can decrease or contribute to the reduction of risks for health and social consequences from drug use?

In addition to these criteria that have a clinical focus, the activity should adhere to agree upon international ethical standards:

1. Must be consistent with UN Declaration of Human Rights and existing UN Conventions
2. Must be designed to promote individual and societal safety
3. Must be designed to promote personal autonomy
4. Shall build over the existing experiences in evidence based standards definition

The International Standards on the Treatment of Drug Use Disorders defines a set of requirements and attributes (standards) that must be in place to initiate any form of outreach, treatment, rehabilitation, or recovery services, regardless of the treatment

philosophy that is used and 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 available similar to the standards used in treatment of other chronic diseases.

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

**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 needs that patients may have. Treatment services must match the needs of the individual patient at the specific phase of their disorder to include outreach, screening, inpatient and outpatient treatment, 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 the minimal wait time. All barriers that limit their accessibility to appropriate treatment services should be minimized. Services should not only offer addiction treatment, but also provide social support and protection and general medical care. The legal framework should not discourage the people affected from attending treatment programs. The treatment environment should be friendly, culturally sensitive and focus on the specific needs and level of preparedness of each patient, the environment that encourages rather than deters individuals from attending the program.

**Standards:**

- 1.1. Essential treatment services for drug use disorders should be available through organization of treatment interventions at different levels of health systems: from primary health care to tertiary health services with specialized treatment programs for drug use disorders.
- 1.2. Essential treatment services are in place that include brief interventions, diagnostic assessment, outpatient counselling, outpatient psychosocial and evidence-based pharmacological treatment of drug use disorders, outreach services and services for management of drug-induced acute clinical conditions such as overdose, withdrawal syndromes and drug-induced psychoses.
- 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 program.
- 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. Treatment services should provide access to social support, general medical care and referrals to specialized health services for the management complex co-morbid health conditions.
- 1.10. Treatment services for drug use disorders should be oriented towards the needs of served populations with due respect to cultural norms and involvement of service users in service design, development 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 in treatment services**

**Description:** Treatment of drug use disorders should be based on the universal ethical standards – respect for human rights and dignity. This includes responding to the right to enjoy the highest attainable standard of health and well-being, ensuring non-discrimination, and removing stigma. The choice to start treatment should be left to the individual. 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 be avoided. 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 respect in all cases human rights and 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 in all cases. 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 with ethical standards and human rights principles



- and norms, and show respectful, non-stigmatizing and non-discriminatory attitudes towards service users.
- 2.5 Services procedures are 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 in treatment services involving human subjects should be subject to review of 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 seen primarily as a health problem rather than a criminal behavior and wherever possible, 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 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 offering choice to enter treatment as alternative to criminal prosecution or imprisonment. Law enforcement and courts professionals and penitentiary system officers should be appropriately trained to effectively engage with the 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 the effective treatment will decrease the risk of reoffending following the release. Continuity of care after release is of vital importance and should be assured or facilitated. In all justice related cases people should be provided treatment and care of equal standards to treatment offered to anyone else in the general population.

#### **Standards:**

- 3.1 Treatment for drug use disorders should be provided predominantly in health and social care systems, and effective coordination mechanisms with criminal justice system should be in place and operational to facilitate access to treatment and social services.
- 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 in 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 treatment and health care that are guaranteed 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 linking with community health and social services in preparation for release.
- 3.7 Appropriate training programs 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 support treatment and rehabilitation efforts.
- 3.8 Treatment of drug use disorders in 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:** Evidence-based practices and accumulated scientific knowledge on the nature of drug use disorders should guide interventions and investments in treatment of drug use disorders. The same high quality of 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. To the extent possible, 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. 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 rather than acute care interventions. Severe drug use disorder is very similar in its 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 life-long recovery, a sustained cessation of drug use, absence of drug-related problems, and enhanced physical, psychological, interpersonal, occupational, and spiritual health. 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 outcome. Traditional treatment systems may be unique to a particular country or setting and may have limited evidence to its 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 programs and efforts should be made to formally evaluate whether such treatments are effective and carry acceptable risks.



**Standards:**

- 4.1 Resource allocation in treatment of drug use disorders should be guided by existing evidence of 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 is 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 are trained in identification and management of the most prevalent disorders due to drug use.
- 4.4 In treatment of drug use disorders health professionals at primary health care should be supported by specialized services for substance use disorders at advanced levels of health care, particularly for treatment of severe drug use disorders and patients with co-morbidities.
- 4.5 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 is determined by individual needs and there are no pre-set limits of treatment or there are no limits that can't be modified according to the patient 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 and training of health professionals including university curricula and programs of continuing education.
- 4.8 Treatment guidelines, procedures and norms are 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.

**Principle 5: Responding to the needs of special subgroups and conditions**

**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, elderly, women, pregnant women, sex workers, sexual and gender minorities, ethnic and religious minorities, individuals involved with 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 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 are vulnerable to risk of domestic violence and sexual abuse, and their children may be at risk of abuse therefore a liaison with social agencies protecting children and women are helpful. Women may require women-focus treatment in a safe single-sex setting to obtain maximum benefit. Treatment programs should be able to accommodate children needs to allow parents caring for children to receive treatment, and support good parenting and child care practices. Women may need training and support on issues such as sexual health, contraception.

### **Standards:**

- 5.1 The needs of special subgroups and conditions are reflected in service provision and treatment protocols, including the needs of women, adolescents, pregnant women, ethnic minorities and marginalized groups such as the homeless.
- 5.2 Special services and treatment programs should be in place for adolescents with substance use disorders to address specific treatment needs associated with this age and to prevent contacts with patients in more advanced stages of drug use disorders, and separate settings for treatment of adolescents should be considered whenever possible.
- 5.3 Treatment services and programs for drug use disorders need to 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 are tailored to the needs of people with drug use disorders from minority groups, and cultural mediators and interpreters are available whenever necessary in order to minimize cultural and language barriers.
- 5.5 A package of social assistance and support in order to achieve means of sustainable livelihoods needs to be integrated into treatment programs for people with drug use disorders living in the street, unemployed, homeless and rejected by their families.
- 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 programs for drug use disorders.**

**Description:** Good quality and efficient treatment services for drug use disorders require an accountable and effective method of clinical governance that facilitates the achievement of treatment goals and objectives. Treatment policies, programmes, procedures and coordination mechanisms should be defined in advance and clarified to all therapeutic team members, administration, and target population. Service organization needs to reflect current research evidence and be responsive to service user needs. Treating people with drug use disorders who often have multiple psychosocial and

sometimes physical impairments is challenging, both to individual staff and organizations. Staff attrition in this field is recognized and organizations need to have in place a variety of measures to support their staff and encourage the provision of good services.

#### **Standards:**

- 6.1 Treatment policies for drug use disorders are based on the principles of universal health coverage, best available evidence and developed with the active involvement of key stakeholders including the target populations, community members (families), non-governmental organizations, religious organizations.
- 6.2 Written service policy and treatment protocols are available, known to all staff and guide delivery of treatment services and interventions.
- 6.3 Staff working at specialized services for drug use disorders should be adequately qualified, and receive ongoing evidence-based training, certification, support and supervision. Supervision and other forms of support are needed for the prevention of burnout among staff members.
- 6.4 Policies and procedures for staff selection, recruitment, employment and performance monitoring are clearly specified and known to all.
- 6.5 A sustainable source of funding is available at adequate levels and proper financial management and accountability mechanisms are in place. Whenever possible, costs for staff education and for evaluation 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 are in place to ensure accountability and continuity of treatment and care.
- 6.8 Service programmes, rules and procedures are periodically revised on the basis of continuous feed-back, monitoring and evaluation processes, as well as the constantly updated data on the drug use trends in populations.

#### **Principle 7. Integrated treatment policies, services, procedures, approaches and linkages must be constantly monitored and evaluated**

**Description:** As a response to a complex and multifaceted health problem, comprehensive systems must be engaged to facilitate effective treatment of drug use disorders. A variety of services should be integrated in the case management of these patients, with the mainstreaming of primary health care delivery and multidisciplinary activities. A coordinating team should include psychiatric and psychological care, municipality social services support work, support for housing and job skills/employment, legal assistance, and specialist health care (HIV, Hepatitis, 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 need to 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, religious organizations.
- 7.2 Links between drug use prevention, drug dependence treatment, and prevention of health and social consequences of drug use are established and operational
- 7.3 Treatment planning is based on estimates and descriptions of the nature and 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 are defined and mechanisms for effective coordination established.
- 7.5 Quality standards for drug treatment services are established and compliance is required for accreditation.
- 7.6 Mechanisms for clinical governance, monitoring and evaluation are in place including clinical accountability, continuous monitoring of patient 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 for planning and development purposes.

## Chapter 3: Treatment Modalities and Interventions

### 3.1 Community Based Outreach

#### 3.1.1 Setting

Community-based outreach refers to activities and organizations that access and engage with people who use drugs in the community to improve their health and wellbeing and reduce the risks of drug use. This strategy is different from intervening with populations who are already in contact with clinics or other care service modalities. Often, outreach workers may themselves have lived experience, be former drug users, or non-drug users who have close links to and have been affected by the groups they serve. Outreach workers and peer supporters typically carry out a set of specific education strategies devised and implemented by members of a subculture, community or group of people for their peers, where the desired outcome is that peer support and the culture of the target group is utilized to effect and sustain change in behaviour.

Models of outreach work have changed considerable over time. Originally, outreach was designed to rely on former and/or current drug users to reach hard to reach or hidden populations who were not in treatment because treatment was either unavailable, inaccessible, or simply unwilling to make use of the existing services. More recent efforts have included other members of the community and spaces drug users occupy to support access to services. Outreach efforts also acknowledge the role of social network dynamics among individuals experiencing drug use disorders and recognize that these networks are important determinants of their risk of negative health and social outcomes and can utilize them as a leverage point to influence and promote healthful behaviour. Many outreach models use a mixture of targeted, individual interventions and also make use of network-based interventions to reach their goals.

#### 3.1.2 Target Population

Outreach activities primarily target individuals who are engaged or exposed to harmful drug use and who are not currently receiving treatment for drug use disorders including those affected by other's drug use (the e.g., sexual partner, needle-sharing partners, significant others etc.).

### 3.1.3 Objectives

The initial efforts aim to identify affected populations, engage them and provide the necessary supports to provide community-based care, or refer to more intensive treatment modalities. The overall goals of the program are to prevent and mitigate potential for morbidity and mortality in affected communities.

Outreach work is possible anywhere with the existing barriers being access to funding and interference with local authorities. Education programmes are necessary for communities at large where the efforts take place in order to highlight the benefits of outreach programs and the serious effects a lack of response could be for the community as a whole.

### 3.1.4 Characteristics

Outreach programmes have been one of the most prevalent of treatment modalities due to their ability to reach populations that traditionally do not make contact with formal clinical treatment and care for a variety of reasons.

Given the often clandestine nature of these populations, it is essential that the outreach workers are knowledgeable of the communities they serve. These front-line workers require:

- Basic training to establish trust and recognize sources of accurate information
- Basic training in recognizing and responding to crisis situations
- Basic training in relevant health educations
  - Signs and response to overdose
  - Prevention and treatment of HIV, TB, hepatitis
  - Mental health and suicidal behaviour patterns
- Knowledge of 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 program itself should be flexible, adaptive, have a clear mission statement, mechanisms for monitoring and evaluation, as well as clear relevant documentation.

### 3.1.5 Treatment Models and Methods

Outreach programmes vary enormously based on the local situation. Normally the programme must provide something seen to be of value of people using drugs. It can vary from distributing sterile injecting equipment on the street and discussing safe injection

practices and overdose prevention to facilitating vaccination and basic health care, basic counseling (even group counseling), to unconditioned distribution of food and shelter provision.

### **Types of methods used**

Outreach program should be able to provide at minimum the following ‘core services’:

1. Provision of basic support (safety, food, shelter, hygiene and clothing)
2. Education on drug-effects and risks involved in drug use
3. Screening for substance use disorders
4. Brief Intervention to motivate change in substance use
5. Referral to substance use treatment
6. Needle exchange and condom distribution

Outreach interventions can be delivered through various modes of delivery and types of interventions such as:

- *Individual sessions*
- *Awareness programs*
- *Brief treatment*
  - *Pharmacological interventions*
  - *Self-help*
- *Personal skill development*

Outreach workers are frequently instrumental in providing a first-line screening of health related issues and facilitating a referral if additional services are needed. The following is a list of common health challenges among drug users:

- Common health care issues of a minor nature (i.e. respiratory tract infections, urinary tract infections, skin disorders).
- Urgent and more serious health problems such tuberculosis, sexually transmitted diseases, infections including abscesses and ulcers, injuries, and dental problems.
- Mental health problems such as anxiety, depression, and psychosis.
- Substance intoxication or withdrawals such as agitation and seizures.
- Chronic diseases such as diabetes, HIV, hepatitis B and C.
- Emergency care services related to overdose.
- HIV or hepatitis testing and immunizations (e.g., hepatitis B)
- Difficulty managing administrative aspects of life (i.e. paperwork necessary for government benefits)



### 3.1.6 Rating of the strength of evidence

The effectiveness of outreach programs targeting drug using populations, often involving risk reduction interventions targeting overdose, HIV, viral hepatitis and other infections, is supported mostly by quasi-experimental and large observational studies<sup>1</sup>.

### 3.1.7 Recommendations

- There is detection of intoxicated persons requiring treatment for intoxication and withdrawal syndromes in public spaces
- There are agreements between health and law enforcement personnel to ensure that drug related services are available in detention and custodial settings
- There is promotion of early intervention for drug related problems
- There is promotion in settings other than health-related facilities of early intervention
- 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 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
- Primary health care, other health care, welfare staff and police are trained during their education in the recognition, basic management and referral of individuals with drug related disabilities.

### 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 headcounts, job profiles, required qualifications and personal and moral bases. The structure and headcount takes into account the needs and current number of users of the service, their needs and organisation operations. The composition and additions to the team correspond to these needs.
- Prevention of work risks has been secured.

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<sup>1</sup> WHO

[http://www.who.int/mental\\_health/mhgap/evidence/resource/substance\\_use\\_q6.pdf?ua=1](http://www.who.int/mental_health/mhgap/evidence/resource/substance_use_q6.pdf?ua=1)



- Cases where a patient's/client's rights have been violated by an employee and the 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.

## 3.2 Screening, Brief Interventions, and Referral to Treatment

### 3.2.1 Brief definition and description of the setting

Screening and brief intervention efforts can be very useful in identifying people with substance use disorders (in non-specialist health settings, i.e. primary care, emergency care settings, hospitalized patients, ante-natal care settings, social welfare services, school health services, prison health services etc). These points of contact may be useful in leveraging health promotion activities and reducing negative health consequences of behaviours related to drug use.

Screening and brief interventions delivered in these settings may have a significant effect on enhancing motivation to change, changing substance use patterns, and, where indicated, linking individuals with higher risk substance use or substance use disorders to treatment. Screening, brief interventions, and referral to treatment 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 does not respond to brief interventions should be considered for referral for specialist assessment.

WHO, 2012

### 3.2.2 Goals

Routine screening in non-specialized settings can support the early identification of individuals experiencing problems related to their drug use and provide brief interventions which may help to prevent the escalation of drug use towards drug use disorders. Screening followed by a brief intervention for positive screens, carried out in a non-judgmental and motivational style, can be effective in altering the trajectory of people at

risk of developing drug dependence or experiencing other severe negative complications related to drug use and dependence.

Screening may also identify a smaller subset of persons with already more significant, chronic or complex substance use problems who will require more extensive assessment and referral for formal treatment.

### **3.2.3 Types of clients this setting is best suited for**

Detection of individuals experiencing substance use disorders occurs in a number of varied settings from emergency wards, primary care settings, or social services to name a few. Generally, first contact is not likely to be in specialized substance use disorder treatment services and associated professionals and clients themselves may not recognize problematic substance use. However, these settings often offer key opportunities to screen, intervene and mitigate the factors contributing to the emergence, presence, or management of substance use disorders.

Candidates for routine screening, brief intervention and referral to treatment include:

- General practice/ primary/ mental healthcare patients
- Hospital patients
  - Emergency rooms patients
  - Plastic surgery ward
  - Orthopaedic surgery ward
- 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
- People in contact with outreach services
  - People with alcohol- or drug-related legal offenses (e.g., driving under the influence)

### **3.2.4 Treatment models and methods used**

#### **Screening**

Screening is usually defined as a preliminary assessment that indicates the probability that a specific condition is present. The primary goal of SBIRT is to detect health problems or risk factors before serious diseases develop.

Personnel operating in different sectors (e.g., education, social services etc.) can be trained to efficiently administer validated, standardized screening tools as a part of their workflow. 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, inexpensive, and sensitive for the detection of possible problems associated with substance use.

Characteristics of a good self-report screening tool include that it is brief (10 or fewer questions), flexible, easy to administer, easy for the patient, addresses alcohol and other drugs, indicates the need for further assessment or intervention when appropriate, and that it has a clinically acceptable degree of sensitivity and specificity.

The accuracy of self-report can be enhanced when the patient is given written assurances of confidentiality, when the patient is interviewed in a setting that encourages honest reporting, when the patient is asked clearly worded and objective questions, and when the patient is provided with memory aids (calendars, response cards). Additionally, self-report can clearly be misrepresented if the patient is under the influence of drugs when making the report, but this should not preclude the initial screening process.

*Biological markers* may be useful when a patient is not be able to respond to an in-person interview but information is required to reach a differential diagnosis (i.e. an unconscious patient in intensive care). For conscious patients, it is preferable to ask about drug use.

Providers should use validated screening tools to identify potentially hazardous substance use and associated risk behaviors such as HIV-risk behaviors, violence potential, suicidal ideation, and reckless driving. The screening tools should be brief and provide clear guidance for service providers.

#### *Evidence-based self-report Screening Tools – a selection*

When selecting which screening tool to use, practitioners should select a tool that is standardized and empirically validated for use with the population being served. When screening results indicate a potentially serious problem, further assessments should be performed by specialized substance use disorder professionals upon referral to ensure adequate follow-up.

The **ASSIST** (Alcohol, Smoking and Substance Involvement Screening Test) has been developed 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 including injecting drug use. It has been especially developed for a primary care setting and is recommended in an interview format (WHO, 2010)

### **3.2.5 Brief Intervention**

According to the Lexicon of alcohol and drug terms (WHO 1994), a brief intervention is:

“a treatment strategy in which structured therapy of short duration (typically 5-30 minutes) offered with the aim of assisting an individual to cease or reduce the use of a psychoactive

substance or (less commonly) to deal with other life issues. It is designed in particular for general practitioners and other primary health care workers.”

Brief interventions often include screening people to identify hazardous and harmful substance use, as well as providing simple advice about associated health problems in a non-confrontational way, and to motivate and support the client/patient to think about behaviour change in relation to their use of psychoactive substances. Accurate assessment is the key to detecting problems that may arise from psychoactive substance use.

If it is available and necessary, the patient may be referred for 1-2 more additional sessions, or followed-up to see if further treatment is necessary.

The healthcare provider or practitioner providing brief intervention services should be trained in using motivational techniques to build rapport with the person, avoid defensiveness, and enhance intrinsic motivation to cease risky substance use before more severe problems develop. Brief interventions are a client-centered and strength-based approach which empowers the patient to take responsibility for the change process.

The components of effective brief interventions can be described 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

There are several basic steps in 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 with the challenge that brought them to this current session. Since the patient is placed at the center of the discussion, the practitioner will listen and use strategies such as summarizing and reflection to provide feedback. The patient will be asked to talk about change and to set realistic goals. At the end of the session, the practitioner will summarize and provide positive feedback to the patient, empowering them to continue to take responsibility for changing their behaviors.

### 3.2.6 Referral to Treatment

Persons who are screened and subsequently assessed as having a clinically significant substance use disorder or serious co-occurring condition should be referred immediately for treatment to the most appropriate facility or practice. In making such referrals, professionals should be trained carefully to use techniques proven to increase follow-through with the referral. These include strategies such as making the appointment at the treatment center with the patient present, use of ‘patient navigators’ who can accompany the patient to the treatment center, following up with the patient regarding enrollment in the

program, and other ‘warm handoff’ techniques. Initiating and providing drug treatment at the setting where SBIRT is delivered is another important strategy to improve outcomes in SBIRT with persons with drug use disorders.

### **3.2.7 Criteria for programme completion and indicators of effectiveness**

The major goal for SBIRT approaches is to reach large numbers of individuals who may have risky substance use or a drug use disorder but who would not otherwise be identified, encouraged to change their behavior, or offered treatment. Performance metrics for implementing SBIRT may include rates of screenings completed by each trained person within the care or service setting, the proportion of those who screened positive (unusually high or low numbers of positive screens may indicate a problem), the proportion of positive screens who received at least one motivational intervention session, the proportion of those with more serious screening results who received formal assessment and referral to treatment, and proportion of those referred to treatment who initiate treatment.

### **3.2.8 Rating of 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 dependent<sup>2</sup>.

### **3.2.9 Recommendations**

- An initial assessment is made in order to prioritize interventions in a coordinated treatment plan
- An assessment is made to detect complicating physical and neurological disorders
- A psychiatric/psychological assessment is made to detect complicating disorders (e.g., depression) which may influence the management of the patient
- An assessment is made of the social circumstances of the patient (e.g., family, employment, housing, financial, and legal position)
- Methods for the rapid identification of the substances used are available through either laboratory tests (e.g., urine, blood) or other procedures
- Laboratory and other facilities are available to assist in the assessment of physical and psychiatric/psychological states
- The assessment of patients employs standardized instruments and procedures, as well as being conducted utilizing established systems of classifications (e.g., ICD-10).

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<sup>2</sup> WHO

[http://www.who.int/mental\\_health/mhgap/evidence/resource/substance\\_use\\_q1.pdf?ua=1](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 headcounts, job profiles, required qualifications and personal and moral bases. The structure and headcount takes into account the needs and current number of users of the service, their needs and organisation operations. The composition and additions to the team correspond to these needs.
- Prevention of work risks has been secured.
- Cases where a patient's/client's rights have been violated by an employee and the 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 of a level capable of managing the symptoms and potential complications likely to occur in the context of drug withdrawal syndromes.

Short-term inpatient treatment provides a temporary respite for the person with drug use disorders, while minimizing the discomfort of the cessation of substance use. The length of stay varies from 1 to 4 weeks according to the local practices and the clinical need. Admission into inpatient treatment allows for monitoring and stabilization of relevant physiological and emotional indicators as well as separating the patient temporarily from the environment in which substance use has been taking place. Given that substance withdrawal syndromes and their 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 7).

### 3.3.2 Goals

The primary goals of short-term residential treatment are to stabilize the patient/client's physiological and emotional state, separate the patient/client from the environment in which hazardous substance use takes place; provide safe and compassionate reduction of withdrawal symptoms should they be present; and engage and motivate patient/client to further treatment. Usually short-term residential treatment is used as an opportunity to facilitate cessation of drug use and management of the drug withdrawal syndrome. Sometimes it may also be used to initiate maintenance medication treatment. In patients who express interest in the next stage of care planning and engagement into an appropriate form of continuing rehabilitative care should be initiated where possible.

Detoxification services are an important aspect of initiating treatment of a substance use disorder often serving as a point of entry into the continuum of care. Detoxification services are also an opportunity for engagement, education, and connection to relevant support systems to foster therapeutic alliances and promote an environment conducive to better health. 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, resulting in an increased risk of overdose post treatment.

### 3.3.3 Types of clients this setting is best suited for

Any person with drug use disorders may benefit from short-term residential treatment, although those in most need are those with potentially severe withdrawal syndrome following the cessation of drug use, and those for whom their current pattern of drug use is causing a significant risk of harm.

In general, people with opioid dependence have better outcomes with longer-term opioid agonist treatment, such as with methadone or buprenorphine, and are at increased risk of overdose following detoxification alone. In prioritizing patients for short-term residential services, preference is usually given to patients with greater severity of substance use and related health and social problems, among whom cessation of substance use and initiation of treatment and rehabilitation are unlikely to occur without medical management and a separation from the environment in which drug use has been occurring to initiate effective treatment.

The following factors should be considered when deciding whether a short-term residential treatment or another treatment setting is indicated for the particular patient:

#### *Type of substances being used and likelihood of withdrawal syndrome.*

Sedative and opioid withdrawal can be severe, and is highly likely for people using high doses over extended periods of time.



### *Severity of substance use disorder.*

The ICD criteria can be used to determine severity by summing the number of criteria met, and also considering the severity of each criterion. In addition scales such as the severity of dependence scale can also be used.

### *Severity of co-occurring medical and psychiatric problems.*

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

Short-term residential treatment provides 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.

A comprehensive assessment of the patient/client should be administered on entry into any treatment program that is as comprehensive as possible and include a medical history, presence of chronic and acute disease and related pharmaceutical therapies, as well as routine documentation of infectious diseases including HIV, tuberculosis, hepatitis etc.

### *Past treatment experiences*

A history of prior attempts to enter treatment is useful in designing a strategy that recognizes and can build on past successes and ways in which treatment may be better tailored to a patient/client's individual needs.

## **3.3.4 Treatment models and methods used**

Achieving the therapeutic goals of short-term residential treatment typically requires combinations of pharmacotherapy, motivational counseling, psycho-education on drug-effects and support through drug withdrawal. Other interventions can also be initiated such as introduction to behavioral therapy, orientation to self-help groups, social services, and the ability to arrange appropriate referrals for ongoing care after discharge. The specific types, amounts and durations of these therapeutic components differ depending upon the nature, complexity and temporal pattern of the substance use, as well as the presence of additional physical and psychiatric problems.

## **3.3.5 Treatment of withdrawal**

A group of symptoms of variable clustering and degree of severity which occur on cessation or reduction of use of a psychoactive substance that has been taken repeatedly,



usually for a prolonged period and/ or in high doses. The syndrome may be accompanied by signs of physiological disturbance. A withdrawal syndrome is one of the indicators of a dependence syndrome. It is also the defining characteristic of the narrower psychopharmacological meaning of dependence.

The onset and course of the withdrawal syndrome are time-limited and are related to the type of substance and dose being taken immediately before cessation or reduction of use. Typically, the features of a withdrawal syndrome are the opposite of those of acute intoxication.

The treatment of withdrawal 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 programs need to be knowledgeable about the various ways withdrawal syndrome can present itself, and be prepared to be both psychologically supportive, motivating the patient to get through the withdrawal phase, and able to prescribe effective medication treatments for withdrawal.

#### Opioid withdrawal

Pharmacological treatment for opioid withdrawal includes short term treatment with methadone and buprenorphine, alpha-2 adrenergic agonists (clonidine or lofexidine).

#### Sedative-hypnotic withdrawal

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

Sedative-hypnotic withdrawal can be effectively treated with long-acting benzodiazepines started at a dose sufficient to relieve withdrawal and tapered 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. Care should be taken to ensure that the treatment is not simply prolonging sedative-hypnotic use.

Short-term residential treatment programs need either to be capable of the medical management of these severe manifestations, or have the ability to transfer such patients to a medical hospital.

### Other withdrawal syndromes

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.

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

### **3.3.6 Evaluation and initiation of treatment for co-occurring psychiatric and medical disorders**

Short-term residential treatment begins with a medical and psychiatric history, physical and mental status examination, and laboratory evaluation. This is an opportunity to identify and initiate or stabilize treatment for medical problems that commonly occur among substance dependent patients.

Acute medical conditions often seen on admission can include: confusion, excessive sedation, poor respiration, hallucinations, seizures, unstable blood pressure, or fever to be managed prior to any further treatment or care. According to local conditions, mechanisms for treating opioid dependence should be combined with treatment for TB, HIV and hepatitis, to ensure continuity of anti-infective agents. A short-term residential treatment program may not have medical expertise, or the time within the short time-frame, to initiate treatment, but consultation and referral to appropriate care should be available.

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.

Co-occurring psychiatric disorders, including depression, post-traumatic stress disorder, and other anxiety disorders, as well as psychotic symptoms, are common among drug dependent individuals. A critical first step in the accurate evaluation of psychiatric symptoms among drug using individuals is to distinguish independent disorders from disorders that are substance-induced and will resolve with abstinence. Acute and chronic drug use, and drug withdrawal syndromes can produce many of the symptoms of depressive and anxiety disorders, included depressed or anxious mood, loss of interest, irritability, fatigue, insomnia, poor concentration, low appetite, weight loss.

### **3.3.7 Development of the treatment plan to follow short-term residential treatment**

Entry and engagement with a short-term treatment centre is an important step in achieving better states of health when an individual is experiencing a substance use disorder.

Associated health care professionals and their allies work together to provide patients/clients with the necessary resources, treatment and care to manage the different challenges and barriers they may face in achieving better health. Maintenance of sustainable healthful behaviours is of particular importance after patients/clients leave treatment as the risk of relapse and overdose increases significantly immediately after discharge.

The effective plan for a treatment to follow short-term residential treatment should include several strategies to maximize chances that the patient will successfully transition to the next level of care and will have maximal chance to maintaining successes in the residential treatment primarily to sustain medical and psychological stability and will remain in abstinence (relapse-prevention focus of treatment). Following treatment dimension needs to be considered when planning a discharge from residential to outpatient treatment or to a long-term residential program:

*Availability of social supports to promote abstinence or drug consumption reduction and recovery.*

An individual's social network may be influential to their patterns of drug consumption. Individuals involved in short-term inpatient treatment should be educated and made aware of the different factors that may be contributing to their hazardous use of substances and equipped with different strategies to create and maintain an environment that promotes health.

*Long-term medication treatment.*

For opioid dependence, the plan should almost always 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. These medications have strong evidence of efficacy, including efficacy for preventing relapse after a residential treatment stay. Ideally, the medication should be started during the residential stay, to be continued at the outpatient medication maintenance program.

*Follow-up care.*

Psychosocial care for substance use disorders needs to continue after a short-term residential treatment stay. For some patients with greater levels of addiction severity and lack of social supports, referral to long term residential treatment is indicated after a short-term residential stay. For some patients with lower severity and better social supports, outpatient treatment is a logical next step. Healthcare and social system navigation support should be present to address aspects of patient/client's life domains that may affect their capacity to maintain their treatment successes, vocational training, stable housing, etc.

An important goal of short-term residential treatment is to identify and initiate treatment for co-occurring disorders. Referrals need to be arranged to continue this treatment after discharge from short-term residential treatment. An ideal arrangement is for treatment for co-occurring medical or psychiatric disorders to be offered within the addiction treatment program. Patients are more likely to stay engaged in treatment if all treatment is integrated at one location.

### **3.3.8 Specific requirements (activities, documentation, staffing, etc.)**

#### **Treatment activities**

Short-term residential treatment programs for people with drug use disorders should include the following activities:

- Comprehensive bio-psychosocial assessment of the incoming patient
- Treatment plan which best addresses the needs of the individual
- 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 addiction treatment
- 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 program
- 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 for the addiction, and ongoing treatment for co-occurring medical and psychiatric problems.

At admission to short-term residential treatment a comprehensive medical and psychosocial evaluation of every patient should be conducted to determine the unique needs and treatment plan for each patient. This should include medical and psychiatric history, physical and mental status examinations. Recording of the findings, evaluation and plan on a structured evaluation note is recommended.

An evidence-based assessment tool such as the Addiction Severity Index (ASI), which evaluates severity of substance use problems and associated problems (medical, psychiatric, family, etc) can be administered by a trained staff member. A structured interview for psychiatric disorders such as the MINI, SCID, or CIDI-SAM may be considered and are particularly useful for both establishing substance use disorders and identifying co-occurring psychiatric disorders.

With the patient's consent, the patient's history and needs should be discussed with the referring agency, and/or with the patient's medical practitioner, particularly if the patient is receiving medication for the treatment of any physical or mental illness, and with the patient's outside therapist if available.

Small gaps in the continuity of treatment may be distressing for dependent individuals as is the risk of subsequent relapse. Essential pharmacological treatment options and services should be clear to individuals (as described in the section on outpatient treatment), and naloxone for the treatment of overdose. Higher doses of medication may be more safely administered in short-term residential treatment settings than in outpatient settings. If methadone and buprenorphine are used for opioid withdrawal management, typically it will be for a shorter duration.

#### *Hepatitis B vaccination*

Hepatitis B is common in many drug use populations, particularly (but not exclusively) 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 for people who have not had a complete course of hepatitis B vaccination before, and without necessarily testing serology beforehand (WHO, 2012).

### **3.3.9 Criteria for program completion and indicators of effectiveness**

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 motivation and development of goals and plans for treatment after discharge. The main long-term goal of treatment is to help the patient develop an ability to maintain a drug-free, healthy and functional lifestyle. The immediate goal during short-term residential treatment is to lay the foundation and establish the long term treatment plan that will serve those ends.

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

- Resolution of withdrawal symptoms
- Development of understanding by the patient of his/her addiction and related problems
- Development of motivation to engage in ongoing treatment after discharge
- 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

- Readiness to engage in continuing care in either long term residential treatment, or outpatient treatment setting following discharge

The effectiveness of a short-term residential treatment program can be evaluated with so called process measures (i.e. what services are delivered or goals met by patients during the treatment stay), or objective measures of patients' long term outcome after discharge. One such objective outcome measure would be the proportion of patients who engage in meaningful treatment for their addiction 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 has rarely been implemented, as it requires tracking and long term follow-up of patients.

### 3.3.10 Rating of the strength of evidence

- There is evidence from Randomized Clinical Trials (RCTs) that specific medications 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 treatment<sup>3</sup>.

### 3.3.11 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 and other interventions appropriate to the specific needs of patients, and to the different groups of drugs
- The protocols are firmly based on research findings wherever possible. If that is not possible, they are in keeping with accepted 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 use experienced by the drug user (health diet, use of sterile injection equipment)

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<sup>3</sup> WHO

[http://www.who.int/substance\\_abuse/publications/opioid\\_dependence\\_guidelines.pdf](http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf)

- 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 effects of the services to assess overall efficiency and efficacy (i.e., programme evaluation)
- Links exist between the dependence treatment programmes and other services facilitate interventions with children and other family members of drug abuser who have suffered psychologically or socially
- There is availability of (or transport to) emergency support in case of life threatening complications of drug use or withdrawal

## **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 headcounts, job profiles, required qualifications and personal and moral bases. The structure and headcount takes into account the needs and current number of users of the service, their needs and organisation operations. The composition and additions to the team correspond to these needs.
- Prevention of work risks has been secured.
- Cases where a patient's/client's rights have been violated by an employee and the 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.
- There are defined criteria for the management of specific risk situations (e.g., intoxication, suicide risk)



## 3.4 Outpatient Treatment

The outpatient treatment setting is that treatment and care for people who do not reside in the treatment facility. While the treatment facility may have the capacity for overnight care (i.e. a hospital), outpatients live at home and visit the treatment facility for their care. Outpatient services vary considerably in terms of their components and intensity. They can range from health education efforts to treatment centres providing continuing care and recovery management.

### 3.4.1 Target Population

Outpatient treatment is most appropriate for individuals who have sufficient social support and resources at home and in the community to participate in ambulatory care. Outpatient treatment is an ideal setting for providing long-term maintenance care for patients with substance use disorders, as the majority of substance use related problems can be managed on outpatient basis where both psychosocial and pharmacological interventions can be offered. The specific target population will depend on the specific outpatient intervention.

### 3.4.2 Objectives

The primary goals of outpatient treatment are to help patients to stop or reduce drug use; to minimize the medical, psychiatric and social complications associated with drug use; to reduce the risks of relapse to drug use and to improve their personal and social functioning, as part of a long-term recovery process. Another important goal to increase accessibility to treatment and health care for individuals severely affected by their condition who do not wish to accept hospitalization or residential treatment as the initial step of intervention.

### 3.4.3 Characteristics

Outpatient treatment programs for people with drug use disorders may look quite different from one another depending on the services' level of intensity they may offer.

#### *High-Intensity Interventions*

Programmes such as intensive day treatment may 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 bio-psychosocial assessment of the new patient
- Treatment plan which best addresses the needs of the patient



- Patient is able to influence care, participation is voluntary
- Medication-assisted detoxification from illicit drugs or alcohol, if indicated
- Initiation of maintenance medication for opioid dependence
- Contact with family and significant others to engage them in the ongoing treatment
- Behavioral and psychosocial treatment for addiction 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 program's expectations of the patient
- Ongoing evaluation of patient's progress in treatment, and continuous clinical assessment that is built into the program
- 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 for the addiction, and ongoing treatment for co-occurring medical and psychiatric problems.

#### *Mid to Low-Intensity Interventions*

Lower intensity interventions may involve weekly group support sessions, individual counseling, or health and drug education.

In the course of outpatient treatment, associated health care professionals may administer regular assessments of drug and alcohol use, and the physical and mental health status of patients. Routine cooperation with allied care services is essential. These include integration of outpatient treatment with infectious disease services for HIV, viral hepatitis, TB and sexually transmitted infections. This coordination should also enable the patient/client to navigate services at relevant psychiatric hospitals if inpatient level of care becomes necessary, e.g. in case of psychosis, suicidality, detoxification.

Outpatient treatment must also have routine cooperation with social support and other agencies, including education, employment, welfare, support sources for disabled, housing, social networking or legal assistance.

### **3.4.4 Models and Methods**

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

There currently does not exist definitive research prescribing a specific approach to treatment of individuals experiencing a drug disorder. Care components must be tailored to meet the needs of each patient/client. Scientific literature supports effectiveness of cognitive behavioral therapy (CBT), motivational interviewing (MI), and motivational

enhancement therapy (MET), family therapy (FT) modalities, contingency management (CM), drug counselling, and 12-step group facilitation among others.

### 3.4.5 Evidence-based behavioral and psychosocial interventions

Psychosocial interventions should be used in outpatient treatment programs to address motivational, psychological, social, and environmental factors contributing to substance use and are effective in promoting abstinence and preventing relapse. Psychosocial treatments can also be used to increase adherence to treatment and medications.

WHO Recommendations:
Psychosocial interventions including contingency management, and cognitive behavioural therapy (CBT) and family therapy can be offered for the treatment of psychostimulant dependence. Although many of the research trials use monetary reinforcement, use of contingency management should be adapted to the culture and population with input from patients.
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)

WHO Recommendation on Psychosocial interventions for the management of cannabis dependence
Psychosocial interventions based on cognitive behavioural therapy (CBT) or motivational enhancement therapy (MET) or family therapy can be offered for the management of cannabis dependence.
mhGAP, 2015

#### Cognitive Behavioral Therapy (CBT)

CBT is an effective and valuable approach in treatment of drug use disorders. CBT assumes that drug use patterns and processes are learned and may be modified. During treatment patients are introduced to new coping skills and cognitive strategies to replace the dysfunctional behaviors and thinking patterns. CBT therapy sessions are structured with a set of specific goals to be accomplished at each session and focus 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 is compatible 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. Monitored 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/client's 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 had greater abstinence during treatment as compared to patients treated as usual. 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 level of employment of drug users in treatment.

### 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 leverage behavioural modifications. MI is also promising as an approach to reduce high-risk behaviors such as unprotected sex and sharing needles. The efficacy of Motivational Interviewing has been demonstrated in many controlled clinical trials. Effects of MI appear to persist up to a year post-treatment.

### 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 addiction and the process of recovery.

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

Evidence demonstrates that in community settings, MDFT showed effectiveness in more dimensions than CBT while treating cannabis dependent adolescents, though both treatment models significantly reduced cannabis and alcohol use.

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.

### 3.4.6 Evidence-based pharmacological interventions

Medications can be very helpful in managing a variety of drug-related disorders such as treatment of drug intoxication and overdose, drug withdrawal, drug use disorder, and treatment of psychiatric complications related to drug use. Pharmacological therapies should be administered alongside psychosocial interventions.

### 3.4.7 Pharmacological Treatment

#### *Opioid Overdose*

Identified by a combination of three signs: 1) pinpoint pupils, 2) unconsciousness, and 3) respiratory depression, opioid overdose may be reversed with the use of naloxone. With a long history of clinical success and extremely rare adverse effects, naloxone should be available in all health-care facilities that may be called upon to respond to opioid overdose.

In some countries, prefilled naloxone syringes are distributed to patients and family members, in combination with training in resuscitation; such use may prevent overdose and evaluation of such distribution systems have been found to be positive. Naloxone distribution is likely to be an affordable approach to the prevention of opioid overdose, particularly where inexpensive prefilled syringes are available. While naloxone administered by bystanders is a potentially life-saving emergency interim response to opioid overdose, it should not be seen as a replacement for comprehensive medical care.

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 which 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 stabilize a patient's physical and psychological health in a way that is humane and keeps the individual's dignity intact while excretion of offending substance occurs. 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 along with specific medications to treat the symptoms of opioid withdrawal as they emerge (i.e anti-emetics, anti-diarrhoeals, analgesics, sedatives), however clinicians should prescribe these

medications for short periods only 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 and completion rates may be greater when psychosocial assistance is made available during the withdrawal management.

WHO Recommendations	
<p><b>Standard</b></p> <p>For the management of opioid withdrawal, tapered doses of opioid agonists should generally 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><b>Strong</b></p> <p>Clinicians should not use the combination of opioid antagonists with heavy sedation in the management of opioid withdrawal.</p>

*Opioid Use Disorder* generally has a chronic and relapsing course and therefore a long-term relapse-prevention treatment should be implemented for individuals who stop use of opioids and wish to remain abstinent. Relapse-prevention treatment should include a combination of pharmacologic 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 include:

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

## Agonist Opioid Treatment

WHO Opioid agonist maintenance treatment recommendations.	
Standard Recommendation	Strong Recommendation
Average buprenorphine maintenance doses should be at least 8 mg per day.	For opioid agonist maintenance treatment, most patients should be advised to use methadone in adequate doses in preference to buprenorphine.
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.	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 or eliminate the illicit use of opioids and maintain abstinence by preventing withdrawal symptoms, reducing drug craving, and decreasing effects of additional opioids if they are consumed.

### Methadone

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

Methadone has to be titrated slowly early in treatment to minimize the risk of methadone overdose. Once inducted safely, the goal is to achieve an optimal dose for longer-term maintenance to prevent cravings and use of opioids (so called ‘blocking dosage’). The optimal maintenance dose should eliminate opioid cravings while producing no sedation or euphoria to allow patients optimal functioning in all areas of their life. Daily administration of methadone is required in order to maintain adequate plasma levels and avoid opioid withdrawal.

Typically, effective methadone maintenance doses are in the range of 60–120mg/day, determined on an individual basis. To reach the optimal dose, it is important to consider individual factors, such as the ability to metabolize medication and the metabolic interferences by other medications that can change blood level of methadone such as HIV

or TB medications, psychiatric, or cardiac medications. Patients should be regularly monitored for adherence to the medication regimen.

#### 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

To minimize the risk of precipitated withdrawal when initiating treatment with buprenorphine, the first dose (2–4 mg) should be administered at least 8-12 hours after last use of opioid or when objective signs of opioid withdrawal become evident. In contrast with the approach recommended for methadone induction ('start low, go slow'), buprenorphine induction should proceed rapidly as the risk of toxicity is low due its partial agonist action.

Aims and principles of buprenorphine maintenance treatment are similar to those of methadone maintenance treatment. Effective maintenance may be achieved with buprenorphine doses in the range of 8–24mg per day, with a maximum daily recommended dose of 32mg. Alternate-day dosing, using double the daily dose, may be considered in patients who require daily supervised doses and do not require an alternate daily dose of more than 32mg. Compared to methadone, buprenorphine has less drug interactions of concern with other commonly administered medications.

Buprenorphine also comes in a formulation combined with naloxone is a single preparation (sublingual tablet or a film) which seeks to reduce the potential for misuse of the medication through self-injection, which has been observed.



**WHO Recommendations: Buprenorphine-naloxone combination**

The limited evidence is inadequate to support any recommendations on a buprenorphine–naloxone combination. However, the combination is likely to have similar efficacy to buprenorphine alone

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

Both methadone and buprenorphine are recommended to be administered daily under supervision at the start of treatment, with take home doses introduced according to local laws and an individual risk-benefit assessment.

**Antagonist opioid treatment with naltrexone**

Treatment with naltrexone can only be initiated following detoxification in individuals who have not used opioids for one week or more (e.g., those leaving residential treatment). Naltrexone is used to prevent relapse; it counteracts effects of opioids in case of use, and most patients, not feeling any effects, give up further attempts to use and remain abstinent.

In contrast to methadone or buprenorphine, naltrexone it is not a controlled substance, it has no abuse potential, and there is no withdrawal symptoms upon stopping treatment as patients treated with naltrexone are not physically dependent on opioids. Naltrexone can be useful in patients who: 1) do not have access to treatment with agonists, 2) have high motivation for abstinence from all opioids, 3) are detoxified and abstinent but are at risk of relapse (e.g. released from a residential program or prison), 4) tried but failed treatment with agonists, and 5) are successful on agonists but would like to discontinue it and be protected against relapse.

Naltrexone is available as an oral tablet that 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 preparations (given as injection or an implant) that can maintain blocking levels of the medication for 3-6 weeks after a single dose.

**WHO Recommendation for Opioid antagonist (naltrexone) treatment.**

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

### Pharmacological Treatment of Psychostimulant-Related Disorders

Psychostimulants such as amphetamines and cocaine are one of the most frequently abused and problematic illicit substances in many parts of the world. There is no well accepted medication proved consistently useful in the management of Psychostimulant Use Disorder. At present, medications are primarily used to manage co-occurring psychiatric disorders.

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

Antipsychotic and sedative medications may be used to manage psychotic syndromes resulting from acute intoxication. As more than half of patients with a psychostimulant use disorder have a co-occurring major psychiatric disorder, such as major depressive disorder, bipolar disorder, or schizophrenia, appropriate psychotropic medications play a major role in managing these patients. Frequently patients with psychostimulant use disorder have another substance use disorder, such as alcohol or opioid dependence, and 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-Related Disorders

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

#### **WHO Recommendation on Psychosocial interventions for the management of cannabis dependence**

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

mhGAP, 2015

### Pharmacotherapy of co-morbid mental disorders

Many patients presenting for treatment of substance use disorder also experience significant psychiatric symptoms such as depression, post-traumatic stress, mania, or psychosis. Many patients who stopped using psychoactive substances experience anxiety or insomnia soon after cessation of drug use.

These symptoms may respond to medications, however sedative-hypnotic medications such as benzodiazepines should not be used as a first line of treatment as they have a higher potential to be abused. Rather, alternative medications should be used, such as sedating antidepressants or low-dose neuroleptics, in addition to behavioral treatment such as relaxation and cognitive behavioral strategies.

### **3.4.8 Recovery Management and Social Support**

Recovery management approach includes a variety of activities that promote and strengthen internal and external resources to help affected individuals voluntarily resolve problems related to drug use and actively manage the vulnerability to recurrence of such problems. Some of those activities are already present in patient's home, neighborhood and community contexts while other can be developed. The following factors and activities have been found to increase social reintegration and improve chances of stable remission from substance use disorders the maintenance of recovery:

- A supportive partner and a network of 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 and spiritual involvement that provides a way to attribute meaning to life's stressors and develop a stronger purpose in life
- 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
- Increased 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

### **3.4.9 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 other approaches, and that some approaches are equivalent to other approaches which have shown to be effective. There is also evidence from RCTs that psychosocial support combined with Opioid Substitution Treatment (OST) is better than OST alone<sup>4</sup>.

- There is strong evidence from RCTs on the benefits of methadone and buprenorphine maintenance, and of the effectiveness of methadone and buprenorphine for detoxification<sup>5</sup>.
- There is weak evidence for the benefits of oral naltrexone for opioid dependence<sup>6</sup>.

### 3.4.10 Recommendations

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

#### **Outpatient Opioid Disorder Management**

- 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.
- Opioid withdrawal services should be structured such that withdrawal is not a stand-alone service but is integrated with ongoing treatment options
- 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 programme rules alone should not generally be a reason for involuntary discharge. Before involuntary discharge, reasonable measures to improve the situation should be taken, including re-evaluation of the treatment approach used.
- Laboratory or other facilities are available for the monitoring or progress and compliance with the treatment being administered

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<sup>4</sup> WHO

[http://www.who.int/mental\\_health/mhgap/evidence/resource/substance\\_use\\_q5.pdf?ua=1](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/](http://www.who.int/mental_health/mhgap/evidence/substance_abuse/q4/en/)

[http://www.who.int/substance\\_abuse/publications/opioid\\_dependence\\_guidelines.pdf](http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf)

<sup>5</sup> WHO

[http://www.who.int/substance\\_abuse/publications/opioid\\_dependence\\_guidelines.pdf](http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf)

<sup>6</sup> WHO

[http://www.who.int/substance\\_abuse/publications/opioid\\_dependence\\_guidelines.pdf](http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf)

### ***Assessment and Choice of Treatment***

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

### ***Availability of 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 headcounts, job profiles, required qualifications and personal and moral bases. The structure and headcount takes

into account the needs and current number of users of the service, their needs and organisation operations. The composition and additions to the team correspond to these needs.

- Prevention of work risks has been secured.
- Cases where a patient's/client's rights have been violated by an employee and the 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.
- 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

Long term residential treatment refers to care in a therapeutic facility which patients spend up to 24 hours for an extended period of time, usually between 6 and 24 months. Residential treatment for drug use disorders exists in a variety of forms, having developed independently in a variety of settings.

Residential treatment intended to produce therapeutic change must be distinguished from forms of supported accommodation that are primarily intended as a housing intervention not providing active treatment. This chapter does not address long-term supported accommodation, which is considered in the section on outpatient treatment.

The primary focus of treatment is on learning skills to control impulses to maintain abstinence and on developing new interpersonal skills, personal accountability, responsibility, and improving self-esteem. Long-term residential treatment programs have rules and activities designed to help residents examine dysfunctional beliefs about self and others, and destructive patterns of behavior 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.

While long term treatment can take place in a hospital environment, typically a psychiatric hospital, the most common form of residential treatment is the therapeutic community (TC) model, a hybrid of therapy and community living developed from programs of drug-free communal living with self-help philosophy. Other forms 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 program allows patients to be removed from the chaotic and stressful environment that might have contributed to continuing drug use and that make abstinence from drugs more difficult. In the new therapeutic environment that is free of drugs, 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 group of people living together to create a supportive environment for people with drug use disorders would necessarily qualify as a health care facility, nor be required to meet health care standards. However once a facility it makes claims about health care benefits, once it accepts funding for therapeutic purposes, it crosses the line into becoming a health care facility, with all the expectations contained in this document of health care facilities providing health services. 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 program's entire community, including other residents, staff, and the social context, as active components of treatment. The environment is "drug free" meaning that residents agree not to bring or use drugs (and usually neither alcohol) in the community grounds, or while resident in the community. Often psychotropic medication was also excluded, although this is changing in many TCs now.

Although the traditional model of long-term residential treatment include only the psychosocial treatment methods, the modern approach may involve the use of medications to decrease drug craving and diminish co-morbid psychiatric symptoms. Similarly, the confrontational style of interactions previously adopted in TC has been replaced by therapy focusing on improving relationships with others, strengthening patient's healthy and adaptive thoughts and behaviors and on enhancing motivation to change behavior.

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 program 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 help 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 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. There is no specific WHO guidance on therapeutic communities. Without commenting, therefore, 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 Goals**

The primary goals of long-term residential treatment are:

- to reduce the risk of a return to active drug use
- to assist the patient in regaining or attaining improved personal health and family, work and social functioning.

- to allow patients to develop effective interpersonal relationships with other residents and staff while acquiring new social skills, gaining self-confidence and receiving appreciation for positive behaviors
- to help patients acquire new habits to support healthier lifestyle such as good nutrition, a stable sleep/wake routine, and routine health monitoring and adherence to treatment.
- To give patients the opportunity 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.

To accomplish these goals residential setting provides opportunity to treat psychiatric and addictive disorders using medication and therapy but also helps to develop:

- 1) skills to cope with cravings and life stressors without drugs,
- 2) interpersonal and communication skills to build a network of friends who are abstinent,
- 3) new habits to support healthier and productive life such as good nutrition, stable sleep/wake routine, health monitoring and treatment adherence.

### 3.5.3 Target population

Patients who are unlikely to maintain abstinence outside of a structured setting to improve their life quality, or to participate in health and social integration. Long-term residential programs 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 addiction, and initiating changes in multiple life domains to facilitate transition to the process of recovery.

Residential treatment services are typically indicated for the following groups of patients:

- Individuals experiencing increasingly severe drug-related difficulties, such as patients with chronic drug use disorders and related problems that significantly undermine their education, employment and social integration process,
- Individuals with a history of unsuccessful treatment, not responding to pharmacological and psychosocial treatment in outpatient programs or short-term residential facilities,
- Individuals with limited personal resources and in a marginalized roles
- Individuals with significant social and family problems, with a chaotic family life, limited social supports and social isolation
- Individuals affected by severe co-occurring mental health disorders that may seriously affect their health and security outside the structured setting (although this group may require hospitalization more than TC treatment)
- Individuals with difficulties in interrupting their affiliation to criminal groups and drug dealing networks
- Individuals who recognize the need and prepared to significantly change life-style and acquire new responsibilities and skills

### 3.5.4 Treatment approaches

Different treatment programs usually develop their own slightly different approaches. Treatment may begin with a detoxification period, or this may occur prior to admission. Usually in TC's the therapy consists of a mixture of group and individual therapy, with community members sharing the tasks of daily living also as a form of therapy. Some are based on the 12-step approach, some use structured psychosocial approaches such as CBT, and others use a less well-defined kind of collective wisdom. While residents are generally supportive of each other, most communities provide for limited scope for provision of feedback, which may be at odds with the way residents view themselves.

### 3.5.5 Treatment Methods

#### *Assessment*

Residential treatment programs should conduct a comprehensive psychosocial evaluation of every patient entering the program to determine the unique needs of each patient and consider their suitability for that setting. Patients with greater mental and physical health problems may need a setting with appropriate level of medical / or psychiatric care.

An initial phone-based assessment may be used prior to the in-person evaluation. The initial meeting allows the staff to become familiar with the prospective patient and it is the first step in developing a therapeutic alliance. During this first meeting prospective residents frequently make the final decision to enter the program and an accepting and welcoming attitude can influence this decision. With the patient's consent, the patient's needs should be discussed with the referring agency and with the patient's medical practitioner, particularly if the patient is receiving medication for the treatment of any physical or mental illness.

All people admitted into a residential treatment program should have a comprehensive assessment, as a foundation to develop a treatment plan that best matches their needs. The assessment may include an tool such as Addiction Severity Index (ASI) or a Composite International Diagnostic Interview Substance Abuse Module (CIDI-SAM).

The following are important areas of evaluation:

- Previous short and long-term treatment received and perceptions of this previous treatment
- Current living conditions, including safe accommodation or 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 to support long-term sobriety
- General health, including any current health concerns, physical, sensory, or cognitive disabilities

- Mental health, including trauma history, abuse history (physical, emotional and sexual), violence and suicide risk, current psychological and interpersonal functioning
- Education and work, including school and work history, vocational training level and needs, income (legal and illegal)
- Legal problems, including criminal activity and any links to drug use
- Leisure activities, hobbies

The unique nature of the residential treatment setting, with the observation over an extended period creates an opportunity for a thorough evaluation. It also allows evaluation after an initial period of abstinence for drugs to assure that the evaluation is not affected by the effect of drug intoxication or withdrawal and the patient fully understands the nature of treatment and is able to fully consent to it. Living with peers and the staff allows for assessment of temperamental and personality traits which can be very useful to help with individualizing treatment to help develop skills to develop and manage relationships after discharge.

Every program should have a written intake policy to assure that admission to the program is voluntary (written consent of the patient) and free from any discriminatory influence. Such a policy clearly describes the eligibility and exclusion criteria. In addition, programs should have a written intake/orientation procedure, which is used for all incoming residents. During the intake process, new residents should be well informed and receive written information about the program including program objectives, the treatment methods used, and the program 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 program staff, the underlying philosophy influencing treatment environment, and the expectations of any visitors, including clear information about visitations. And finally, during this initial intake procedure, administrative details such program's cost and payment methods should be discussed. Staff of the program should be well trained in these policies and procedures.

#### Non-acceptance into a program

If a potential resident is not to be accepted to a program, a full explanation of the reasons for non-acceptance should be clearly explained verbally, and provided in writing to the potential resident and, where feasible, to the referring agency. If a potential resident is not accepted, an appropriate referral must be made. The evaluation staff must be aware of appropriate alternative services for referrals, and a network of services must be pre-established.

#### **Treatment Engagement**

Higher levels of treatment engagement can predict more positive treatment outcomes. Factors that foster treatment retention include client and program variables such as:

- 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 service staff
- Inclusion of relapse prevention training.

The first few days in treatment are the key time to focus on clients' engagement and assure that they remain in treatment, as the risk of dropout and relapse is highest during this period. Dropping out continues to be common during the first three weeks in treatment. During that time many residents may continue to experience psychological distress related to protracted withdrawal (insomnia, anxiety, irritability, drug craving), may be ambivalent about giving up drugs, and may find it difficult to adapt to the rules of the program. Therefore, it is important that residents receive individualized attention focused on enhancing motivation to remain in treatment. Retention in the early stages of residential treatment may also be improved by educating the patient about treatment thus reducing natural anxiety about "what will happen". Information sessions should cover themes such as: the program's philosophy and expectations as well as its approach to treatment and recovery, program's retention and health outcomes, and frequently encountered concerns that residents have during early phases of treatment.

To address wavering motivation for treatment and ambivalence about change program staff should implement the following:

- Maintenance of a friendly and welcoming atmosphere
- Establish a therapeutic alliance built on trust as early as possible in the process
- Rapid response to requests for treatment in order to maximize the client's motivation
- Focus on the client's immediate concerns, not those of the program
- Provision of more intensive support to clients during their first 72 hours in treatment through methods such as closer observation, increased general interaction and the use of a "buddy system" (pairing of new resident with an established resident)
- Caring and respectful approach in all aspects of the treatment program, as confrontation often results in anger and early drop out
- Give objective feedback about the problem and the 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.

## **Therapeutic Interventions**

At a minimum, long-term residential treatment (mainly those based on the therapeutic community model) should provide drug and alcohol free environment and a variety of regular group meetings (e.g., morning meetings, non-confrontive groups, special groups for female residents, peer evaluations groups), and some opportunity for individual psychosocial support if needed. Program rules should have clear procedures for admission and discharge and consequences for negative behavior, and a clear structure of activities and responsibilities in the residence. Hospital-based residential programs should provide medical and psychiatric care, individual and group therapy, and sessions with family members.

Long-term residential programs may include a broad range of therapeutic modalities such as individual and group psychosocial intervention, life skills training, employment or training options and recreational activities. Specific psychosocial treatment methods that may be utilized include: Cognitive-behavioral Therapy, Motivational Enhancement Therapy, Social Skills Training, and Cognitive Restructuring techniques. Structured Relapse Prevention and active practice of relapse prevention are essential elements of therapy in preparation for re-integrating residents into the community. Evidence-based interventions that are routinely used in the outpatient treatment setting could be adapted and used in the long-term residential treatment setting (see chapters 6.4.2 and 6.4.3). Therapeutic interventions such as art and creative therapy, movement therapy, meditations, relaxation and physical activity (exercise and group sports) can help patients discover and develop new hobbies and recreation activities that can continue after the return to the community and support recovery.

As employment is vital to recovery, many long-term programs include interventions to prepare residents for work, including educational services, vocational services and job training. Young adults may have an opportunity to complete the general school curriculum or learn new trades. Vocational services include job counseling, interviewing coaching, resume writing and job application/placement services. Job training allows residents to learn skills and develop confidence. Treatment programs use work and learning new skills, as a therapeutic intervention integrated with other methods, to prepare residents to re-enter the community following successful completion of treatment.

Interventions that should be avoided include: harsh verbal confrontation or shaming techniques, punitive or restrictive techniques (including physical restraints), approaches such as counter-conditioning, punitive interventions, or shock therapy, and any other intervention that compromises individual safety or dignity,

## **Length of Treatment**

A sufficient duration and intensity of treatment is necessary to ensure that behavioral changes have been consolidated and internalized, and to prepare residents for return to the community. This time varies for each resident. People who stay at least 3 months in long term residential treatment usually have better outcomes when they leave treatment.



If a residential treatment program is struggling to retain clients they may change their program to include a short-term residential evaluation and orientation period before any decision to undertake long-term residential treatment. Additionally, the duration of treatment can be reduced by providing a step-down approach with halfway accommodations that provide continuing care and can be used in combination with outpatient treatment. It is also essential to make sure to support family members, including services to accommodate children and psychosocial services integrating relevant family members.

### **3.5.6 Specific program requirements**

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

- Comprehensive bio-psychosocial assessment of the incoming resident
- Treatment plan which best addresses the needs of the individual
- Treatment contract which clearly outlines all treatment procedures, services and other policies and regulations as well as program's expectations of the patient
- Ongoing evaluation of patient's progress in treatment, and continuous clinical assessment that is built into the program
- Discharge planning with relapse prevention and continuing care strategies for the period after residential treatment

#### **Documentation**

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

- A consent to treatment and agreement to follow program rules to be signed by new residents once they are accepted into a program
- Signed confidentiality and ethics policy
- Appropriate treatment and management plans for each resident, developed with input from a treatment team and including the patients input
- Resident records updated regularly with details of treatment, progress and any changes to the original goals
- A completion summary on the resident's record at the end of the program (advise the resident of its contents)

#### **Staffing**

Medical supervision is required of the therapeutic aspects of TCs and other long-term residential treatment. Depending on the size of the TC, usually a team of trained professionals and volunteers is necessary for the delivery of optimal care in the long-term residential treatment program. Counsellors, nurses and social workers should be present in the program at all times.



At a minimum, medical doctors, including if possible psychiatrists, should be on call, or available for a certain numbers of hours every week. Facilities with residential treatment of co-occurring mental health disorders need the presence of the medical care on site every day with the “on call” availability during the night.

Individuals who are themselves in recovery such as former residents of a similar program can be valuable role models for the residents. Preferably they have had a job outside a treatment program before they are hired as staff. They should also have followed 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 they are hired, preferably as a resident. There should be a strict code of ethics for the staff. Staff should refrain from humiliating or degrading measures for residents and advocating personal beliefs. Optimally, an external board provides oversight to assure that TC directors do not abuse their power.

### **Safety requirements**

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

The physical environment of the program where residents stay for many months is important. It should not look like a prison or a hospital but as a home. Abstinence from alcohol and drugs should be required and assured. However, psychoactive medications used under medical supervision to treat psychiatric or addiction 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.

Some behaviors are not acceptable in the residential program and may be grounds for the removal from the program. This usually includes use of drugs or alcohol, violence, stealing, and sexual activity between residents. Programs may choose to implement a policy that includes regular toxicology screening with additional screening on returning from the pass outside the facility and when drug use is suspected. Procedures to report unsafe incidents such as physical or sexual abuse should be in place. There should be clear procedures for responding to breaches of program rules and values, with differing levels of response to reflect the specific circumstances. Contact with visitors should be monitored or supervised, and possibly restricted, particularly in the early stages of treatment.

### 3.5.7 Criteria for program completion and indicators of effectiveness

During treatment, residents are regularly monitored and periodically evaluated with the goal of providing the resident with feedback regarding progress towards treatment goals and his/her readiness for program completion.

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

- Improvement in physical and mental health
- Understanding of factors and triggers that may contribute to relapse as well as demonstration of skills to recognize them and manage drug craving
- Improvement in social functioning and willingness to move away from network of people using drugs towards social networks valuing abstinence and recovery
- Development of new hobbies and interests to continue following discharge
- Readiness to engage in continuing treatment and recovery maintenance following discharge
- Ability and motivation to engage in work and contribute to the life of the community

Some long-term residential treatment programs offer a transitional or re-entry treatment phase during which residents gradually spend increasing amount of time in the outside community (pursuing school or work) but are still residing in the program. This period of increased contact with the wider community while maintaining the safety, stability, and support provided by the program gives the residents 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, within a network of program support. The focus of this re-entry treatment period is to prepare residents for a final discharge from the program.

### 3.5.8 Rating of the Strength of evidence

There is a very limited amount of rigorous controlled studies evaluating 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 effective<sup>7</sup>.

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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 client members' physical health
- Where clients 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 headcounts, job profiles, required qualifications and personal and moral bases. The structure and headcount takes into account the needs and current number of users of the service, their needs and organisation operations. The composition and additions to the team correspond to these needs.
- Prevention of work risks has been secured.
- Cases where a patient's/client's rights have been violated by an employee and the 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.
- There are defined criteria for the management of specific risk situations (e.g., intoxication, suicide risk)
- Discharge is based on determination 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 “after-care”, or social support represents a long-term recovery-oriented model of care for patients with drug use disorders that follows stabilization of abstinence achieved during outpatient or residential treatment. It focuses on reducing the risk of relapse to drug use by supporting change in an individual’s social functioning, personal wellbeing, as well as in their place in their community and wider society. Recovery management is focused on stabilizing, supporting and strengthening one’s recovery over the lifespan and moves the focus to the patient taking increasing personal responsibility for managing their disease building on the strengths and resilience of individuals.

Longitudinal studies have repeatedly demonstrated that treatment of drug use disorders is associated with major reductions in substance use, problems, and costs to society. However, post-discharge relapse and eventual re-admission are also very common. The majority of patients admitted to treatment have been in treatment before. The risk of relapse does not appear to abate until after 4 to 5 years of abstinence. Recovery however is possible. A sustained recovery is possible in up to 40% of patients with drug use disorders.

Ideally, residential and intensive outpatient care should both be followed by a step down to a less intensive level of care that continues long-term. Recovery-oriented continuing care is an alternative to often encountered care characterized by repeated episodes of acute treatment with post discharge aftercare limited to passive referrals to self- help groups. 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 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 coaching, active linkage to communities of recovery, recovery community resource development, and early re-intervention when needed. Rather than cycling individuals through multiple self-contained episodes of acute treatment, recovery management provides an expanded array of recovery support services for a much greater length of time, but at a much lower level of intensity and cost per service episode.

This increasing focus on a long-term management as opposed to single-episode treatment approach is supported by the evidence suggesting that drug dependence is best understood and managed as a chronic and relapsing disorder, similar to diseases like hypertension, asthma and diabetes, rather than acute illnesses such as injury or infection. Individuals affected by drug use disorders should be offered medical and psychosocial interventions over a lifetime, with intensity matching the severity of symptoms. The

continuing care, recovery management approach should include long-term pharmacological, psychosocial, and environmental treatment strategies to maximize chances of improvements across a range of outcomes, including substance use, physical and mental health, criminal behavior, risk-taking, and social functioning.

“Continuing Care” and “Recovery Management” (RM) are two terms that are used interchangeably to describe this aspect of care, characterized by longer duration and attenuated intensity. The use of the more recent term “Recovery Management” (RM) better describes the more comprehensive aims related to well-being and social reintegration, and a life course perspective for treatment efforts.

### **3.6.2 Goals**

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

Recovery can be successfully maintained by individuals who either remain actively involvement in treatment (take medication and attend regular therapy) and/or maintain engagement with broader community of recovering individuals such as self-help 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 supports focus on reducing stressful stimuli that could provoke the recurrence of compulsive drug seeking.

The resurgence of psychiatric symptoms that have been “masked” by drug use must be anticipated during early recovery. This will allow for the provision of appropriate treatment and care, including pharmacological and psychosocial interventions. In general, recovery-oriented care assists patients by improving and stabilizing a good quality of life and opportunities for social reintegration in the community.

### **3.6.3 Types of clients this setting is best suited for**

The majority of the patients treated for drug use disorders may need “recovery management” interventions for a long time after a treatment episode, at intensity matching

the needs of the individual. Patients with high disease complexity, in particular those with early onset drug use disorders who may have global impairment of functioning, low effective life skills and limited coping mechanisms for stress, need more intensive recovery management programs. Additionally, patients with a clinical history of multiple relapse episodes, poor family and community support, financial, legal and housing problems, physical and mental health disorders should be the best candidates to receive the support of recovery management. It is important patients with a high vulnerability for relapse are connected with appropriate and personalized components of recovery management before the discharge from long-term residential or intensive outpatient treatment program.

### **3.6.4 Treatment models, methods used, length and intensity of treatment**

Continuing Care and Recovery Management (RM) basic activities offer the patient opportunities, after being discharged from intensive treatment, to maintain stable relationships with the health care system, the social services and drug use disorders treatment facilities. In the most common cases, a counsellor will coordinate the case management, meet the patient frequently, provide positive indications and support, encourage engagement in the community and help manage stressful conditions. The counsellor will help connect the patient with other professionals who can be helpful in the process of social reintegration. In particular, he will refer the patient to social workers and psychologists, medical practitioners, sex and reproductive health professionals, legal services officers, in response to specific needs. All these interventions will be coordinated by the case manager in the perspective of continuing care.

#### **Principles of recovery management approach**

Recovery-oriented care includes the Strengths-Based Case Management which views recovery as more than the achievement of abstinence from drug use, but to also as a means to build meaningful and satisfying lives which will become a strong buffer against relapse. This approach is characterized by:

*Focus on increasing strengths rather than reducing deficits.* The recovery-focused approach seeks to identify, nurture and further develop a client's skills, talents, resources, and interests rather than emphasizing needs, deficits, and pathologies.

*Flexible rather than fixed approach.* A recovery-supporting program must respond to patient changes through modifications made over time, offering choice by providing a flexible range of supports and services to meet needs of the individual patient.

*Consideration for patient's autonomy.* Recovery management is a self-directed approach, rather than a mandated non-voluntary program, that encourages and supports individuals in making informed choices about their life and treatment. The importance of incorporating patient choices has been stressed in other areas of medicine, especially with regards to



the management of chronic diseases, and was found to increase individual's responsibility for their recovery.

*Participation of community.* Recovery management involves family, friends, and the whole community to strengthen social aspects of recovery as opposed to overcoming addiction in isolation. It encourages others to play a role in the recovery process and draws on the resources of the community, including professional and non-professional organizations, faith-based organizations, and schools. Members of family and community organizations are incorporated, when appropriate, in recovery implementation.

### **Treatment Activities**

Recovery management approach includes a variety of activities that promote and strengthen internal and external resources to help affected individuals voluntarily resolve problems related to drug use and actively manage the vulnerability to recurrence of such problems. Some of those activities are already present in patient's home, neighborhood and community contexts while other can be developed. The following factors and activities have been found to increase social reintegration and improve chances of stable remission from substance use disorders the maintenance of recovery:

- A supportive partner and a network of family members and friends that can monitor the stability of recovery, abstinence from drugs and compliance with treatment
- A 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 and spiritual involvement that provides a way to attribute meaning to life's stressors and develop a stronger purpose in life
- 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
- Increased 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 is associated with sustained recovery

### **Specific Requirements**

Any treatment plan should be developed with a help of a team of professionals with patient's involvement. Treatment plan should be individualized, and consistent with the management of other chronic illnesses. During the acute and/or intensive care programs treatment plans are modeled on a variety of health care professionals playing a central role. In contrast, During recovery-oriented care the focus of plan expands from the primarily medical, characteristic of earlier phases of treatment, to include social dimensions of recovery and includes other professionals such as social workers, psychologists, peer counsellors, tribal elders, clergy, as well as friends and supportive family members.



Recovery management treatment plan usually involves a regular monitoring or follow-up evaluations that can be done by a counselor, 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. Recovery checkups serve a role of an intervention by providing feedback on assessment, help identify barriers to maintaining improvement and discuss motivation to pursue recovery. The checklist may ask the patient to provide an update on their work performance, living conditions, coping 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. For example, a Recovery Management Checkup is an intervention that includes a structured interview or assessment as part of a regular follow up to assess the stability of recovery and to provide earlier detection of people in need of help and linkage to treatment

### **3.6.5 Criteria for program completion and indicators of effectiveness**

A recovery management approach adopts a “life course” perspective that shuns terms of “discharge” or “graduation” used in more traditional treatment models. It embraces the chronic disease management approach that aims to help individuals effectively manage their own health problem with a goal of improving their well-being. Recovery management is open-ended and may continue for a lifetime.

The success of recovery management programs should be evaluated with respect to its capacity to reduce the relapse rate (controlling drug use and avoiding the associated harms) and improve individual’s physical and psychological health, functioning, and social integration. Structured instrument that evaluate global functioning of the individuals such as Addiction Severity Index can be used to assess 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 of the strength of evidence**

This treatment phase describes a new and evolving conceptualization of drug use disorders treatment that does not stop after a single treatment episode, or after a short-term, after-care program. It is more a treatment approach than a specific intervention and thus is difficult to evaluate through the traditional Randomized Clinical Trials (RCTs) approach.

## Chapter 4: Special Populations

### 4.1 Treatment of pregnant women

#### 4.1.1 Treatment Principles

Women who have a substance use disorder and then become pregnant represent a unique population in need of treatment for substance use disorders for two reasons. First, a pregnant woman with a substance use disorder presents a challenge to health service providers because the health issue may impact both herself and her fetus – and, the treatment of which may adversely impact one or the other, or both members of the dyad. There are both medical and ethical challenges that come with providing treatment for drug use disorder to a dyad, rather than a mother and child separately. Second, many pregnant women with substance use disorders 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 both the mother and fetus and then the mother and child if the child is provided services too. Thus, there are often two ‘dyads’ that are involved in treatment of a pregnant mother with a substance use disorder – the mother-fetus dyad, and the mother-child dyad.

Issues for pregnant women with substance use disorders mirror the issues found for substance-using adults. Several of the issues are common to both men and women, such as lack of formal education or likely legal involvement. Several other issues may have a more adverse impact for women such as stigma, shame, and the lack of positive and supportive relationships – key reasons why women do not seek, enter or engage in treatment. Women may be 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. Finally, women have better long-term outcomes when they receive treatments that focus on the issues more commonly found in women with substance use disorders compared to treatments that lack such a women-centred focus.

World Health Organization has recently stressed the unique needs of treatment services for pregnant women with substance use disorders. Women should not be ejected from treatment nor prevented from receiving treatment on the basis of pregnancy alone. Treating women for a substance use disorder is usually no more complicated than treating

other populations of patients. Further, pregnant women with substance use disorders must have the same rights as other pregnant and non-pregnant persons. No woman with a substance use disorder should have involuntary abortions and sterilizations. Programs must have procedures and safeguards in place to prevent detention and forced treatment of pregnant women.

#### **4.1.2 Treatment Methods**

##### **Screening and Intake**

Programs that provide treatment to pregnant women with substance use disorders and their children will typically have a screening and intake procedure that allows for determination of suitability of the women for entry into the program. 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 the three problems might suggest that a woman be referred or transferred to a more specialized medical or psychiatric unit to manage the risk, at least on a short-term basis, prior to entry into the treatment program. Patient's needs and whether these fit with the services provided by the program should be considered the first step in establishing a patient-provider relationship and a chance to build rapport.

There should be written policy regarding screening and intake procedures to 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 and the indication what staff will have access to screening information.
- Policy regarding eligibility for admission to the program and what and how women are told about non-admission to the program and where else they could go to receive services so that acceptance and non-acceptance is fair and without bias.

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

##### **Assessment**

A clinical assessment would occur after a woman has entered into the program. Assessment has as its goal an examination of a 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 a woman's current life circumstances and gather information regarding her physical, psychological, family, substance use and social history to determine specific treatment needs, so that a treatment plan can be developed that matches her strengths and needs. Pregnancy

specific information such as when she is due, past pregnancies and where she plans to deliver is 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 and 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 treatment progress. Standards for assessment are similar to those standards for screening and intake as described above.

## **Treatment Planning**

Pregnant women with substance use disorders need to be considered to be part of a treatment team that focuses both on her health and her infant's health. A pregnant woman should not be seen as a patient to be passively informed of her health status, and her approval sought for a course of action. Rather, she should be seen as actively participating in treatment decisions that affect not only herself but also her child.

## **Treatment Approaches**

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

There are two distinct dimensions that can be used to organize such treatment programs: Setting and Type of Intervention. On one end of the treatment continuum setting would be outpatient treatment programs; on the other, full-time residential programs. Treatment interventions would 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 to achieve favorable outcomes. Women should not be denied treatment with opioid agonist medication only due only to her state of pregnancy. Opioid medication choices should be made on a patient by patient basis considering each women's individual characteristics. Both methadone and buprenorphine are effective treatments with favorable risk to benefit ratio but they are not always comparable in an individual patient. Research evidence shows a less severe neonatal abstinence syndrome (NAS) for buprenorphine than methadone exposure in utero, 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 reduces opioid use and allows the patient 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 to and reduce or eliminate drug use and maintain abstinence.

If a woman becomes pregnant while on either methadone or buprenorphine, she should continue on the same medication, especially when she has a good response to treatment. 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 model of women-centered comprehensive treatment includes treating the whole person and mother-child dyad that 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 all the above services is necessary but not sufficient to make a treatment women-centered. Rather, a women-centered treatment program for substance-using pregnant women needs to be sensitive to specific biological as well as cultural, social, and environmental factors affecting drug use in women in order to optimize the outcome of treatment

- Significant interpersonal relationships and family history play an integral role in the initiation of drug use
- Pattern of use, and continuation of substance abuse for women seeking treatment
- Support for recovery, and relapse
- 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 delay in treatment entrance or presentation for treatment in a more severe stage of the disease with additional medical and psychiatric pathology
- Stigma serves to deter treatment entry for women.
- Women often enter treatment for substance use disorders from a wider array of referral sources
- Treatment programs should be able to accommodate children to allow mothers to receive treatment
- Women may require adjustment of medication dosages
- Women are more vulnerable to risk of domestic violence and sexual abuse, and their children may be at risk of abuse therefore a liaison with social agencies protecting children and women may be helpful
- Women are more likely to engage in help-seeking behavior and in attending treatment after admission

- Women may require women-focus 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

### *Delivery Protocol*

Programs that include delivery services for pregnant women with substance 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 are needed. 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 substance use relapse and other adverse maternal outcomes and potentially infant outcomes if the mother is not able to care for the child.

### *Postnatal Treatment Protocol*

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

### *Breastfeeding*

Although every effort should be made to encourage breastfeeding in substance-using mothers, breastfeeding on the part of post-partum women should be evaluated on a case-by-case basis. Decision about breastfeeding is particularly complex in the case of HIV-positive mothers, and for mothers with other medical conditions taking certain psychotropic medications for which breastfeeding would be contraindicated. Other contraindications or precautions regarding breastfeeding would occur in the case of maternal use of inhalants, methamphetamines, stimulants, tranquilizers, and alcohol.

Specific guidelines on this issue have been published to help physician 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. Finally, it is important to recognize that many women may use more than a single substance, and little information is known about the impact on the newborn of multiple substances in breast milk. Hence, it is best in all these circumstances to reach clear, written agreements with mothers about their breastfeeding practices.



### 4.1.3 Specific requirements for the program

#### Staff Training

Any staff who have direct contact with patients (secretaries, office managers) must be knowledgeable and sensitive to the issues pregnant women face. All staff should be trained on who to contact if a woman goes into labor and where she should wait for staff to arrive or where she should go for medical help. Unlike other individuals who use substances, 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. Staff need to be aware of these feelings and concerns and be prepared to respond appropriately and supportively. Further shaming and stigmatizing women for substance use during pregnancy is not an effective 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 services received, proper documentation of the treatment of a pregnant woman for substance use disorders should include all of the elements specified for general population of patients with drug use disorders such as a treatment contract, individualized treatment and management plan, and a treatment completion summary. Programs that provide services to pregnant women with substance use disorders have an added burden regarding a proper documentation of all medical, psychiatric, and addiction services to assure that all necessary care is recommended and that there is an opportunity for a closely coordinated care between these various providers.

#### **Summary**

Treatment of pregnant women with drug use disorders is an evolving medical field. Best outcomes are for treatment that use all evidence based treatments while addressing the myriad of complex medical and psychosocial problems. With optimal treatment, outcomes of these mothers and babies can be significantly improved to assure that the children will be able to gain their highest potential and decrease the chance for the intergenerational transmission of drug addiction in those children.

## 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, neonatal sepsis, stillbirth, perinatal asphyxia, poor mother–infant attachment, deprivation, neglect, Failure to Thrive, and Sudden Infant Death Syndrome. 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). 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 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 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. Medication dose should be promptly escalated, 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, physical, sexual and emotional abuse. Children are used in war, terrorism, are subjected 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, are used in the growing, manufacturing, selling, buying, and 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 is the risk for more rapid progression to heavy use and use disorders. Children who use substances are unlikely to it as a problem for themselves or others in their lives; however, substance use – both their 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 treatment for this population is limited and although there is encouraging evidence that psychosocial treatment is effective in older children, guidance regarding treatment for children has often been based on research findings from treatments provided to adults or adolescents. However, such an approach to treat children with substance 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 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 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 a distinctive developmental period and adolescent brains are especially vulnerable to substance use disorders. Given the neurotoxic effects of drugs or alcohol on developing brain, substance use needs to be identified and addressed as soon as possible. Adolescents can also benefit from interventions for substance use even if they are not dependent on a 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 supports than do adults. Given 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 programs 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 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 programs that provide treatment to children will typically have a screening and intake procedure that allows for determination of suitability of the child for entry into the program. Thus, screening for three risk factors, at a minimum, is necessary as part of the admissions process: intoxication, threat for self-harm 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 her physical, psychological, family, and social history to determine specific treatment needs, so that a treatment plan can be developed that matches her strengths and needs. Standards use in screening and assessment of children should be no different than those use for other patient populations (see section 10.1.2 above).

#### **Treatment Planning**

Children with drug use disorders need to be considered to be part of a treatment team that focuses both on his physical and psychological well-being. A child should not be viewed as a patient to be passively informed of his health status, rather, he should be seen, along with his 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 agonist, especially methadone in adolescents when they are considered able to consent to such treatment and it should be used for adolescents with severe drug use disorder and high risk for continuing drug use. The consent should be provided by the parents and in compliance with national legislative policies. Adolescents with a short duration of opioid use disorder who have a lot of 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 to 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, the exchange of sex for drugs among girls than boys, at least portion of a treatment program 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 address in all children.

### 4.3.3 Specific requirements for the program

#### Staff Training

Staff need to be educated not only in the treatment of children and adolescents with drug use disorders, but about developmental milestones and their age-appropriate cognitive, language, and social development. Children especially may not have the cognitive complexity to discuss issues and ability to fully articulate their feelings. Staff must be aware of the legal status of children and the special protections that are in place for them. It is vital for staff to know and practice keeping same age groups together. It is well known that mixing older and more experienced substance users with younger less experienced patients can lead to worse outcomes for the younger children and adolescents.

#### Child Protection Policy

Programs providing treatment for substance use disorders to children, inclusive of adolescents, must have a child protection policy. This policy provides a safety net and protect children from or against: 1) any perceived or real danger/risk to their life, their personhood and childhood, 2) their vulnerability to any kind of harm and 3) social, psychological and emotional insecurity. Child protection refers to protection from violence, exploitation, abuse and neglect. It is integrally linked to every other right of the child. It should contain guiding principles that assert the respect for dignity, liberty and freedom of the child; the recognition of the best interests of the child; the belief that a child is entitled to express his/her opinion and can make decisions for him/herself; respect for the child's right to privacy and confidentiality; no tolerance of any form of abuse whether direct or indirect; belief that child protection is the responsibility of all staff, administration, board of directors, consultants, interns, and volunteers. It should also contain a code of conduct documenting what individuals should and should not do.

#### Physical Space

Regardless of the type of treatment setting, several issues must be considered. The name of the program should avoid stigmatizing, addiction-related names. The program should have a child-friendly atmosphere, including free and open play spaces with adequate play materials both indoors and outdoors. An adequate number of toilets and washrooms are needed for both staff and children. Classrooms should have adequate space for children to sit and move around freely. For residential centers there should not be overcrowding with adequate spaces between beds. For example, there should be at least 2 feet between each bed. Children ages 7-13 need to be segregated from children that are 14 years of age or older to avoid negative influence. Additionally, older children should sleep in separate areas, taking into consideration cultural and safety considerations.

#### Documentation

Programs that provide treatment to children and adolescents should have clear and detailed records of services provided. Each child should have a registration number to track the child and a separate documentation file. All files must be locked with every child's confidentiality and privacy maintained. Treatment staff must have access to records that



document the child's treatment course and status at last contact with a treatment staff member. Children should not be overburdened with documentation.

## **4.4 Treatment in Criminal Justice Settings**

### **4.4.1 Brief definition and description of the setting**

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

It should be noted that the three International Drug Control Conventions do not compel Member States to enforce criminal justice sanctions for use and possession for personal use. The provision of treatment and rehabilitation services as a complete alternative to criminal justice sanctions, including incarceration, is clearly articulated for minor drug-related crime. Those who use drugs regularly and end up involved in the criminal justice system are often offered drug treatment services in an effort to break the on-going cycle of drugs and crime. In confined settings, such as in jails and prisons, the criminal justice system has a "captive" audience that can benefit from providing effective treatment services. For those not confined, treatment services can be provided under a variety of conditions, such as probation or parole, diversion and drug court programs, and when appropriate, police referral to treatment rather than arrest. By making sure those who need treatment services receive them, significant decreases in drug use and criminal activity are likely to occur and public health outcomes are increased (e.g. decreased spread of Hepatitis C, HIV, etc.). Left untreated, individuals who have an extensive drug use and criminal history will most likely continue using drugs and committing crime, and posing a serious on-going public health threat.

Providing drug treatment and rehabilitation services in the context of the criminal justice system must be based on the same principles of evidence-based treatment like in any other medical field. In addition, the following principles relevant to this specific context apply.

### **4.4.2 Goals**

Evidence-based approaches, including interventions based on assessments of an individual's level of recidivism risk and criminogenic needs, can be effective in breaking the drug-crime cycle. The primary goal of 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 desired outcome. Similarly, providing high intensity treatment services to those with less serious



drug-related problems also can be problematic, and sometimes can even make the situation worse by exposing the individual to others who are at a higher level of risk and needs. Decisions regarding matching individuals to intervention services and the tailoring of services to specific risk 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**

It is critically important to identify the most appropriate type of individuals that should receive drug treatment services and continuing care in the context of criminal-justice environment. People who use drugs and those with different degrees of severity of drug use disorders without any criminal behavior should not be incarcerated on account of their drug use. The criminal behavior observed in most individuals with drug use disorders is most often secondary to the drug use disorder, criminal acts are sometimes committed to finance the 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 using drugs. The offer of effective drug treatment is the best public health and public security response for individuals with drug use disorder and secondary low-level criminal offenses.

Populations suitable for treatment interventions in the context of criminal-justice system are those who have a drug use disorders and some degree of involvement in criminal activities that is to some extent independent of drug use. Drug use and criminal behavior in a person with drug use disorder could be independent or linked, but in any case the interference between these two problematic behaviors, in addition to interference from many other problematic life domains, changes the trajectory of each problematic behavior, usually for the worse, as evident by a greater level of criminal recidivism and more frequent relapses in individuals with drug use disorder that are also involved in crime.

#### **4.4.4 Treatment models and methods**

##### **Fundamental principles**

##### **Screening and Assessment is the key to treatment matching**

Within the criminal justice system, the screening process often is considered part of determining “eligibility” for treatment. Subsequent assessment is used to determine “suitability,” such as results from a psychiatric assessment to determine if placement in a dual-diagnosis program is warranted. Because much of the information used in the screening and assessment process is based on self-report, it is critical that collateral sources of information (e.g., drug test results, correctional records) also be obtained when making treatment placement decisions. For example, within a community supervision setting, successive positive urine test results may need to trigger a referral to treatment services even if the individual denies using drugs.

Based on screening and assessment results as well as a review of existing information, concrete criteria to determine the most appropriate type and intensity of treatment need to be established and made part of policy governing treatment in criminal-justice setting. In particular, criteria for establishing drug use problems that require professional intervention as well as the degree of “criminal thinking” that warrants intervention need to be based on objective criteria, not on the subjective opinion of an interview or brief encounter with the individual. The optimal type and level of treatment, including the choice of the most cost-effective intervention, will depend on the careful assessment of the severity of individual’s problems and the level of risk they pose to society. This is achieved through the proper use of validated screening and assessment instruments.. Unfortunately, individuals with serious drug problems often are referred to a “one-size-fits-all” treatment approach without consideration of the individual’s level of risk and needs.

#### *Risk for Re-Offending Principle*

The most effective programs are those that can appropriately match the type of intervention to the individual patient. It is well established that programs that only provided sanctions or that provided services not based on the risk of the individual had little to no impact on outcomes, and in some cases, were associated with poorer outcomes than the untreated comparison groups. As a result of these findings, many criminal justice systems have adopted an approach of reserving 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 or not.

#### *Need Principle*

The Need Principle states that services for individuals involved in the criminal justice system should focus on “criminogenic” needs, on addressing behaviors and attitudes that are associated with recidivism and that are amendable to change as a result of providing targeted treatment services. Specifically, services should target changes in antisocial attitudes, feelings, and associates. 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 arena has concluded that there are four general categories of criminogenic need that need to be addressed: history of antisocial behavior, antisocial personality pattern, antisocial cognition, and antisocial associates, with four additional areas that warrant consideration (substance use, family, school or work, and leisure and recreation).

#### *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 within 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 based on deterrence and punishment, as well as those that lack structure, should be avoided.

#### *Equity of services*

The basic premise of health service provision in the criminal justice setting is that health services should be similar in type and scope to what is available at the community level. The sentence availed should not deprive that person of his right to access the health care service needed.

#### *Linkage to services at the community level*

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

#### *The structure of the treatment services*

Most programs begin by providing individuals with highly structured treatment services, including a stringent toxicology monitoring, and reduce the intensity of services over time as progress is being made. Effective programs 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 and punishers needs to be used far less frequently and administered in a timely and sure manner when used (e.g., immediate increase in the frequency of urine testing when 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 involved in criminal-justice system it is important that a treatment program can adequately address additional needs of patients such as housing, legal, financial, and family problems.

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

To assure that the patient will remain drug and crime free, treatment should continue beyond the primary treatment episode (aftercare). Sustaining treatment benefits require a continuum of care that is designed to assist an individual in transitioning to 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 on-going care, such as: 1) fragmented nature of the criminal justice system, 2) lack of coordination between criminal justice practitioners and treatment providers, 3) absence of incentives and sanctions for individuals to remain drug free following unsupervised release from jails and prisons, 4) lack of community treatment programs, and 5) the fact that treatment providers often are inexperienced in treating individuals involved in the criminal justice system.

## **Treatment as an alternative to incarceration**

After years of increasing prison growth, alternatives to incarceration have been explored as a means for reducing the prison population. One of the popular approaches is to identify “low risk” individuals and providing them with intensive court or community supervision as an alternative to prison. This often includes requiring community-based treatment as a condition of supervision. This approach has been embraced for several reasons, including the fact that it gives the courts more sentencing options, saves resources, and helps keep families and communities together. Non-incarceration approaches for minor drug-related crime are specifically allowed under the drug control conventions.

### **Drug courts**

Drug courts are an increasingly popular approach to providing an alternative to incarceration. A specialized branch of courts (drug court) is created within existing jurisdictions to oversee court-supervised drug treatment and community supervision to individuals who have serious drug-related problems. The structure of drug courts varies, but most require participants to complete random urine tests, attend drug treatment counselling, meet regularly with probation or court officers, and often participate in self-help groups.

Unlike the standard adversarial court proceedings, drug courts are considered supportive environments where judges will praise and reward individuals for successful program participation, limiting “punishment” to those who do not comply. While a promising diversion approach, the use of drug courts often is limited to non-violent individuals who have few (or no) prior convictions. In some cases, the drug court option is only provided after a plea of guilty occurs, therefore treatment is not immediately available to those involved in the criminal justice system that have an immediate need for it. In most drug court programs, however, individuals who successfully complete the program avoid prison or jail time and, in many cases, can have certain convictions (e.g., drug convictions) removed from their record.

### **Community corrections**

Community corrections is another alternative to incarcerating 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 remaining drug-free, supervision requirements may require participation in treatment services. For the most serious offenders, intensive supervision probation (ISP) is often used and includes more frequent monitoring by the law enforcement practitioners as well as more frequent meetings. The use of “day reporting” is another option where individuals must report to a location like a probation office on a frequent (usually daily) basis. In some jurisdictions, there are treatment options dedicated to those under ISP 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 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 the process of providing treatment services to those on under court or community supervision. As described above, this can include drug courts as well as different types of community supervision instead of incarceration. But in many cases, the drug-related offense does not warrant consideration of incarceration. In these cases, an individual can be placed directly under community supervision with a requirement that they receive probation or court supervised treatment services. Although their freedom is curtailed, those under community supervision retain access to alcohol and drugs in the community, and therefore are at greater risk for continued drug use. And unlike those who are incarcerated, individuals in the community often struggle with meeting basic needs, such as finding appropriate housing as well as employment, contributing to their daily stress. However, remaining in the community helps maintain positive family relationships and address negative relationships (e.g., domestic violence).

#### **Treatment interventions**

In general, treatment intervention should be that same as available to general population (as described in prior chapters), with some considerations to address unique characteristics of individuals in criminal justice setting. However, treatment must always be voluntary and with an informed consent. All persons who access services, including individuals under the supervision of the criminal justice system, should have the right to refuse treatment.

Medication-assisted detoxification is often required as a 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, but it can be dangerous.

Outpatient treatment approaches that involve a period of intensive treatment followed by less intensive outpatient treatment provide a “step down” in treatment intensity and is particularly suited to those receiving intensive treatment services while incarcerated and who need continued, but less intensive, services once they return to the community. Decreasing intensity over time should be based on whether or not an individual is meeting the goals of treatment.

Residential treatment can be provided in dedicated units within a prison. Such programs are particularly valuable when targeting specific high risk populations, such as young offenders, females, those with psychiatric disorders. The dedicated residential environment allows for minimizing exposure to those who might victimize the individual (e.g., general prison population) and provides the ability to specifically target areas pertinent to the subgroup (e.g., addressing trauma among victimized women). Clients in residential programs 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 to accomplish goals, this is a potentially highly-effective comprehensive treatment approach for those individuals with a history of problematic drug use. This approach, however, should not stand alone; all residential treatment should be followed by on-going services after the residential treatment program is completed.

Therapeutic community (TC) is a model of residential treatment that can be adapted to the prison population and has been found to be effective in randomized controlled trials (Smith et al., 2006). Prison-based TC programs should be located in a separate unit of the prison with the structure and services similar to comparable programs outside. The participation in this kind of 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 drug use and should be avoided. Such ineffective approaches typically incorporate a highly regimented, military-style schedule combined with confrontation, discipline, and behavior modification, in an effort to instill discipline and a strong desire to live a drug and crime free lifestyle in order to avoid the shock of experiencing these types of programs.

Self-help groups can provide critically important 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 many reject the use of medication-assisted treatment, it is important that these factors be considered before recommending or requiring an individual to participate in one.

Pharmacotherapy can be among 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 but the sole fact of involvement with criminal justice should not play a role in making recommendation for medication-assisted treatment.

To reduce the risk of opioid overdose on discharge from prison, persons with a history of opioid use and their families and friends should be given naloxone to take home along with training in its use in the management of opioid overdose.

#### **4.4.5 Specific requirements for treatment in custody environments**

Providing treatment within custody environments presents an array of complex issues that need to be addressed. These range from deciding on logistics, such as who should provide treatment, where should it be provided, and when should it be provided to taking steps to making sure the best possible treatment is provided.

One of the more complex issues relates to the most appropriate staffing of treatment programs. 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. The decision should be based on which approach is likely to achieve the best outcomes at the lowest possible costs, and in general the outcome depends 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 standalone treatment environments are not possible, then 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 sentence also impacts treatment decisions as an individual may be in the middle of treatment and then be released from prison prior to completing treatment. Agencies need to consider the amount of time an individual will be incarcerated and then require completion of assigned treatment services prior to 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 effective 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 the social care services and other community services. At the systems level it needs to be ensured that treatment services are

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

The availability of services capable to treat patients with drug use disorders is a very first step.

The accessibility of such treatment services refers to their reach, which could be a matter of geographic proximity, threshold to access, attitude towards certain population groups and other factors.

The affordability of a treatment service is closely linked with its accessibility for patients. A treatment system also needs to be affordable for the health and social system at the same time in order to be sustainable.

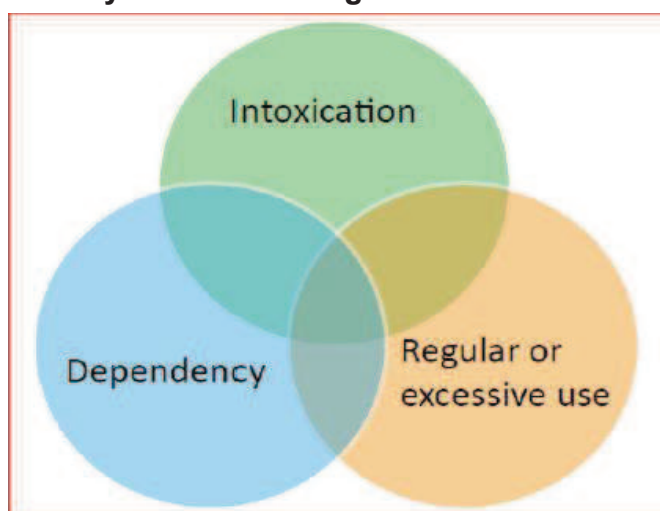
The evidence-base and therefore the quality of treatment services and what that requires has been discussed in this document at large. Given the overall limitations in funding available for the treatment of drug use disorders, interventions should be made available that have a good chance of being effective as they have proven in previously to be effective.

As for any other disorder, not one approach will fit for all, therefore a diverse range of interventions needs to be in place in various settings and at various stages of the disease to address the needs of people with drug use disorders. Recovery remains the ultimate perspective of all treatment and care services.

### 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 a similar way between intoxication, regular or excessive use and dependence (Figure “Thorley’s model of drug use”). 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 people are problem drug users and almost half of whom are people who inject drugs (PWID)(UNODC, 2015).

### Thorley’s model of drug use



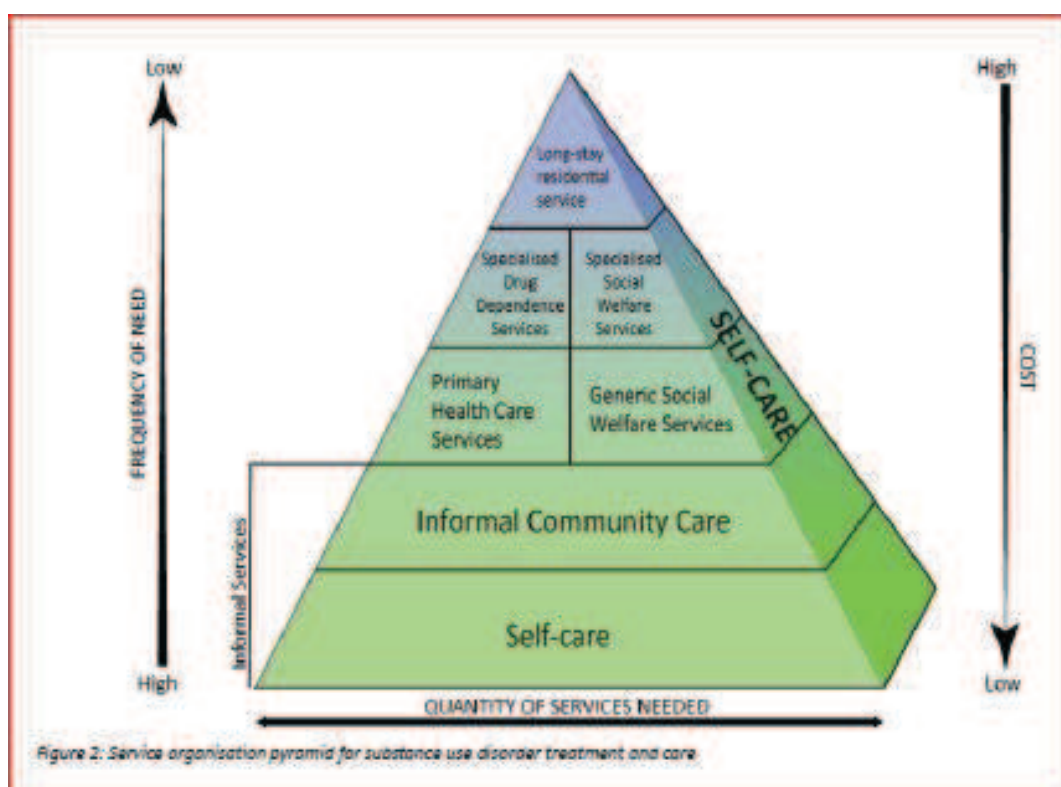
When developing a comprehensive treatment system to wisely allocate available resources and respond best to patient’s needs, the key public health principle to apply is offering the least invasive intervention possible with the highest level of effectiveness and the lowest cost possible. This is an important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

Evidence-based drug dependence treatment is a smart investment from a public budget perspective as the costs to treat drug use disorders are low 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 reduced drug-related crime, criminal justice and law enforcement costs and healthcare costs (NIDA, 2012).

Overall, the intensity and level of specialization of services should be corresponding to the needs and the addiction severity of patients– not one size fits all. Someone who has been taking drugs maybe once will obviously need a different type and intensity of support then someone with a long history of drug use and other related health and social problems.

As captured in the service organization pyramid (Figure “Service organization pyramid”), most services are required at levels of lower intensity and if implemented can prevent people from developing more complex drug use disorders. While more services will be required at the less intensive spectrum of the pyramid, these services are usually also less specialized and less costly, which makes a treatment system designed in line with the service delivery pyramid more cost-effective, always given that the actual services offered are implemented based on available scientific evidence (Figure “Service organization pyramid” and Table “Suggested interventions at different service levels”) as described in other chapters of this document. As drug treatment services at the outpatient level are in general less interruptive for patients and less costly for the health system, such services are recommendable from a public health perspective as long as the addiction severity of the patient allows.

### Service organization pyramid



### Suggested interventions at different service levels

Service level	Possible interventions
<b>Informal community care</b>	Outreach Self-help groups Informal support through friends and family
<b>Primary health care services</b>	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
<b>Generic social welfare</b>	Housing/shelter Food Unconditional social support Ensuring access to more specialized health and social services as needed
<b>Specialized drug dependence treatment</b>	Assessment Case management Treatment planning Detoxification Psychosocial interventions Medication-assisted treatment Relapse prevention Recovery management services
<b>Specialised health care services</b>	Mental health treatment Internal medicine Dental treatment Treatment of HIV and Hep C
<b>Specialized social welfare services</b>	Family support and reintegration Vocational training/Education programmes Income generation/micro-credits Leisure time planning Recovery management services
<b>Long term residential service</b>	Housing Vocational training Protected environment Life skills training Ongoing therapeutic support Recovery management services

However, in reality investments are too often made to a too high degree in highly intensive and highly costly treatment services at the top of the pyramid. This may lead to a situation where people with low addiction severity end up in highly intensive services, which is not a good investment of public funds, rather than matching the severity of the disorder with the intensity of treatment to maximize outcomes and more efficiently distribute resources. World Drug Report (UNODC, 2015) data show that globally a big gap exists 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. 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 a situation where people who use drugs only get in contact with the health system only when they have already developed highly severe drug use disorders instead of having received less intensive (and less costly) support in earlier stages of their disease. 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 help screen those in most need of further support from specialized drug dependence treatment services and this way contribute to reduced overall health-care costs.

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. Available data on drug demand and supply at various levels can provide important guidance on the design of a treatment system (UNODC, 2003).

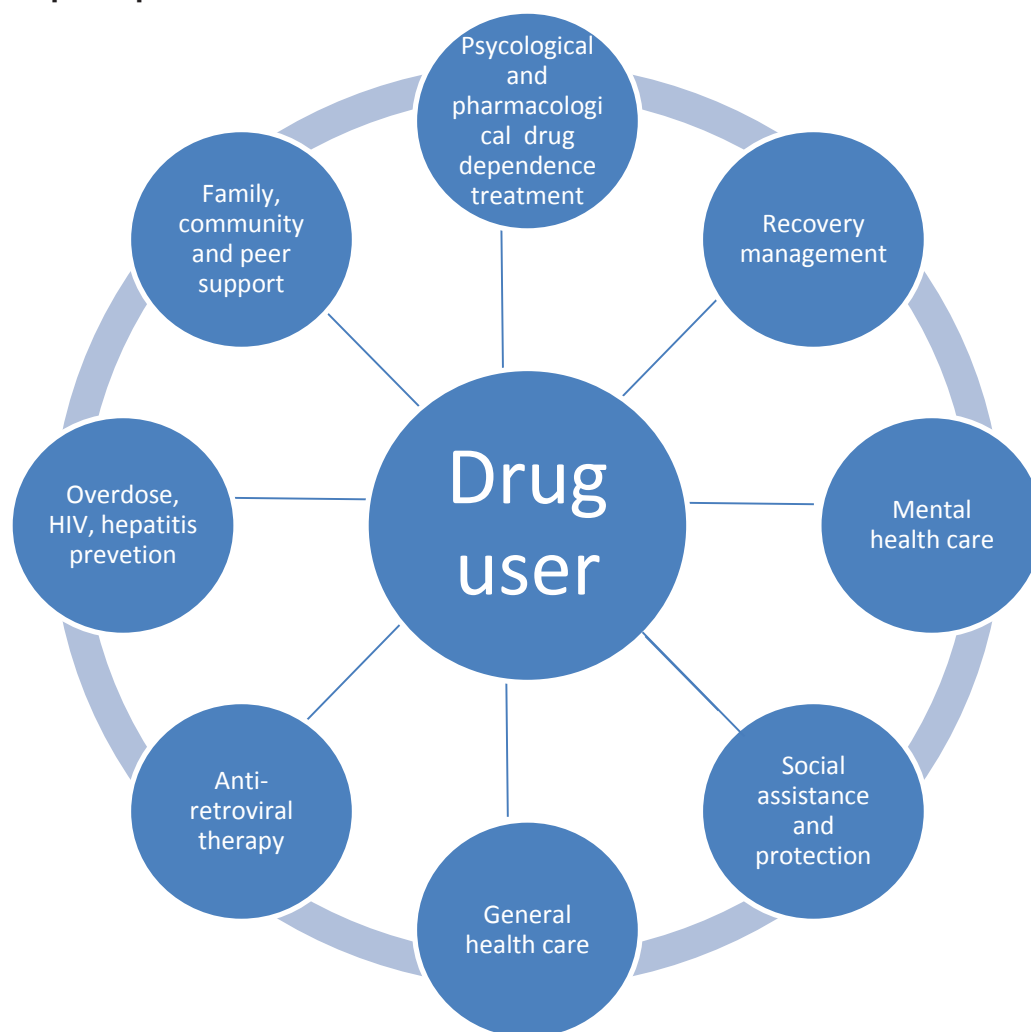
The non-availability of data or systematic data collection systems should not be an excuse for the non-delivery of drug dependence treatment and care services. Some of the indicators, such as the Treatment Demand Indicator (“service utilization for drug problems”) can actually only be effectively collected 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 for the treatment of drug use disorders**

Given the multiple needs of people affected by drug use disorders ideally a wide range of medical and social services should be literally available under one roof. Such an integrated service provision with the potential to remove barriers to treatment service provision (Rapp et al, 2006) could be described as a “one-stop-shop” that improves accessibility to comprehensive drug dependence treatment and care services (Figure “One-stop-shop”).

## One-stop-shop



In order to ensure access, there should be always a low-threshold entry level (outreach, drop-in) services with defined referral mechanisms to the actual clinical treatment services and the accompanying social services.

In the situation where the program integrating all services (one-stop-shop) cannot be realized the development of a coordinated comprehensive continuum of care, including various components of care system, can be developed. It includes the clinical services as a core element but offers many auxiliary services at the municipality/community level that share a mission and a vision and work in close coordination and with established referral mechanisms (see below).

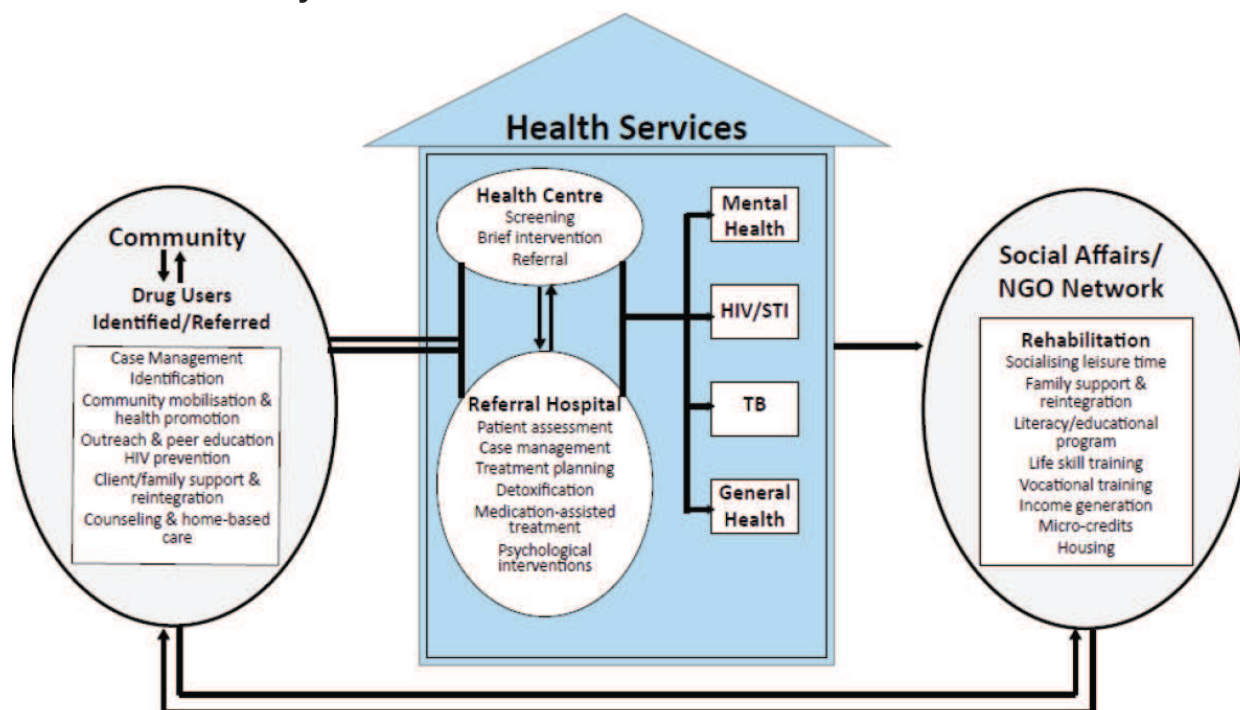
### **Treatment service organization model: Community-based drug dependence treatment and care**

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 (Figure “Model of community based treatment”).

### Model of community based treatment



In a community-based network broad partnerships can be formed not only between different services from the public health and public social sector but also with other community stakeholders. To coordinate all the services that are provided carefully it is beneficial to develop a locally effective community-based treatment approach, which aims to provide services utilizing all resources already available in the community. Community-based treatment services form a multifactorial and multi-sectorial approach to problems that may affect persons with drug use disorders. Such perspective 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 for a patient through effective referral and case management strategies to guarantee a continuum of care. The advantage of a community-based treatment network is that it provides a range of low-threshold entry point and eases access to different treatment and care services.

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
- Delivery of services in the community – as close as possible to where drug users live
- Minimal disruption of social links and employment



- Integrated into existing health and social services
- Involve and build 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
- Comprehensive approach, taking into account different needs (health, family, education, employment, housing) and a recovery perspective
- Close collaboration between civil society, law enforcement and the health sector
- Provision of evidence-based interventions
- Informed and voluntary participation in treatment
- Respect for human rights and dignity, including confidentiality
- Acceptance that relapse is part of the treatment process and will not stop an individual from re-accessing treatment services

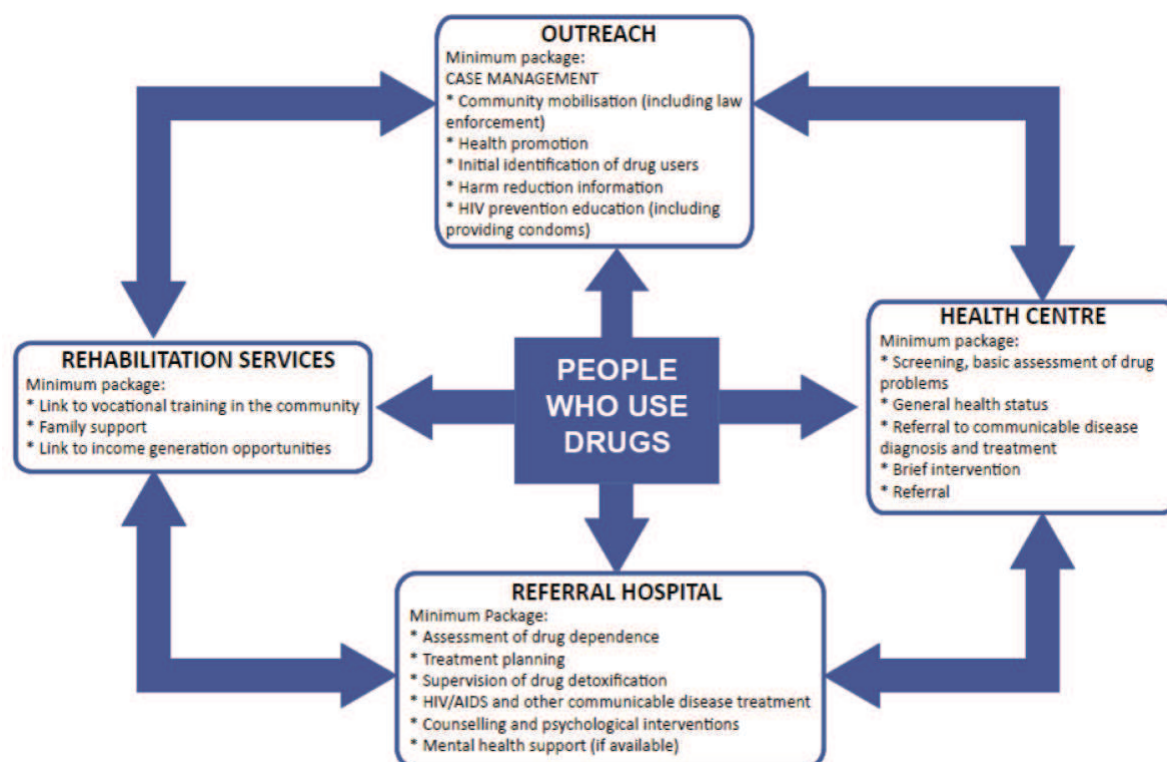
Health services such as primary health care, specialized drug treatment services, hospitals and clinics and social services (access to housing and shelter, food vouchers, etc.) are key partners in a community-based treatment and care network. Broader partnerships can though be formed also with other community stakeholders such

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

To make sure patients are linked and referred to the appropriate services that suit their needs, case management is an essential component. Case managers work with the client, other members of the treatment team, and other services or organizations, to select the best mix of interventions and support. Case management ensures that the network of referral and other ancillary support services remains accessible and resources are utilized efficiently. Case manager also provide a continuous assessment of the treatment progress. As drug dependence is a chronic disease it is likely that the patient will relapse

and be welcome to the network of services again. The following chart depicts a functioning case management system from the perspective of a person with a drug use disorders accessing the system and – as said above -an important feature is that there is “no wrong door”.

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



### The continued treatment service model: Sustained Recovery Management

Recovery is considered to be a “... a continuum process and experience through which individuals, families, and communities utilize internal and external resources to address drug dependence and substance abuse problems, actively manage their continued vulnerability to such problems, 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 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 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.

Recovery services can be implemented in a range of settings and stages of the disease 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.

### Essential supports for achieving rehabilitation and social reintegration



### Recommendations

- It is important to make best use of available data when planning for a drug dependence treatment system, but not necessary to wait for perfect data to deliver services
- In a treatment system, resources should be invested where they are most needed, initially with a focus on low threshold and easily accessible treatment and care services
- A one-stop-shop (a range of health and social services available under one roof of the integrated program) or an integrated network of health and social services in the community are models to deliver a continuum of care of accessible, affordable, diversified and evidence-based care for drug use disorders

- All treatment should be delivered with recovery as the ultimate focus and sustained recovery management services as an integral part of all treatment and care interventions

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