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Follow-up to the implementation at the national,
regional and international levels of all
commitments, as reflected in the Ministerial
Declaration of 2019, to address and counter the
world drug problem

UNODC/WHO International Standards for the Treatment of Drug Use Disorders[**]

I. Introduction

A. Objectives and target audience of the international standards

1.   This document, "The International Standards for the Treatment of Drug Use Disorders" (hereafter the Standards), is the work of UNODC and WHO to support Member States in their efforts to develop and expand effective, evidence-based and ethical treatment for drug use disorders.

2.   The Standards are intended for all those involved in the policy development, planning, funding, delivery, monitoring and evaluation of treatment services and interventions for drug use disorders.

3.   This document is based on currently available scientific evidence on treatment for drug use disorders and sets out a framework for implementation of the Standards, consistent with principles of public health care. The Standards identify major components and features of effective systems for the treatment of drug use disorders. They describe treatment modalities and interventions to match the needs of people at different stages and severities of drug use disorders, in a manner consistent with the treatment of any chronic disease or health condition.

4.   The Standards are aspirational, and such, national or local treatment services or systems are not expected to meet all the standards and recommendations made in this document all at once. However over time, progressive quality improvement, with "evidence-based and ethical practice" as an objective can and should be expected to achieve better organized, more effective, and ethical systems and services for those with drug use disorders.

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5.   UNODC and WHO invite those responsible for local or national policy development, planning, funding, delivery, and monitoring, and for the evaluation of treatment for drug use disorders, to review local systems and services for the treatment of such disorders against the Standards. They should identify gaps and areas that fall short of the Standards and work with the appropriate stakeholders to improve the systems and services. While many principles and sections of the Standards may also apply to the treatment of other mental and substance use disorders (such as those due to alcohol and nicotine use), the Standards' primary area of focus is on drug use disorders.

6.   The document sets the overall scene but does not attempt to provide all the necessary details for the organization, functioning and development of services. Additional tools, such as treatment guidelines, capacity building materials and toolkits for implementation, monitoring and evaluation, can be used for these purposes. The Standards maintain a degree of flexibility to ensure their applicability in different social, cultural and legal frameworks.

B. Objectives and target audience of the international standards

7.   The international community, in 2009, called on UNODC and WHO to develop standards for the treatment of drug use disorders. The call came in the form of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem, adopted at the high-level segment of the 52nd Commission on Narcotic Drugs. UNODC and WHO jointly established a Global Programme on Drug Dependence Treatment and Care to support evidence-based and ethical treatment policies, strategies and interventions to reduce the health and social burden caused by drug use disorders. To this end, the two organizations also sought to disseminate good treatment practices and promote parity of quality, availability and affordability of treatment for drug use disorders as that provided by health systems for any other chronic disease.

8.   UNODC and WHO developed the initial draft of the Standards based on the results of their previous initiatives regarding the treatment of drug use disorders. The initiatives included "Principles of Drug Dependence Treatment" (UNODC and WHO, 2008), UNODC "TreatNet" project (UNODC, 2012), relevant WHO guidelines and technical tools, as well as results of the work of other international organizations that have previously developed standards and guidelines on various aspects of treatment for drug use disorders. The International Standards for the Treatment of Drug Use Disorders (2016) document was released as a draft for field-testing during the 2016 Commission on Narcotic Drugs (CND). The (2016) UNGASS Outcome Document (UN, 2016), as well as 2016 CND Resolution 59/4 (CND, 2016) on the "Development and dissemination of international standards for the treatment of drug use disorders" reiterated the importance of disseminating "the Standards" to promote a balanced and health-centred approach to drug use disorders.

9.   WHO, working in collaboration with UNODC, field-tested "the Standards" to assess their comprehensiveness, appropriateness, utility, feasibility and evaluation capability, and identify areas for improvement. Methods used in the field-testing included: surveys, focus groups, expert reviews and testing services' compliance with "the Standards". The field-testing was carried out in countries with different health systems, including Australia, Brazil, Chile, China, India, Indonesia, the Islamic Republic of Iran, Mexico and Thailand. Over 1,200 health professionals participated in the field-testing survey, while 43 experts from countries participating in the field-testing provided detailed feedback on the draft Standards. Additionally, 43 focus groups comprising over 300 participants discussed the Standards, which were also presented and discussed at international fora, including: the WHO regional capacity building workshop for the management and care of substance use disorders, hosted by the National Rehabilitation Center in Abu Dhabi (UAE); the Interagency meeting on standards of care for problematic drug users in the Region of the Americas, hosted by the Pan American Health Organization in Washington D.C.; the First and Second

WHO Forums on Alcohol, Drugs and Addictive Behaviours; and the expert group meeting in Vienna during the International Conference on Drug Prevention, Treatment and Care of the International Society of Substance Use Professionals. Furthermore, several professional organizations and civil society organizations, including organizations of service users, were invited to provide feedback on *the Standards* during field-testing. Following an analysis of the preliminary results of the field testing, UNODC and WHO convened an expert group meeting to discuss the revision process and key changes to be introduced into the document upon completion of the field-testing process. This version of *the Standards* is a revised draft incorporating results of the field-testing.

10.   The Standards will benefit policy makers, managers of health and social services and practitioners working with people across the globe who have drug use disorders. They aim to help achieve health target 3.5 of the United Nations 2030 Agenda for Sustainable Development for "strengthening prevention and treatment of substance abuse" as well as universal health coverage for people with drug use disorders (WHO, 2019b, 2019c) for people with drug use disorders. The Standards will also support the evaluation and ongoing improvement of services as well as the development of new policies and treatment systems. This is an effective investment in the future of people with drug use disorders, as well as in their families and communities.

C.   Drug use, drug use disorders and treatment needs

11.   The use of psychoactive drugs or narcotic drugs and psychotropic substances without medical supervision is associated with significant health risks. For this reason, international treaties (such as the United Nations: Single Convention on Narcotic Drugs, of 1961; Convention on Psychotropic Substances, of 1971; and; Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, of 1988) regulate the production, sale, distribution and use of many of these substances with the aim of preventing negative effects that could significantly undermine health and security (UN, 1961, 1971, 1988).

12.   Traditionally, psychoactive drugs were mainly plant-derived substances such as cocaine, heroin and cannabis, consumed in the regions where they were grown or along trade routes to their final market. Increased global trade and travel are globalizing the market for plant-based substances that were previously largely confined to specific regions. In recent decades, new psychoactive substances synthetized in illicit laboratories have become more widely available and consumed in every region.

13.   The UNODC World Drug Report 2019 estimates that around 271 million people, or 5.5% of people aged 15 to 64 years worldwide – used an illicit drug at least once in 2017. Some 35 million of the people who used drugs (0.7% of the adult population) have drug use disorders. A proportion of disorders due to drug use are associated with the non-medical use of prescription drugs such as synthetic opioid analgesics (medicines for pain management), anxiolytics (medicines for the management of anxiety disorders and related health conditions), hypnotics (medicines for the management of sleep disorders), or psychostimulants (often used to manage attention deficit hyperactivity disorder). The increase in the availability of strong opioids and their use in the management of chronic pain in the last 10 years in some parts of the world has resulted in a dramatic rise in deaths from opioid overdose. Of the 11 million people across the globe who injected drugs in 2017, nearly one in eight are living with the Human Immunodeficiency Virus (HIV) and over half are living with the hepatitis C Virus (HCV), about half a million deaths worldwide were attributable to drug use in 2017 (UNODC, 2019).

14.   Although countries around the world are reporting increasing use of new psychoactive substances, these have not replaced larger-scale use of traditional drugs (UNODC, 2019). While globally opioids remain a major threat to public health, amphetamine-type stimulants are now not far behind.

15.   At least 8% of individuals who start using psychoactive drugs will develop a drug use disorder over time, with significant variations for different classes of psychoactive substances (Wagner and Anthony, 2002; Lopez-Quintero et al., 2011). According to the 11th revision of International Classification of Diseases (ICD) (WHO, 2019a) the term "drug use disorder" comprises two major health conditions: "harmful pattern of drug use" and "drug dependence". The harmful pattern of drug use is defined as a pattern of continuous, recurrent, or sporadic use of a drug that has caused clinically significant damage to a person's physical (including blood-borne infection from intravenous self-administration) or mental health (such as substance-induced mood disorder), or has resulted in behaviour leading to harm to the health of others. Substance dependence is defined in ICD-11 as a pattern of repeated or continuous use of a psychoactive drug with evidence of impaired regulation of use of that drug which is manifested by two or more of the following: (a) Impaired control over substance use (including onset, frequency, intensity, duration, termination and context); (b) Increasing precedence of drug use over other aspects of life, including maintenance of health and daily activities and responsibilities, such that drug use continues or escalates despite the occurrence of harm or negative consequences (including repeated relationship disruption, occupational or scholastic consequences and negative impact on health), and; (c) Physiological features indicative of neuroadaptation to the substance, including: 1) tolerance to the effects of the substance or a need to use increasing amounts of the substance to achieve the same effect; 2) withdrawal symptoms following cessation or reduction in the use of that substance, or 3) repeated use of the substance or pharmacologically similar substances to prevent or alleviate withdrawal symptoms.

16.   "Disorders due to drug use" comprise a broader category of health conditions that include drug intoxication, withdrawal syndrome and a range of drug-induced mental disorders. Drug use disorders often go hand-in-hand with a significant urge to use psychoactive drugs, which can persist, or easily be reactivated, even after a long period of abstinence. Very often drug use disorders are associated with hazardous or harmful use of other psychoactive substances such as alcohol or nicotine, or with alcohol and nicotine dependence.

17.   The nature of the drug dependence is rooted in a complex dynamic interaction between biological, psychological and social factors. Neurobiological mechanisms range from inherited genetic vulnerabilities to disruptions of neuronal pathways in brain areas that regulate functions such as motivation, experience of pleasure, memory and learning (WHO, 2004; Koob and Volkow, 2016). Various psychosocial factors may increase the risk of both the initiation to drug use and development of drug use disorders. Family-related factors such as early childhood neglect, child abuse and parental modelling of substance use may contribute towards harmful patterns of drug use and drug dependence. At a societal or community level extreme poverty, displacement, favourable norms and media towards drug use have been shown to increase vulnerability to drug use disorders (UNODC, 2015).

18.   In addition to drug use disorders, some individuals who use drugs develop other health conditions that often are associated with drug-related health risks and behaviours. Those who inject drugs are at high risk of exposure to blood-borne infections such as HIV or HCV, as well as to tuberculosis infection (TB). There is an increased risk of fatal overdose, road traffic and other injuries, cardiovascular and liver problems, violence and suicides. Drug dependence is associated with a reduced life expectancy: the mortality rate of people with opioid dependence is significantly higher than the rate expected in the general population and death occurs more often at a younger age (Degenhardt et al., 2018; GBD 2017 Risk Factor Collaborators, 2018).

19.   The relationship between substance use disorders and other mental health disorders is very complex. Often another mental health disorder predates the onset of substance use, putting affected individuals at greater risk of developing substance use disorders (WHO, 2004). Other mental health disorders may develop secondary to the substance use disorder, due in part to biological changes in the brain resulting from

substance use. The risk of developing drug dependence and psychiatric complications is particularly high when children and young adults are continuously exposed to the effects of drugs before their brain can fully mature, a process that usually occurs during the mid-twenties (J. Conrod and Nikolaou, 2016; Silveri et al., 2016).

20.   Many years of medical research has led to conclusions that drug dependence is a complex multifactorial health disorder with well-documented biological and psychosocial mechanisms of evolvement. Scientific advances also made it possible to develop effective treatment and care interventions that support individuals with drug use disorders in changing their behaviour to improve their health. The overall public health approach to drug use and drug use disorders prompted the development of interventions that reduce the short- and long-term harms to people using drugs. This has proved to be particularly useful for HIV prevention, treatment and care among people who inject drugs (WHO, 2012b).

21.   Perceptions of drug use disorders have been changing in recent times among policy makers, health professionals and the public. There is a greater recognition that substance use disorders are complex health conditions with psychosocial, environmental, and biological determinants, which need multidisciplinary, comprehensive and public health-oriented responses from different institutions and organizations working together. There is an increasing understanding that rather than being a "self-acquired bad habit", drug dependence is the result of a long-term interaction of biological and environmental factors including social disadvantages and adversities, and that it can be prevented and properly addressed to improve population health and public safety.

22.   Unfortunately, outdated views about drug use disorders persist in many parts of the world. Individuals with drug use disorders, their family members and professionals working with them generally face stigma and discrimination. This has significantly compromised the implementation of quality treatment interventions, undermining the development of treatment facilities, the training of health professionals and investment in treatment and recovery programmes. Evidence clearly shows that drug and other substance use disorders are best managed within the public health system, like other chronic medical problems such as HIV infection or hypertension. Nevertheless, the idea of including the treatment of drug use disorders in the health care systems still faces resistance, partly owing to a delay in transferring science to policy and ultimately to the implementation of evidence-based clinical practices.

23.   In some countries drug use disorders are still seen primarily as a public safety and criminal justice problem, with the relevant agencies of the interior, justice or defence ministries handling responses to drug use disorders by providing services, often without the supervision or engagement of the health ministry or other public health agencies and institutions. The exclusive use of law enforcement strategies and methods is neither an effective response to drug and other substance use disorders nor a cost-effective way of spending public funds. Biopsychosocial treatment strategies that acknowledge drug dependence as a multifactorial health disorder, treatable using medical and psychosocial approaches, can help reduce drug-related harms. This in turn will improve the health, well-being and recovery of affected individuals while reducing drug-related crime and increasing public safety and beneficial community outcomes (such as reduced homelessness, social welfare requirements and unemployment).

24.   Drug use disorders often take the course of a chronic and relapsing disorder. This implies that treatment services have to work with patients over the long term – often for years and sometimes during a patient's entire life – maintaining contact, offering crisis interventions and support when needed and at different levels of intensity. This is similar to the system of care for patients with other chronic diseases (such as diabetes, asthma and cardiovascular diseases). Such a system is designed to manage periods of remission, as well as disease exacerbations, by modifying interventions to match the severity of the problem at hand without raising the

expectation that a short-term treatment episode will bring about a cure. Recognizing the nature of drug dependence or ongoing drug use and the fact that they often involve relapses does not imply that managing them is ineffective and therefore useless. On the contrary, appropriate treatment delivered repeatedly (even in the face of ongoing drug use or intermittent relapses to drug use) is essential for preventing drug-related deaths. It helps improve health and the quality of life despite persistent ill health and frequent social problems. Effective approaches to the prevention and treatment of substance use disorders and their health and social consequences can reduce harms to patients and their communities, and enhance the chances of achieving a long and healthy life (UNODC and WHO, 2018).

25.   Many regions and countries are seeing a growth in the numbers of people with special treatment and care needs such as: children and adolescents; the elderly; women and pregnant women; different sexual identity and gender orientation groups; indigenous populations; migrants; illiterate people and those with limited education; people with comorbid health conditions including mental disorders, HIV, TB, and HCV; individuals in contact with the criminal justice system; individuals who are homeless or socially marginalized.

26.   The changing patterns in the use of drugs and other psychoactive substances, compounded by the changing profiles of people who use them and develop drug use disorders create new challenges for health care systems, which must adapt to the new realities in a timely, effective and efficient manner. This may require additional investments in prevention and treatment programmes, including the relevant human resources. Health care systems often struggle to respond appropriately to emerging new health problems among people who use drugs. For example, in parts of the world where opioid use was previously uncommon, health systems may lack the capacity to deliver medically assisted treatment, such as opioid agonist maintenance treatment, for opioid use disorders. Similarly, parts of the world where the treatment systems have focused on opioid use disorders are now seeing large increases in the prevalence of disorders due to psychostimulant use.

27.   According to UNODC and WHO global estimates, at best only one in six people who can benefit from drug dependence treatment has access to treatment programmes. This proportion declines in Latin America and Africa, where only one in 11 and one in 18 people who can benefit from drug dependence treatment has access to treatment programmes, respectively (UNODC, 2018). In many countries treatment is only available in large cities. The concept of universal health coverage should be as applicable to drug use disorders as it is to any other health condition. This would give people with drug use disorders and their communities access to the prevention and treatment health services they need, ensuring sufficient quality to achieve the desired effects, while also protecting service users from exposure to financial hardship (WHO, 2019c, 2019b).

28.   Drug use disorders are serious health conditions that present a significant burden for affected individuals, their families and communities. Untreated drug use disorders trigger substantial costs to society including lost productivity, increased health care expenditures, and costs related to criminal justice, social welfare, and other social consequences. The social cost of illicit drug use is estimated at 1.7% of the gross domestic product in some countries (UNODC, 2016). Providing effective treatment and care services for drug use disorders as part of an integrated and well-coordinated treatment system is therefore an investment in the health of people with drug use disorders. It is also an investment in the healthy and safe development of families, communities and countries.

II.   Key principles and standards for the treatment of drug use disorders

29.   Drug use disorders can be effectively treated using a range of pharmacological and psychosocial interventions.

30.   In the management of drug use disorders, the aim of treatment is to improve the health and quality of life of people with drug use disorders, and the ultimate objective is to help individuals achieve recovery to the extent possible. Specifically, treatment goals include to: *stop or reduce drug use, improve health, well-being and social functioning of the affected individual; and prevent future harms by decreasing the risk of complications and relapse.*

31.   Many interventions that are commonly used in managing drug use disorders do not meet accepted scientific criteria for clinical efficacy. Such interventions may be ineffective or even harmful: the necessary clinical trials may not have been conducted, and the treatment's effectiveness may be unknown.

32.   In addition to clinical effectiveness, the treatment of drug use disorders should meet the common standards of health care: *be consistent with the UN Declaration of Human Rights and existing UN Conventions; promote personal autonomy; and promote individual and societal safety.*

33.   The Standards define a set of requirements that have to be in place for any treatment modality or intervention to be considered safe and effective, regardless of the treatment philosophy that is used or the setting it is used in. This is critically important, because individuals with substance use disorders deserve nothing less than ethical and science-based standards of care similar to those applied to the treatment of other chronic diseases.

A.   Principle 1. Treatment should be available, accessible, attractive, and appropriate

34.   Drug use disorders can be treated effectively in most cases if people have access to a wide range of services that cover the spectrum of issues that individual patients may face. Treatment services and interventions must be based on scientific evidence, and match the specific needs of individual patients at a particular phase or severity of their disorder. The services include: community-based outreach; services in non-specialized settings; inpatient and outpatient treatment; medical and psychosocial treatment (including the treatment of alcohol and other substance use disorders as

35.   Standards:

(a)   Essential treatment services for drug use disorders should be available at different levels of health systems: from primary health care to tertiary health services, with specialized treatment programmes for substance use disorders;

(b)   Essential treatment services include: outreach services; screening and brief psychosocial interventions; diagnostic assessment; out-patient psychosocial and pharmacological treatment; the management of drug-induced acute clinical conditions (such as overdose, withdrawal syndrome); inpatient services for the management of severe withdrawal and drug-induced psychoses; long-term residential services; the treatment of comorbid substance use and psychiatric and physical disorders; and recovery management services delivered by trained clinicians;

(c)   Selected and properly trained peers can work in treatment services, providing specific interventions aimed at helping identify patients, engage them and retain in treatment;

(d)   Essential treatment services for drug use disorders should be within reach of public transport and accessible to people living in urban and rural areas;

(e)   It is necessary to extend low threshold and outreach services, as part of a continuum of care, to the "hidden" populations most affected by drug use, but often un-motivated to receive treatment or that relapse after a treatment programme;

(f)   Within a continuum of care, people with drug use disorders should have access to treatment services through multiple entry points;

(g)   Essential treatment services for drug use and related disorders should be available during a sufficiently wide range of opening hours to ensure access for individuals with employment or family responsibilities;

(h)   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;

(i)   If not otherwise accessible, affordable or available, treatment services should provide access to social support, general medical care and the management of comorbid substance use disorders, as well as psychiatric and physical health conditions;

(j)   There is a need to put information on the availability and accessibility of essential treatment services for drug use disorders within easy reach, using multiple sources including the Internet, printed materials and open access services.

B.   Principle 2: Ensuring ethical standards of care in treatment services

36.   Treatment for drug use disorders should be based on universal ethical healthcare standards – including respect for human rights and the patient's dignity. This includes responding to the right to enjoy the highest attainable standard of health and well-being and avoiding any form of discrimination and/or stigmatization. The individuals with drug use disorders should, to the extent that they have the capacity to do so, make treatment decisions, including when to start and stop treatment, and its nature. Treatment should not be forced or against the will and autonomy of the patient. The patient's consent should be obtained before any treatment intervention. There is a need to maintain accurate and up-to-date clinical records, and guarantee the confidentiality of treatment records. It is critical to avoid circumventing health records in registering patients entering treatment. Punitive, humiliating or degrading interventions (such as beatings, chaining, withholding of treatment and food, etc.) should never be used. A strict code of ethics for staff should apply. Staff should refrain from advocating personal beliefs and should not use humiliating or degrading practices. The individual with a drug use disorder should be recognized as a person with a health problem who deserves treatment similar to that delivered to patients with other psychiatric or medical problems.

37.   Standards:

(a)   In all cases, treatment services for drug use disorders should respect the human rights and dignity of patients and never use humiliating or degrading interventions;

(b)   The patients should grant informed consent before treatment begins and have a guaranteed option to withdraw from treatment at any time;

(c)   Patient data should be strictly confidential. Circumventing the confidentiality of health records in order to register patients entering treatment should be prohibited. Legislative measures, supported by appropriate staff training and service rules and regulations, should ensure and protect the confidentiality of patient data;

(d)   Staff of treatment services should receive proper training in the delivery of treatment in full compliance with ethical standards and human rights principles, and show respectful, non-stigmatizing and non-discriminatory attitudes towards service users;

(e)   Service procedures should require staff to adequately inform patients of treatment processes and procedures, including their right to withdraw from treatment at any time;

(f)   Any research conducted in treatment services involving patients should be subject to the review of human research ethical committees. Ethical committees are encouraged to consider the voice of people who have experienced drug use and drug treatment and are recovering from drug use disorders. The participation of patients in the research should be strictly voluntary, with informed written consent obtained in all cases;

(g)   Ethical standards of care in treatment services should apply to all populations with special treatment and care needs, without discrimination.

C. Principle 3. Promoting treatment for drug use disorders through effective coordination between the criminal justice system and health and social services

38.   Description: drug use disorders should be considered primarily as health problems rather than criminal behaviours and as a rule, people with drug use disorders should be treated in the health care system rather than the criminal justice system. Not all people with drug use disorders commit crimes and even if they do, these are typically misdemeanours or low-level crimes committed to fund drug use. This typically stops with the effective treatment of the drug use disorder. It is important to consider drug use by people with drug use disorders exclusively as a primarily health issue requiring access to appropriate support and treatment, where required, rather than criminal sanctions. The criminal justice system should collaborate closely with the health and social systems to ensure that treatment for drug use disorders in the health care system takes precedence over criminal prosecution or imprisonment. Law enforcement, court and penitentiary or prison system staff should receive appropriate training to effectively engage in and support treatment and rehabilitation. If imprisonment is warranted, treatment should also be offered to prisoners with drug use disorders during their stay in jail and after their release as effective treatment will lower the risk of relapse, overdose death and reoffending. It is vital to ensure and facilitate the continuity of care, relapse and overdose prevention interventions after the release of prisoners with drug use disorders. In all justice-related cases people should receive treatment and care of a standard equal to the treatment offered in the community.

39.   Standards:

(a)   Treatment for drug use disorders should be provided predominantly in health and social-care systems. Effective coordination mechanisms with the criminal justice system should be in place to facilitate access to treatment and social care services for people in contact with the criminal justice system;

(b)   Effective treatment should be available to people who offend and have drug use disorders and, where appropriate, be a partial or complete alternative to conviction or punishment;

(c)   Appropriate legal frameworks should safeguard the treatment of drug use disorders when used as an alternative to incarceration or provided within criminal justice settings;

(d)   Criminal justice settings should provide opportunities for individuals with drug use disorders to receive parity of treatment, health and social care that are available in the community;

(e)   Treatment interventions should not be imposed on individuals with substance use disorders in the criminal justice system against their will;

(f)   Individuals with drug use disorders in criminal justice settings should have access to essential prevention and treatment including: mechanisms of early identification and referral to treatment; the prevention of the transmission of blood-borne infections; pharmacological and psychosocial treatment of drug use disorders and comorbid substance use disorders as well as psychiatric and physical health

conditions; rehabilitation services and through-care links with community health; and social services in preparation for their release.

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

40.   Description: the cumulative body of scientific knowledge on drug use disorders and their treatment should guide interventions and investments in treatment. The same high standards required for the approval and implementation of pharmacological or psychosocial interventions in other medical disciplines should be applied to the treatment of drug use disorders. It is important to limit applicable pharmacological and psychosocial interventions to those whose effectiveness has been demonstrated through research and/or those endorsed by the appropriate expert bodies. Where other treatment approaches are deemed useful, before deploying them, it is necessary to ensure that their effectiveness and safety are adequately evaluated, including through clinical trials. The duration and intensity of interventions should comply with evidence-based guidelines. Multidisciplinary teams should integrate different interventions tailored to each patient. There is a need to plan and deliver treatment services for drug use disorders using the approach required for treating chronic conditions, rather than the acute care model. The reason is that long-term treatment and care have a greater chance of promoting long and healthy lives. It is important to adapt interventions to the cultural and financial situation of the country without undermining the core elements that science considers crucial for effective outcomes. "Traditional" treatment interventions or systems may be unique to a particular country or setting and may have limited evidence of their effectiveness beyond the local experience of patients and their clinicians. Such systems should learn from and adopt as much as possible of evidence-based interventions into their services. There is a need to carry out evaluation research to formally establish whether "traditional" treatments are effective and whether the risks they carry are acceptable risks.

41.   Standards:

(a)   Resource allocation in the treatment of drug use disorders should be guided by existing evidence of the effectiveness and cost-effectiveness of treatment interventions;

(b)   A range of evidence-based treatment interventions of different intensity should be in place at different levels of health and social care systems, with appropriate integration of pharmacological and psychosocial interventions within a continuum of care;

(c)   Treatment services should be gender-sensitive and oriented towards the needs of the populations they serve with due respect to cultural norms and the involvement of patients in the service design, delivery and evaluation;

(d)   Primary health care professionals should be trained in the identification of drug use, as well as diagnosis and management of drug use disorders and related health conditions;

(e)   The treatment of drug use disorders in primary health care should be supported by specialized services with the required skills and competences, particularly for the treatment of severe cases and patients with comorbid psychiatric and physical health conditions;

(f)   Whenever possible, the organization of specialized treatment services for drug use disorders should feature multidisciplinary teams trained in the delivery of evidence-based interventions. The teams need to have competencies in addiction medicine, psychiatry, clinical psychology, nursing, social work, counselling and involve people with lived experience of drug use and drug treatment in recovery;

(g)   Individual needs should determine the duration of treatment, with no pre-set limits and the possibility of modification at any point, based on the patient's clinical needs;

(h)   The training of health professionals in the identification, diagnosis and evidence-based treatment of drug use disorders should be in place at different levels of education including university curricula and programmes of continuing education;

(i)   There is need to update guidelines for the treatment of drug use disorders, procedures and norms regularly to keep up with new evidence of the effectiveness of treatment interventions, knowledge about the needs of patients and service users and results of evaluation research;

(j)   Treatment services should benchmark their performance against standards for comparable services;

(k)   The development of new treatment interventions should be conducted through the clinical trial process and overseen by an authorized human research ethics committee.

E.   Principle 5: Responding to the special treatment and care needs of population groups

42.   Description: within the larger population, subgroups of individuals with drug use disorders should have special consideration and, if required, specialized, tailored care. Individuals from groups with specific needs may include, but are not be limited to: women and pregnant women; children and adolescents; the elderly; indigenous populations; migrants; sex workers; people with different sexual orientation and gender identity; people with disabilities; illiterate people and those with limited education; people with comorbid health conditions; people in contact with the criminal justice system; and people without social support such as the homeless or the unemployed. Working with individuals with special needs requires differentiated and individual treatment plans that consider their unique requirements, vulnerabilities and needs. Individuals with drug use disorders often face stigma and discrimination – which may be heightened for individuals from population groups with specific needs. Special considerations may need to be addressed directly in every setting on the treatment continuum.

43.   Children and adolescents should not be treated in the same setting as adult patients with drug use disorders. Children and adolescents with drug use disorders should be treated in facilities that are able to manage issues such as child safety and protection. Child and adolescent facilities should also encompass broader health, learning, and social welfare in collaboration with family, schools and social services. Similarly, women entering treatment should have special services and may require protection. Women with drug use disorders are often more vulnerable to domestic violence and sexual abuse, and their children may also be vulnerable to neglect and abuse, therefore a liaison with social agencies protecting women and children is recommended. Women may require differentiated treatment services in a safe single-sex setting to obtain maximum benefit. Treatment programmes for parents with drug use disorders should recognize and have the capacity to accommodate the paramount needs of the latters' children. It is necessary to provide good parenting support and childcare practices, as well as training on issues such as sexual health, including contraception.

44.   Standards:

(a)   Service provision for drug use disorders and service treatment protocols should reflect the needs of specific population groups;

(b)   Special treatment services should be in place for children and adolescents with drug use disorders to address the specific treatment needs associated with this

age group. Differentiated treatment services for children and adolescents should be provided whenever possible to secure the best possible treatment outcomes;

(c)   Treatment services and interventions should be tailored to the needs of women and pregnant women. This is relevant for all aspects of their intervention's design and delivery, including location, staffing, programme development, child friendliness and content;

(d)   Treatment services should be tailored to the needs of people from minority groups with drug use disorders, and provide them with cultural mediators and interpreters whenever necessary to minimize cultural and language barriers;

(e)   Social assistance and support packages should be integrated into the treatment services for people with drug use disorders, particularly those without social support, such as the homeless or the unemployed;

(f)   Outreach services should be in place to establish contact with people with drug use disorders who may not seek treatment because of stigma and marginalization;

(g)   All efforts should be made to reduce the burden of stigma and discrimination faced by people with mental and substance use disorders, including public awareness-raising and anti-stigma campaigns, dissemination of correct information about substance use disorders, reducing structural barriers to treatment and implementing measures to enhance the self-efficacy of people with drug use disorders.

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

45.   Description: good quality and efficient treatment services for drug use disorders should have accountable and effective methods of clinical governance. The treatment programme, policies, procedures and coordination mechanisms should be defined in advance and made clear to all therapeutic, administrative and management staff and patients. Service organization should reflect current research evidence and respond to the service user's needs. Treating people with drug use disorders (who often have multiple psychosocial, psychiatric, physical health and social needs) is challenging, both for individual staff and organizations. Staff attrition in this field is recognized and organizations should have in place a variety of measures to support their staff and encourage the provision of good quality services.

46.   Standards:

(a)   Treatment policies and plans for substance use disorders should be formulated by relevant governmental and other authorities, as appropriate, and should be based on the principles of universal health coverage, consistent with the best available evidence and developed with the active involvement of key stakeholders, including the target populations, patients, family and community members, including NGOs;

(b)   Written service policy and treatment protocols should be available, known to all staff and guide the delivery of treatment services and interventions;

(c)   Staff working in specialized services for drug use disorders should be adequately qualified, and receive on-going evidence-based training, certification, support and clinical supervision. Clinical supervision, mentoring, safety protection measures and other forms of support are needed to prevent "burnout" among staff members;

(d)   Policies and procedures for staff recruitment and performance monitoring should be clearly articulated and known to all;

(e)   A sustainable source of adequate funding should be secured and proper financial management and accountability mechanisms put in place. Whenever

possible, the relevant budget should include resources for on-going staff education, and the evaluation of service quality and performance;

(f)   Services for the treatment of drug use disorders should network and link with all levels of health care including primary and specialized health services, social services, and others as appropriate in order to provide comprehensive care to their patients;

(g)   Patient record and data collection systems in line with international indicators should be in place to ensure accountability and continuity of treatment and care, whilst respecting patient confidentiality;

(h)   It is essential to revise service programmes, rules and procedures periodically, and develop mechanisms of continuous feedback, audit, monitoring and evaluation (including patient feedback);

(i)   Patterns of drug use and related health and social consequences and substance use, psychiatric and physical health comorbidities should be regularly monitored and results made available to help the planning and governance of treatment services.

G.   Principle 7. Treatment services, policies and procedures should support an integrated treatment approach, and linkages to complementary services require constant monitoring and evaluation

47.   Description: in response to a complex and multifaceted health problem, comprehensive treatment systems should be developed to facilitate effective management of drug use disorders and associated health and social problems. No treatment modality exists that could on its own adequately cater for all. Therefore the response should be wholistic and tailored to the needs of individuals. Whenever possible, different services need to be engaged in treatment delivery with appropriate coordination, including: psychiatric, psychological and mental health care; social care and other services (including for housing and job skills/employment and, if necessary, legal assistance), and; other specialized health care services (such as services for HIV, HCV, TB and other comorbid health conditions). It is vital to monitor, evaluate and adapt the treatment system constantly. This requires multi-disciplinary planning and the implementation of services in a logical, step-by-step sequence that ensures the strength of links between: policy; needs assessment; the planning of treatment systems; the implementation and monitoring of services; the evaluation of outcomes; and, quality improvements.

48.   Standards:

(a)   Policies and plans for the development of treatment systems for drug use disorders should support an individualized, holistic and integrated treatment approach, and linkages to complementary services within and outside the health sector;

(b)   Links between efforts to prevent drug use, treat drug use disorders, and reduce health and social harms associated with drug use should be established and operational;

(c)   Links between communities (involving families, caregivers, mutual support and self-help groups, relevant religious and community settings), social services (such as those delivered in educational, sport and recreational facilities), the criminal justice system and primary health care and specialized health services should be established and operational, with full respect for the confidentiality of patients' data;

(d)   Treatment system planning and development should be based on estimates and descriptions of the nature and extent of the drug problem and the characteristics of the population in need;

(e)   Roles of national, regional and local agencies in different sectors responsible for the delivery of treatment and rehabilitation for drug use disorders should be defined, with mechanisms established for effective coordination;

(f)   Quality standards for drug treatment services should be developed and established with appropriate mechanisms for ensuring compliance, quality assurance or accreditation;

(g)   Each service should have mechanisms of clinical governance, monitoring and evaluation in place including clinical accountability, continuous monitoring of the patient's health and well-being, and intermittent external evaluation;

(i)   Information on the number, type, and distribution of services available and utilisation of the treatment system should be monitored for planning and development purposes.

III.   Treatment systems for drug use disorders

A.   System level of service provision

49.   This chapter highlights the key characteristics of effective treatment systems for drug use disorders and provides guidance on the planning of treatment services. It also proposes frameworks for health service organization and models of care.

50.   An effective national system for the treatment of drug use disorders requires a coordinated and integrated response by many actors. The aim is to deliver services and interventions in multiple settings and targeting different groups at different stages in terms of the severity of their drug use disorder and their additional needs. The public health system, often working in close coordination with social care and other community services, is best placed to take the lead in delivering effective treatment services for people with drug use disorders. In some countries private sectors play a vital role in providing treatment for people with drug use disorders. The suggested standards and characteristics may be equally valuable to treatment services in the private sector.

51.   Treatment services should be: *available; accessible; affordable; evidence-based; and diversified.*

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

53.   The accessibility of treatment services refers to their reach or availability for the whole population. Treatment services must be conveniently located and in proximity to public transport (including in rural and urban areas), with opening hours allowing for adequate service provision. Certain service design factors will increase access for sub-groups in need of treatment for drug use disorders (such as childcare facilities for parents). In addition, attitudes towards certain population groups or other factors must not hinder access to services.

54.   The affordability of treatment services refers to affordability both for patients and the local treatment system. Treatment services for drug use disorders should be affordable for patients from different socio-economic groups and levels of income. Ideally treatment for drug use disorders should be provided free of charge, so that the costs do not become a barrier to treatment. Additionally there is a need to make treatment systems for drug and other substance use disorders affordable for the health and social system in order to sustain treatment services. Treatment interventions should be based on scientific evidence and follow evidence-based guidelines like the

treatment of any other health disorder. This is key to ensuring the quality of treatment services.

55.   It is necessary to diversify treatment services to meet the needs of the target population and offer different treatment approaches. No single approach fits all types, severities or stages of drug use disorders. Services should provide access to treatment and recovery for patients with drug use disorders as well as to community-based interventions aimed at reducing the negative health and social consequences of drug use. Therefore, a diverse range of treatment modalities needs to be in place in various settings (outreach, outpatient, inpatient, residential) to address the range of needs of patients with drug and other substance use disorders adequately. As recovery remains the ultimate goal of all treatment and care services, sustained recovery management services should be an integral part of the treatment system.

B.   Treatment system organization

56.   Drug use disorders can be described on a spectrum from lower to higher severity and complexity.

57.   From a public budget perspective evidence-based treatment of drug use disorders is a smart investment, as the costs to treat drug use disorders are much lower compared to the costs of untreated drug dependence (UNODC and WHO, 2008). The rate of savings to investments can exceed a ratio of 12:1 through reductions in drug-related crime and costs of criminal justice, law enforcement and healthcare (NIDA, 2012).

58.   Those responsible for developing or reviewing local comprehensive treatment systems for drug use disorders, in line with "the Standards" are advised to allocate available resources to respond optimally to the population's needs. There is a need to develop treatment systems for drug use disorders in line with the key public health principle of prioritizing the least invasive intervention with the highest level of effectiveness and the lowest cost to patients.

59.   The volume and type of treatment services needed by the population should determine investments of public funds. Usually, a local area has a number of people who use drugs occasionally and a smaller number of people with drug use disorders (of whom a small proportion will have severe or complex drug use disorders).

60.   As shown in the service organization pyramid (Figure 1), most treatment interventions are required at levels of lower intensity. The low intensity, effective interventions in community or non-specialized settings (such as screening and brief interventions) can prevent people from developing severer drug use disorders, can be delivered by non-specialist trained staff and are cheaper. Similarly, most people with drug use disorders may be effectively treated in out-patient or community settings rather than more intensive and costlier in-patient or long-term residential settings.

Figure 1
Service organization pyramid for substance use disorder treatment and care (UNODC, 2014) based on the WHO Pyramid of Mental Health Services (WHO, 2003)
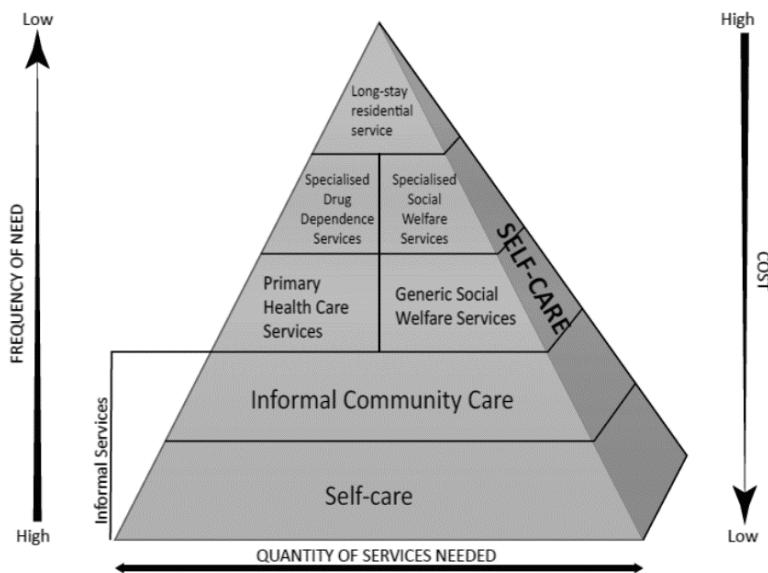
61.   Treatment systems designed in line with the service delivery pyramid are more cost-effective. However, in systems where investment is disproportionally made in high intensive/high cost treatment services (at the top of the pyramid) only, this can lead to people with low severity need being "over treated" in high intensity services and/or a system with limited overall capacity. This is the result of lack of funds to develop other components of a comprehensive system, as described in the Standards. Out-patient treatment for drug use disorders is in general less disruptive to patients' lives, and cheaper for the health system than in-patient and residential treatment. Outpatient treatment is the recommended first choice of setting from a public health perspective as long as it is evidence-based and can meet the patient's needs. In-patient and residential treatment may be required based on an individualized assessment for those with more severe or complex drug use disorders or additional social problems.

62.   A mismatch between the range in the severity of drug use disorders in the population and the range of intensity of modalities in a local treatment system leads to the inefficient distribution of resources and minimizes outcomes, which is not a good investment of public funds.

63.   Lack of low intensity low threshold interventions (such as screening and brief interventions at the primary health care level or community-based outreach services) may also compel people who use drugs to contact treatment services only when they have developed severe drug use disorders. Yet, support at earlier stages of their disorder would have been less intensive (and less costly). Data show that primary care practitioners rarely screen their patients for drug use disorders (Ernst, Miller and Rollnick, 2007). However, providing screening, brief interventions and treatment in primary health care settings is feasible and helps identify, support and, if necessary, refer people with drug use disorders, which helps reduce health-care costs.

B.1   Suggested interventions at different system levels

64.   As presented in Table 1, a variety of interventions should be available to patients to assure continuity of treatment and care.

Table 1
Suggested interventions at different system levels

System level	Possible interventions
Informal community care	Outreach interventions Self-help groups and recovery management Informal support through friends and family
Primary health care services	Screening, brief interventions, referral to specialist drug use disorder treatment Continued support to people in treatment/contact with specialized drug treatment services Basic health services including first aid, wound management
Generic social welfare	Housing/shelter Food Unconditional social support Referral to specialized drug treatment services, and other health and social services as needed
Specialized treatment services (out-patient and in-patient)	Assessment Treatment planning Case management Detoxification/withdrawal management Psychosocial interventions Medication-assisted treatment Relapse prevention Recovery management
Other specialized health care services	Interventions by specialists in mental health services (including psychiatric and psychological services) Interventions by specialists in internal medicine, surgery, paediatrics, obstetrics, gynaecology and other specialized health care services) Dental care Treatment of infectious diseases (including HIV, Hepatitis C and tuberculosis)
Specialized social welfare services for people with drug use disorders	Family support and reintegration Vocational training/education programmes Income generation/micro-credits Leisure time planning Recovery management services
Long-term residential services for people with drug use disorders	Residential programme to address severe or complex drug use disorders and co-morbid conditions Housing Vocational training Protected environment Life skills training On-going therapeutic support Referral to out-patient/recovery management services

C. Planning and funding of treatment systems

65. Decisions regarding the allocation of resources and services offered at different levels of health and social systems are crucial to the planning of a functional and sustainable drug treatment system.

66. An assessment of local needs, using available data on drug demand, treatment and care delivery at various levels, should inform the allocation of resources and the design of treatment systems (UNODC, 2003).

67. Lack of data or systematic data collection systems should not be a major obstacle to the implementation and delivery of drug treatment services. Some important indicators, such as the treatment demand indicator ("service utilization for drug problems"), can only be effectively collected if drug treatment services are in place and patient data are available.

68. The development of a functional national drug information system may require support from partners at all levels and from different sectors. The reason is that it takes technical component as well as a participatory process to establish governing policies for a national drug information system and a national drug observatory.

69. Treatment systems for drug use disorders should not be considered separately from broad health, social care systems or local services. Their design and delivery are likely to be influenced by and inextricably linked to wider health and social services. The planning, design and implementation of treatment and recovery systems for drug use disorders require the involvement of a range of stakeholders including governmental health and social care providers, criminal justice and police, patients and advocacy groups, NGOs and other community groups.

70. Stigma and discrimination against people with drug use disorders are major barriers to treatment. There is a need to make every effort to raise awareness, promote non-stigmatizing attitudes and address structural discrimination against people with drug use disorders. To achieve this, it is essential to implement comprehensive, people-centred and balanced policy interventions, remove barriers to treatment, eliminate and prevent inhuman or degrading treatment or punishment in the name of treatment, provide better care, increase awareness and understanding of drug use disorders in the general population, and improve the knowledge of decision- and policy-makers, health professionals and other relevant stakeholders. Interventions aimed at raising self-efficacy and empowering people, for example through mutual-help groups, can reduce the burden of self-stigma (Livingston et al., 2012; Corrigan et al., 2017).

D. Models of service organization

71. This section outlines different models of service organization that may be implemented at different levels – depending on population needs, the organization of health and social care services, legislative frameworks and policies and resources. The models are not mutually exclusive and may overlap.

D.1 A one-stop-shop approach

72. Given the diverse and multiple needs of people with drug use disorders, ideally a wide range of medical and social services should be provided in one facility or service, which could be described as a "one-stop-shop" (Figure 2). Such integrated service delivery without barriers in accessibility includes the full range of care services and provides people who use drugs with comprehensive and ethical drug dependence treatment when it is needed (Rapp et al., 2006).

Figure 2
**One-stop-shop approach**

D.2   Community-based network approach

73.   If a local treatment service cannot integrate all evidence-based modalities and interventions (such as the one-stop-shop approach), there is a need to develop a coordinated comprehensive network of treatment and care services. This should include various components of the local health and social care system. This approach positions specialized drug treatment clinical services as a core element but offers many municipal/communal auxiliary services that share a perspective and work in close coordination with established referral mechanisms. In order to ensure access, it is necessary to put in place low-threshold entry-level services (such as outreach, drop-in) with defined referral mechanisms for clinical drug treatment services and accompanying social services.

74.   In a community-based treatment network approach (Figure 3) broad partnerships exist not only between different services from health and social sectors (including local hospitals, primary care and social care services) but also with other community stakeholders (including NGOs and self-help groups). To coordinate all services delivered, it helps to develop an effective community-based treatment approach that utilizes all resources already available in the community as assets. Community-based drug treatment services offer a multifactorial and multi-sectoral approach to the management of drug related problems and health issues. Such an approach encourages: the use of various pathways to treatment; recovery management and support; and an improved quality of life for the entire community. Partners in a community-based network of services need to work in close collaboration and coordination to provide the best possible support through effective referral and case management strategies in order to guarantee a continuum of care. Community-based drug treatment networks provide a range of low-threshold entry points and ease access to different treatment and care services.

Figure 3
Model of community-based treatment network approach (UNODC, 2014)
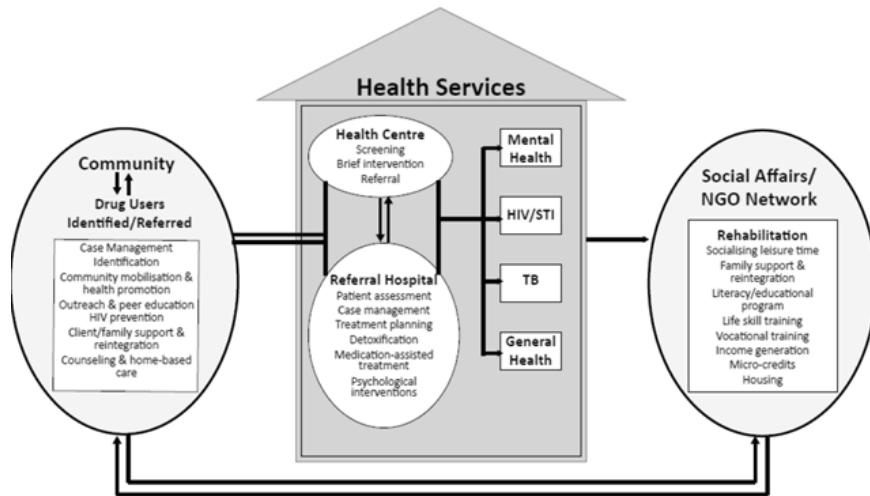
75. Key principles of community-based drug treatment and care include (UNODC, 2014):

(a) Continuum of care from outreach, basic support and the reduction of negative health and social consequences related to drug use treatment and social reintegration, with no "wrong door" for entry into the system;

(b) Close collaboration between civil society, law enforcement/criminal justice system, health and social care sectors;

(c) Minimal disruption of social links and employment;

(d) Integration of the treatment of drug use disorders into existing health and social services;

(e) Delivery of services in the community – as accessibly as possible to people who use drugs;

(f) Involvement of and building on community resources and assets, including families;

(g) Participation of people who are affected by drug use and dependence, families and the community-at-large in the planning and delivery of the service;

(h) Provision of evidence-based and gender-sensitive interventions;

(i) Informed and voluntary participation in treatment;

(j) Comprehensive approach with a recovery perspective that takes into account various needs (health, family, education, employment, housing);

(k) Acceptance that relapse is part of the treatment process and that individuals can re-access treatment services;

(l) Respect for human rights and dignity, including confidentiality;

(m) Addressing the stigma and discrimination associated with drug use disorders.

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

(a) Civil society/NGOs (including those providing outreach services, vocational training, aftercare activities);

(b) Police (including screening, referrals to health services);

(c)   Criminal justice system (including provisions for treatment as an alternative to conviction or punishment and the delivery of treatment in prison for drug use disorders, and arranging follow-up services in the community for those released from prison);

(d)   Professional organizations (including those providing legal support);

(e)   Trade and services establishments (such as those creating vocational opportunities);

(f)   Organized groups of people who use drugs and people in recovery (providing self-help groups);

(g)   Organized groups who identify themselves based on gender and ethnicity;

(h)   Educational and research institutions;

(i)   Youth organizations and youth leaders;

(j)   Spiritual/religious organizations (for instance, those offering places for overnight stays);

(k)   Spiritual and community leaders;

(l)   Neighbourhood associations;

(m)   Family members.

77.   To ensure that patients are linked and referred to appropriate services that suit their needs, it is essential for services and sectors to coordinate their treatment planning and case management (UNODC, 2014). Case managers must work with patients, members of the treatment team, and services or organizations to select the best combination of interventions and support. Case managers also provide a continuous assessment of the treatment progress. In this way case management ensures that the network of referral and other support services remains accessible and that resources are utilized efficiently. The following chart depicts a functioning case management system from the perspective of people who use drugs and enter the treatment system. There is "no wrong door" for entry into the system, as different treatment services are connected and collaborate, so that patients can be referred to the service facility that corresponds to the severity of their disorder and their individual needs.

Figure 4
Model of case-management and treatment and care for people who use drugs and are affected by drug use disorder (UNODC, 2014)
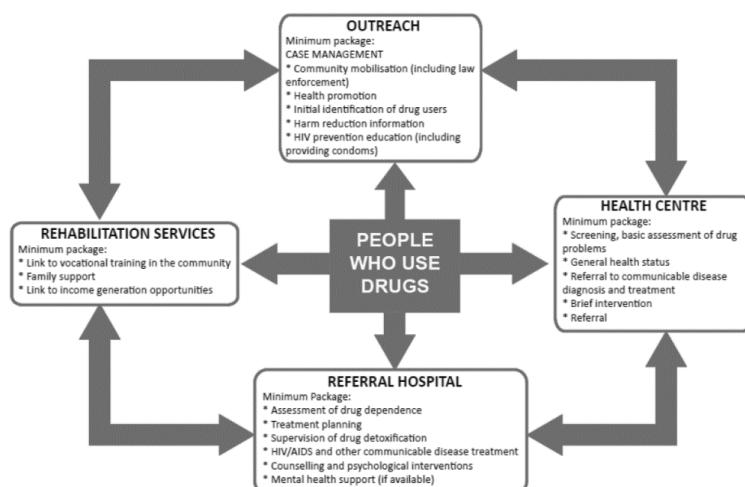
D.3 Sustained recovery management

78.   Recovery is considered to be "[…] a continuum process and experience through which individuals, families, and communities utilize internal and external resources to address substance use disorders, actively manage their continued vulnerability to such disorders, and develop a healthy, productive and meaningful life" (Adapted from (White, 2007)). In this model, recovery is an ultimate goal at every stage of the treatment continuum, at every stage of the disorder and across a variety of settings (see Table 1): from low threshold outreach services to intensive in-patient or residential treatment. Patients may require different services and interventions at different points in their recovery journey, and it is important to ensure the continuity of treatment and care services and recovery management.

79.   Treatment services based on the sustained recovery management model, like any other drug dependence treatment services, excluding life-endangering emergency situations, should be voluntary and aim to minimize disruption for the person in treatment. Despite recovery being the ultimate goal of treatment, it is important to recognize that drug use disorders often take the course of chronic and relapsing disorders and that patients may repeatedly require the network of treatment services for adequate support and positive treatment outcomes.

80.   It is possible to implement broad-ranging recovery-orientated services and interventions, across different domains, in various settings and at different stages of treatment of drug use disorders. UNODC has published a good practice document on sustained recovery management (UNODC, 2008b), which provides examples from around the world and detailed practical guidance. The "good practice document" defines eight domains of recovery capital as a suggestion for interventions to be considered on a continuing basis (Figure 5).

Figure 5
Essential elements of recovery-oriented rehabilitation and social reintegration (UNODC, 2008b)

E.   Effective treatment systems: conclusions

81.   The treatment system should ensure that treatment services for people with drug use disorders are accessible, affordable, evidence-based, diversified and delivered with a focus on improved functioning and wellbeing towards the highest attainable standard of health.

82.   Treatment system resources should be invested where they are most needed. It is necessary to focus on low-threshold and easily accessible outpatient treatment and care services as a first step.

83. Systems should be developed in line with the key public health principle of prioritizing the least invasive intervention with the highest level of effectiveness and the lowest cost to patients. Treatment systems should feature a "pyramid" of drug treatment modalities with more intensive interventions reserved for patients with more severe or complex needs.

84. Effective treatment systems for drug use disorders should be designed and planned using available data generated and collated in the scope of needs assessment and drug information systems. However, lack of data should not be for a reason to delay the implementation and delivery of drug dependence treatment and care services.

85. Information systems should be established to guide the development of treatment systems for drug and other substance use disorders. Such developments must take into consideration the prevalence of drug use and substance use disorders in the population and the results of system function monitoring.

86. Different models of service organization can be used to deliver an accessible and diversified continuum of treatment and care for drug use disorders. Effective service provision for people with drug use disorders requires close coordination between different sectors (health, social, justice, etc.).

IV. Treatment settings, modalities and interventions

87. The purpose of this chapter is to provide an overview of treatment settings, modalities and evidenced-based interventions available for the management of drug use disorders and associated health conditions

88. Section A describes five key groups of settings for providing prevention and treatment interventions, namely:

(a) Community-based outreach;

(b) Settings not specialized for the treatment of people with substance use disorders;

(c) Specialized outpatient treatment;

(d) Specialized short-term inpatient or residential treatment, and;

(e) Specialized long-term residential treatment.

89. Section B more details on specific treatment modalities and interventions that can be delivered in all the settings mentioned above. These modalities and interventions include:

(a) Screening, Brief Interventions and Referral to Treatment (SBIRT);

(b) Evidence-based psychosocial interventions;

(c) Evidence-based pharmacological interventions;

(d) Overdose identification and management; and

(e) The treatment of co-occurring psychiatric and physical health problems.

90. As shown in Figure 2, effective treatment for drug use disorders requires a stepwise, integrated approach. People with drug use disorders require a continuity of care between all treatment settings and modalities to improve their health and wellbeing (see sections B and B 6 for more details on interventions and recovery management, respectively).

Figure 6
Effective and integrated treatment system model for the relevant services and modalities
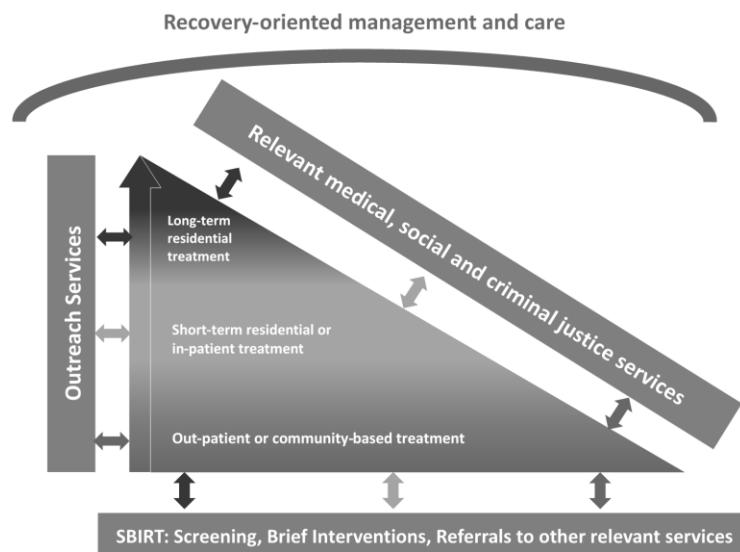
91.   Certain population groups with specific needs may require special treatment and care provisions. These include needs related to: particular psychoactive drugs or their combinations; the health of people with comorbid health conditions, such as HIV or mental disorders, and with disabilities; specific age groups (such as children, adolescents and older people) and gender (women and pregnant women); people with different sexual orientation and gender identity; social care (such as among people who are homeless, socially marginalized, living in poverty, illiterate and those with limited education); people living in remote and rural areas; ethnic minorities, refugees and migrants; sex workers, and; people in contact with the criminal justice system. Chapter 5 describes in details specific considerations in delivering treatment and care for certain populations or groups with special needs.

A.   Treatment Settings

A.1   Community-based outreach

92.   Description: outreach activities are essential components of a comprehensive treatment system for drug use disorders. On average, many years pass between the onset of the drug use disorder and the time the individual seeks treatment. It is during that period that outreach activities pro-actively seek to establish contact with and motivate individuals who use drugs to engage with health-care professionals. The aim is to minimize the time between the onset of the disorder and the initiation of treatment, thereby reducing the negative health and social effects of drug use. Community-based outreach services also target individuals who are affected by other people's drug use (including sexual partners and needle-sharing partners). Outreach workers are often from the local community. Being based in or coming from the community they serve, the outreach workers know local drug use subcultures and the resources available at the community level. Indeed, they themselves may be people who formerly or occasionally used drugs. Operating outside structured treatment and health care institutional facilities, outreach workers establish informal and unconditionally supportive relationships with people who use drugs. This approach helps to build a positive bond between the outreach worker and people who use drugs. Consequently, it provides easier access to basic health and social services as well as available specialized treatment services for drug use disorders. People who use drugs become more motivated to use health care and social services, including treatment for drug use disorders. This is attributed to the new, positive experience – the interaction

between the individual and the outreach worker – a stark contrast to previous experiences marked by social exclusion, helplessness and hopelessness. The degree of stigma that surrounds drug use may leave people who use drugs unaware of available treatment options. It may also impede their access to care through traditional medical and social service agencies. Outreach workers play an important role in educating people who use drugs about treatment services. The workers help protect health, remove barriers to social services and introduce people with drug use disorders to treatment.

93. Outreach workers acknowledge the influence of social networks on individuals with drug use disorders. Additionally, they recognize the importance of such networks in determining health and social outcomes and use them to influence and promote healthy behaviour. Many outreach models use a mixture of individual and network-based interventions.

94. Target population: outreach activities primarily target individuals who engage in high-risk drug use behaviours (such as injecting or polydrug use) often associated with drug use disorders, particularly in communities that are hard to reach, and that may lack access to health care and social services. The individuals include:

(a)   People who lack access to health services because of extreme poverty, social exclusion and discrimination;

(b)   People who do not recognize their drug use and associated disorders as a problem, or are not motivated to get treatment or abstain from or reduce their drug use;

(c)   People with a history of unsuccessful treatment and repeated relapses to drug use who despaired and became distrustful of treatment services;

(d)   Hidden populations of people who use drugs, such as women, sex-workers, illegal immigrants and people living in remote areas;

(e)   People engaging in high-risk behaviours, such as needle sharing or unprotected sex, associated with drug use, and;

(f)   Young people who are exposed to synthetic drugs and unaware of the possible effects of drug use on their health.

95. Goals: community-based outreach aims to identify target populations, engage them and provide them unconditional community-based services and interventions – including harm reduction interventions. It also aims to offer and encourage access to available treatment modalities. Outreach work is possible in any community, including online "virtual" communities.

96. First and foremost, outreach works to establish contact with and deliver services to target drug-using population groups. Outreach seeks to create a friendly and welcoming environment to help individuals in need overcome their apprehension and lack of trust.

97. In the next stage, outreach staff can start addressing the health and social needs of people who use drugs and help prevent adverse outcomes, such as overdose, infections, interpersonal and physical abuse, sexual exploitation, accidents, starvation, homelessness and involvement in criminal activity. Initiatives to protect and improve the health of people who use drugs in a public health perspective always extend to cover health and well-being for the wider community.

98. Over time, outreach workers may be able to motivate people who use drugs to start making positive changes regarding their drug use and health behaviours and voluntarily participate in treatment activities. However, getting people to engage in treatment for drug use disorders is not the primary or only focus of outreach.

99. Outreach services are well placed to restore the link between the targeted population and the community – building trust within the community, reducing stigma

and discriminatory attitudes against target groups – and ultimately to achieve an overall positive impact on the community.

100. Models and components: several models and types of outreach interventions have been developed. Generally, the diversity of outreach strategies reflects the chances of reaching target populations and providing them with services. Diversity also makes it possible to establish which particular outreach activity is likely to achieve the optimal returns, and to select a combination of outreach strategies that best complement each other.

101. Outreach programmes vary enormously depending on the local situation but typically the following core services have to be in place based on a prior local assessment:

(a)   Information on and linkage to services catering for basic needs (safety, water, food, shelter, hygiene and clothing);

(b)   Needle and syringe programmes;

(c)   Condom distribution programmes;

(d)   Overdose prevention, identification and management, including take-home naloxone;

(e)   Voluntary HIV/hepatitis testing and counselling;

(f)   Information on and linkage to services providing prevention, diagnosis and the treatment of HIV/AIDS;

(g)   Information on and linkage to services providing vaccination (for hepatitis B), prevention, diagnosis and the treatment of viral hepatitis;

(h)   Information on and linkage to prevention, diagnosis and treatment services for sexually transmitted infections and tuberculosis;

(i)   Targeted information, education and communication, for people who use drugs and their sexual partners, on the effects of drugs, risks associated with drug use as well as approaches to minimize health and social harms due to drug use;

(j)   Information on and access to mutual help groups (such as Narcotics Anonymous, Nar-Anon, Cocaine Anonymous and other peer-driven and mutual support groups);

(k)   Anti-stigma activities, awareness raising and promotion in the community;

(l)   Screening and brief interventions for substance use;

(m) Basic counselling;

(n)   Information on and access to basic medical (such as wound management) and social support (including food, hygiene and shelter) services;

(o)   Crisis interventions;

(p)   Legal support;

(q)   Referral to other treatment and care modalities and recovery management services, and;

(r)   Referral to other health care and social services, as needed.

102. For people who inject drugs, a WHO, UNODC and UNAIDS publication, Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, originally published in 2009, offers a description of evidence-based interventions to prevent HIV and certain other infections associated with injection drug use, as well as to improve access to HIV treatment and care

103. Three main types of outreach work have been identified: detached outreach, peripatetic outreach and domiciliary outreach:

(a)   Detached outreach is work undertaken outside of any agency, such as work on the streets, in bars, clubs, squats or railway stations. This work is mostly mobile and may be done on foot or using a designated vehicle;

(b)   Domiciliary outreach is work undertaken in the homes of target populations. This is important in areas where there are no street drug scenes, or where people who use drugs are isolated from their communities because of stigma and discrimination. Domiciliary outreach involves regular visits to the homes of people who use drugs;

(c)   Peripatetic outreach is work undertaken in settings: where people are either already accessing some services (such as needle and syringe programmes), or; where it is highly likely to encounter target populations (for example prisons, brothels, shelters for homeless people or housing projects). Instead of focusing on individuals, peripatetic outreach focuses on organizations and settings where target populations can be found. Peripatetic outreach places emphasis on broadening the range of people who receive health education messages, and on training more workers and staff to provide education and outreach to their clients.

104.   Outreach interventions are commonly delivered by a mobile outreach unit, a team operating from a van or other mobile vehicle, which makes it possible to deliver services to a wider group of individuals particularly in rural locations and suburban areas of larger towns.

105.   Outreach drop-in centres may accommodate outreach and/or low-threshold services in communities. Drop-in centres provide accessible and continuous services, often throughout the night, for people who use drugs contacted through detached outreach. Drop-in centres cater for basic necessities, such as food, clothing, personal hygiene and shelter. The centres may also provide health care information and referral, HIV/hepatitis testing, legal services, basic social support and other additional services.

106.   Outreach workers should be familiar with the local communities they serve and benefit from health and social services themselves. They require adequate training in:

(a)   Establishing trust and providing accurate information for people who use drugs;

(b)   Recognizing and responding to crisis situations;

(c)   HIV/hepatitis testing and counselling, and;

(d)   Providing support for the: *identification and management of an overdose; prevention and treatment of HIV, TB and viral hepatitis; prevention and treatment of sexually transmitted infections, and; identification and management of other health conditions, including mental disorders and suicidal behaviour*;

(e)   Providing access to health and social care services in the community;

(f)   Raising awareness in the community and preventing stigma and discrimination against people with drug use disorders;

(g)   Interactions with law enforcement and the criminal justice system, and;

(h)   Managing documentation.

107.   An effective outreach programme is flexible, adaptive and sensitive to the needs of individuals and population groups (depending on patterns of drug use, age, gender, social situation, among other things). It guarantees the confidentiality of people involved in its activities. Additionally, it has a clear mission statement, mechanisms for monitoring and evaluation, as well as articulate and relevant documentation.

108.   Key requirements for community-based outreach:

(a)   Strategies should be in place to identify people in the community or in public spaces who need outreach or treatment interventions;

(b)   There must be agreements in place between health and law-enforcement staff as well as a mutual understanding of the benefits of outreach work;

(c)   "Core outreach interventions" (see above) should be available;

(d)   Early interventions for drug use disorders and related problems must be promoted;

(e)   Early interventions must be promoted in population groups with special needs (including pregnant women, individuals involved in sex work, adolescents and people who are homeless);

(f)   Information about available treatment services should be disseminated to individuals and services that are the initial contact points for potential patients;

(g)   Outreach workers should promote voluntary access to treatment (with patients' consent) for drug use disorders;

(h)   Procedures must exist to support family members and communities in helping engage individuals with drug use disorders in treatment programmes;

(i)   Records of onward referrals must be kept to ensure continuity of care;

(j)   Peer outreach workers should be officially employed and provided with all the necessary support;

(k)   Outreach services should meet accepted safety standards as well as having policies for safe working conditions and the management of unsafe situations

(l)   Specialized treatment interventions (such as medical interventions, the dispensing of medication, psychological counselling or psychotherapy) must always be administered by personnel with the relevant qualifications and licences;

(m)   Community-based outreach should establish links and work actively with communities and stakeholders outside the health sector, including: civil society groups and NGOs intervening with regard to drug use; mutual self-help groups; spiritual and community leaders; educational, sports and recreational facilities and organizations, and; the criminal justice system, among others.

A.2   Settings not specialized for the treatment of people with substance use disorders

109. Description: these are settings that play a role in screening for, identifying, preventing and treating drug use disorders, as well as in brief intervention and referral to treatment, but that are not designed or designated for the delivery of specialized treatment for drug use disorders. They include such health settings as primary care, emergency care, general hospitals, antenatal care, social welfare services, school health services, prison health services and some mental health facilities. Screening and brief interventions can be implemented in a rapid and cost-efficient manner that causes minimal disruption to the delivery of other services.

110. Target population: the target population includes people who use drugs, among them those who experience adverse effects or have already developed drug use disorders but are not in contact with specialized health care settings. Such settings are suitable for people who use drugs or who have drug use disorders, including those with harmful patterns of drug use. People with drug dependence may need referral to more comprehensive treatment in specialized services. However, many people with disorders caused by drug use can receive appropriate treatment in non-specialized settings, with support, whenever needed, from specialized services for the treatment of drug use disorders

111. Goals: where drug use is concerned, the main aim of the settings is to identify, in a timely manner, people who use drugs and those with drug use disorders, provide them interventions to encourage behaviour change and refer them to specialized treatment, as needed. For people who screen positive for drug use, it may be appropriate and effective to carry out a brief intervention in a non-judgmental and motivating way. Screening may also help to identify individuals with substance use

disorders. Early interventions can prevent complications and the progression to advanced stages of drug use disorders that could eventually necessitate a more comprehensive assessment as well as specialized treatment. Non-specialized settings can be well positioned to provide treatment for drug use disorders, including pharmacological treatment such as opioid agonist maintenance treatment for opioid dependence. This requires the appropriate training of clinical staff and the support of specialized treatment services. In the absence of health services designed and designated for the treatment of drug use disorders, non-specialized treatment facilities may function as the main treatment settings for drug use disorders.

112. Models and components: Generally, screening, brief intervention and referral to treatment (SBIRT) is the main approach used in health settings that are not specialized in the treatment of drug use disorders. See section B1 for more details on SBIRT. Systematic screening of all clients is recommended in clinical settings with a high prevalence of psychoactive substance use among clients. The settings may include:

   (a)   Primary care settings in economically disadvantaged areas;

   (b)   Mental health care services without specialized treatment programmes for substance use disorders;

   (c)   General hospitals, including emergency services;

   (d)   Sexual health clinics;

   (e)   Infectious disease clinics, HIV/hepatitis/TB services;

   (f)   Social services and welfare agencies, including services for people: *experiencing insecure housing conditions; living and working on the street; transitioning from institutions, and; in contact with the criminal justice system*.

113. Other settings may necessitate opportunistic screening based on specific health or social features associated with drug use or an increased likelihood of drug use.

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

115. Non-specialized treatment settings can play an important role in delivering pharmacological and psychosocial treatment for drug use disorders. This is particularly true when efforts to develop a health service response to drug use disorders concentrate on primary health care's capacity to address drug use and drug use disorders. Support from specialized services is then built at a later stage. Many patients with drug use disorders could receive appropriate treatment in non-specialized settings at lower overall cost to the health systems and the clients. It is necessary to increase the capacity of doctors, nurses, midwives, clinical psychologists and social workers to identify drug use and drug use disorders, and engage patients in treatment and care while protecting their confidentiality and human rights. This is crucial for enhancing the coverage and quality of treatment for drug use disorders. Non-specialized treatment settings should have the capacity to diagnose, manage and, whenever necessary, refer drug-induced acute clinical conditions, such as overdose, withdrawal syndromes and drug-induced psychoses, to specialized treatment services. It is important to formalize relationships between service providers as well as to agree referral and back-referral procedures between different levels of service delivery in order ensure that referral systems run effectively.

116. Non-specialized settings have an important function in providing and disseminating scientific information on drug use and its effects on health. They play an essential role in addressing the stigma and discrimination associated with drug use

disorders. Additionally, they raise public awareness of substance use, its effect on health and of available effective and ethical treatment options for substance use disorders.

117. Key requirements for settings not specialized for the treatment of people with substance use disorders:

(a) Health care facilities and settings, within and outside the health sector, serving populations with a high prevalence of drug use and drug use disorders should have the capacity to screen people for drug use and drug use disorders;

(b) Patients in all health care settings should undergo screening for drug use and drug use disorders when there are clinical signs of drug use and its effects on health. This should be done with the patients' informed consent and in a manner that respects their privacy, confidentiality and preferences;

(c) Health and social care personnel must be trained in Screening, Brief Intervention and Referral to Treatment for drug use disorders, and have access to continuing training and supervision;

(d) Risks associated with SBIRT for drug use and drug use disorders must be mitigated and respect for human rights and dignity, including patient confidentiality, should be guaranteed;

(e) Screening and subsequent treatment activities must be voluntary, based on the patient's informed consent and their right to withdraw from participation at any stage;

(f) Non-specialized settings should have the capacity for diagnostic assessment, management and, whenever necessary, the referral of drug-induced acute clinical conditions;

(g) Formal coordination and relationships should exist between service providers, in addition to referral and back-referral procedures between different levels of service delivery;

(h) Specialized care–including medical, psychological, psychotherapeutic, social and educational care–must always be administered by personnel with the relevant qualifications and licences.

A.3 Specialized outpatient treatment

118. Description: specialized outpatient treatment settings are usually community-based, available for local community members, and designed and designated for the treatment of drug use disorders. Outpatient services vary considerably in terms of their components and intensity. Typically, outpatient treatment for drug use disorders is either carried out by health and social care professionals specialized in the treatment of substance use disorders, or more broadly within the context of mental health treatment.

119. The main treatment interventions usually offered in outpatient settings include:

(a) Comprehensive assessment;

(b) Psychosocial interventions;

(c) Pharmacological interventions;

(d) The management of mental and physical health comorbidities, and;

(e) Social care and support.

120. All patients should be assessed and receive individualized treatment plans that undergo regular review. Discharge planning should ensure continuity of treatment for drug use disorders or recovery management and onward referral to treatment for the management of comorbid psychiatric and other health conditions (as indicated).

121. Target population: specialized outpatient treatment settings can provide a broad range of prevention and treatment interventions and cater for a broad range of individuals. Some interventions, such as psychological therapies, pharmacotherapy or psychosocial interventions may initially be more appropriate for individuals who are motivated for treatment. However, with additional support (such as housing) made accessible, outpatient treatment may benefit most people with drug use disorders (see also service pyramid in III).

122. Goals: the primary objectives of outpatient treatment are to: help patients stop or reduce drug use; minimize the negative health and social effects of drug use; identify and manage comorbid psychiatric and physical health conditions; provide psychosocial support; reduce the risk of relapse and overdose, and; to improve well-being and social functioning, as part of a long-term recovery process.

123. Models and components: outpatient treatment services and programmes vary considerably depending on the services' level of intensity and the range of interventions they offer:

(a)   High-intensity programmes: programmes, such as intensive day treatment, involve interactions with patients (including daily, or several hours of intensive treatment one or more days in a week);

(b)   Mid- to low-intensity programmes: lower intensity interventions may involve weekly group support sessions, individual psychological treatment, health and drug education, peer support and lower intensity social support.

124. In the course of outpatient treatment, health care professionals may regularly assess drug and other substance use, as well as the physical and mental health status of patients. Routine cooperation with allied care services is essential and should include the integration or linking of outpatient treatment with medical services for mental disorders, HIV, viral hepatitis, tuberculosis, sexually transmitted infections, as well as with other relevant health services.

125. There is a need for routine cooperation with social support and other agencies to facilitate access to education, employment, housing, legal assistance, welfare, and social support for people with disabilities. Outpatient services should encourage a more active and participative role for patients in organizing and delivering treatment. Additionally, they should use, as resources, people who have lived the experience of drug use and drug treatment and who are in recovery.

126. Treatment objectives can be best accomplished by using, when and as appropriate, a combination of pharmacological and psychosocial interventions. Ideally, outpatient treatment programmes for drug use disorders should offer a comprehensive range of services to manage various problems affecting patients from different walks of life.

127. Components and activities in specialized outpatient settings can include:

(a)   Comprehensive medical and psychosocial assessment upon admission;

(b)   The development of individual treatment plans (based on comprehensive assessments);

(c)   Continuous evaluation, clinical assessment and review of the patient's progress in their treatment plans, and the patient's active participation in treatment decision-making;

(d)   Medication-assisted detoxification, if indicated;

(e)   Psychosocial treatment interventions for drug use disorders;

(f)   Pharmacological treatment interventions for drug use disorders, such as initiation of opioid agonist maintenance treatment, if indicated;

(g)   Pharmacological and psychosocial treatment for co-occurring psychiatric and physical health conditions;

(h)   Establishing contacts with families and significant others in the patient' social network to engage them in ongoing treatment;

(i)   Intensive social support, including accommodation and employment, and;

(j)   Discharge planning that includes: relapse and overdose prevention, referrals to other services; recovery management, and; continuing treatment for co-occurring psychiatric and physical health conditions (as required).

128.   Psychosocial interventions should be used in outpatient treatment programmes to address motivational, behavioural, psychological and social factors. They should have a demonstrated ability to reduce drug use, minimize associated risks, increase adherence to treatment, promote abstinence and prevent relapse. Section 4.2 provides more details on psychosocial and behavioural interventions.

129.   Pharmacological interventions can be very helpful in managing and/or treating a variety of drug use disorders and health conditions due to drug use, such as acute intoxication and overdose, withdrawal syndromes, as well as a variety of comorbid disorders. Pharmacological interventions should be administered, when appropriate, alongside psychosocial interventions. Section 4.2 provides more details on pharmacological interventions.

130.   Organization of treatment: specialized outpatient treatment settings should have a defined structure and management system, with clear descriptions of individual positions and defined competencies for the staff. The methods for selecting, hiring and training staff should correspond to valid legal norms and established internal rules. The organization of treatment services should take into account patient needs and numbers. There is a need for treatment plans to ensure continuity of care and consider alternative treatment pathways, in the event of partial or complete failure of the original treatment plan and of discharge from the treatment programme.

131.   The delivery of specialized treatment and care (for instance medical, psychological, psychotherapeutic, social and educational) requires personnel with the relevant qualifications.

132.   For patients with comorbid conditions, treatment should be provided either on-site within the integrated service delivery framework, or in other locations as part of linked services and appropriate coordination and referral systems. There is no need to wait for abstinence from opioids or other drugs to commence treatment either for TB, hepatitis or HIV infection.

133.   Involuntary discharge from treatment may be justified to ensure the safety of staff and other patients. However, before resorting to involuntary discharge, it is important to take reasonable measures to rectify the situation, including by re-evaluating the treatment approach used. Non-compliance with a treatment programme alone should not generally warrant involuntary discharge. If inevitable, all efforts should be taken to refer the patient to other facilities or branches of care.

134.   It is essential to discuss cases where an employee has violated a patient's rights, evaluate them and document the appropriate measures taken, in personnel records.

135.   Recovery management and social support: recovery management combines a variety of activities that promote and strengthen internal and external resources (or "recovery capital") to help patients voluntarily and actively manage drug-related problems and their recurrence, and improve health, well-being and social integration. Some of these activities may already exist in a patient's home, neighbourhood and community while others need to be developed. B provides more details on recovery management.

136.   Key requirements for specialized outpatient treatment settings:

(a)   All available treatment services, procedures, policies and regulations as well as the patient's expectations of programmes should be to clearly outlined and made accessible (with the patient's consent and according to their preferences and needs);

(b)   A variety of structured psychosocial interventions should be available, including but not limited to: different forms of individual and family counselling; psychotherapy and psychosocial interventions, and; social support in terms of housing, employment, education, welfare and legal matters;

(c)   Pharmacological treatment options should be available. These should include: symptomatic treatment for stimulant, cannabis and other drug use disorders (such as those caused by polysubstance use); opioid maintenance and opioid withdrawal pharmacological treatments; naltrexone for relapse prevention in opioid dependence, and; naloxone for the management of overdose;

(d)   The choice of treatment and development of an individualized treatment plan for a person with a drug use disorder should be based on: a detailed assessment of treatment needs; the treatment's appropriateness to meet the needs; the patient's acceptance of the treatment, and its availability. All patients should have individualized treatment plans that include some short-term goals while taking a long-term perspective;

(e)   Voluntary testing for HIV and common infectious diseases should be available as part of an individual assessment, accompanied by counselling before and after testing. Additionally, patients at highest risk of contracting hepatitis B infection should be offered hepatitis B vaccination;

(f)   Treatment for patients with HIV, hepatitis or TB should be integrated into or linked with specialized medical services for these conditions;

(g)   Access to other treatment modalities, recovery management and psychosocial support, should be offered to patients, as needed;

(h)   Information about 24-hour emergency services should be provided to patients and their relatives;

(i)   On-site treatment and care for co-occurring psychiatric and physical health problems or, whenever necessary, referral to appropriate health care services, should be provided to patients with comorbidities;

(j)   Laboratory services should be available to monitor the progress of and compliance with the treatment, when appropriate;

(k)   Patients should be tested at initial assessment for recent drug use;

(l)   Both the process and outcomes of the treatment being provided should be subject to sporadic or continuing evaluation;

(m) Discharge planning should ensure continuity of care, recovery management and alternative pathways that might be followed in the event of partial or complete failure of the original treatment plan;

(n)   Generally, non-compliance with a treatment programme alone should not warrant involuntary discharge from treatment;

(o)   Defined policies should be in place for the management of specific risk situations (such as intoxication or suicide risk);

(p)   The treatment facility or programme should have a defined structure and management, with clear roles and competences for individual positions, and staff selection, hiring and training methods that correspond to valid legal norms and established internal rules;

(q)   Cases involving the violation of a patient's rights by an employee and the appropriate measures that were taken should be properly documented in personnel records;

(r)   Specialized care–including medical, psychological, psychotherapeutic, social and educational care–must only be administered by personnel with the relevant qualifications and licences.

A.4 Specialized short-term inpatient treatment

137. Description: the short-term inpatient treatment setting is an environment offering 24-hour care with the capacity to manage acute manifestations of drug use disorders. The manifestations include the complicated intoxication states, drug withdrawal syndrome or other drug-induced acute clinical conditions, including those that are likely to occur in the days and initial weeks following the cessation of drug (or polysubstance) use. Short-term inpatient treatment can be provided in specialized hospitals for the treatment of substance use disorders, as well as in mental health hospitals or specialized units or programmes of general hospitals, if they have properly trained personnel and the necessary medical equipment.

138. Short-term inpatient treatment provides an opportunity to give up drug use with minimal discomfort and risk to health. It offers a temporary reprieve from the environmental stressors in a person's life. Additionally, it makes it possible to initiate treatment for a drug use disorder and receive required psychosocial support, which may be the start of a long-term recovery process. The length of stay usually varies from one to four weeks, based on local practice and the clinical situation. Depending on the drugs concerned, the withdrawal syndrome and other acute drug-induced health conditions and their treatment may carry significant health risks. Accordingly, short-term inpatient treatment requires a higher degree of medical supervision than long-term residential treatment, which normally follows the acute withdrawal phase (see A5).

139. Target population: he typical target population includes people with drug (or polysubstance) use disorders who are susceptible to significant withdrawal symptoms upon cessation of their drug use or to other acute clinical conditions caused by drug use. Sedative and opioid withdrawal can be severe, particularly among people using high doses of sedatives (such as benzodiazepines or barbiturates) or opioids over extended periods of time. Short-term inpatient treatment can also serve to initiate opioid agonist maintenance treatment for opioid dependence.

140. Anyone who is susceptible to a severe withdrawal syndrome following cessation of drug (or polysubstance) use, or whose current drug (or polysubstance) use carries a significant risk of harm, urgently needs short-term inpatient treatment.

141. The decision on whether to opt for a short-term inpatient treatment or another treatment setting should take into account the following criteria:

(a) The type of drugs (or other substances) being used;

(b) The likelihood of withdrawal syndrome;

(c) The severity and complexity of the drug use disorder;

(d) The low effect of treatment in outpatient or non-specialized treatment settings;

(e) Related health and social problems, and;

(f) Co-occurring psychiatric and physical health problems.

142. Goals: the goals of short-term inpatient treatment are to: diagnose and manage clinical conditions due to drug use; facilitate the cessation or reduction of drug use; initiate the treatment of drug use disorders, and; motivate patients to continue with treatment after the short-term inpatient treatment. Treatment for drug use disorders may involve evidence-based psychological and pharmacological treatment accompanied, as needed, by social support. Medically assisted detoxification can be provided in short-term inpatient treatment settings. While this can also be accomplished successfully and safely on an outpatient basis, and with fewer resources, the rates of completion of detoxification may be lower. Evidence points to high rates of relapse to drug use following short-term detoxification, particularly in cases of opioid dependence. Accordingly, detoxification on its own is not considered an effective treatment for drug use disorder and can result in an increased risk of opioid overdose.

143. Models and components: achieving the therapeutic goals of short-term inpatient treatment typically requires a combination of interventions, such as pharmacotherapy, psychotherapy, psycho-education, motivational counselling and social support through psychosocial interventions. Other possible interventions include introduction to self-help or mutual aid groups, available social services and referrals for continued treatment or recovery management after discharge. The specific types and duration of these interventions vary depending upon the nature, complexity and severity of an individual's drug use disorder, as well as the presence of co-occurring psychiatric and physical health problems.

144. Management of withdrawal syndrome and other acute drug-induced clinical conditions: unrecognized and untreated withdrawal syndromes run the risk of driving a patient out of treatment. Therefore, short-term inpatient treatment programmes must have staff who are highly competent in diagnosing and managing withdrawal syndromes and acute drug-induced disorders, as well as providing psychosocial support and pharmacological treatment. The staff of short-term inpatient treatment services must have the option to transfer patients with particularly severe and complex conditions to another level of health care. See section 4.2.3 for more details on the management of withdrawal syndromes.

145. Treatment for co-occurring psychiatric and physical health problems: the use of different drugs and alcohol can cause or aggravate psychiatric symptoms that may resolve when drug use is stopped. In other cases, psychiatric symptoms may persist after discontinuation of substance use and require additional attention in short-term inpatient treatment. See section 4.2 for more details on co-occurring psychiatric and physical health problems.

146. Recovery management and social support: initiating and engaging in short-term inpatient treatment may be an important step in treating drug use disorders. However, it is particularly important for patients to maintain sustainable healthy behaviours after they leave inpatient treatment because the risk of relapse and overdose increases significantly immediately after discharge. As such, it is necessary to continue psychosocial and recovery management interventions for substance use disorders after short-term inpatient treatment. Strategies to help patients successfully transition to the next stage of treatment and care should be part and parcel of effective treatment through the care or aftercare plan. This enhances the chances of maintaining physical and psychological health. Health and social care professionals should work together to provide patients with the necessary resources and through care when planning a discharge from inpatient to a long-term residential programme, outpatient treatment or recovery management. Following short-term inpatient treatment, patients should have access to: long-term medication treatment, if indicated; psychosocial support and navigation through the social care system so as to benefit from vocational training, stable housing and other support, as needed; continuing treatment of comorbid physical health and psychiatric conditions, and; overdose prevention interventions, among others. See section 4.2.6 for more details on recovery management.

147. Treatment components: short-term inpatient treatment programmes for drug (and polysubstance) use disorders should include the following treatment components:

(a) Comprehensive drug (and polysubstance) use, medical and psychosocial assessment – including mental health and physical health assessment;

(b) Individualized treatment plans;

(c) Medication-assisted withdrawal management, if indicated;

(d) Initiation of opioid agonist maintenance treatment for opioid dependence, if indicated;

(e) Interventions to foster patients' motivation to change their behaviour;

(f)   Contact with and engagement of individuals of significance in patients' social network to engage them in the treatment plan (with patient's consent);

(g)   Sharing information and facilitating connection with mutual help groups;

(h)   Initiation of psychosocial or behavioural treatment interventions for drug use disorders;

(i)   Initiation of (or referral for) treatment for co-occurring psychiatric and physical health disorders, if time and resources permit;

(j)   Continuous evaluation of patient's progress in their treatment planning and review, as well as clinical assessment that is built into the programme;

(k)   Discharge planning with relapse and overdose prevention; continuing care strategies for post-inpatient treatment (including maintenance medication if indicated); an appropriate level of psychosocial treatment; recovery management and continuing treatment for co-occurring psychiatric, and; physical health problems.

148.   A comprehensive medical and psychosocial assessment is necessary preferably before, or on admitting someone for short-term inpatient treatment. This will help determine each patient's specific needs and develop their treatment plan. The assessment should include the patient's psychiatric and physical health history, the history of pharmacological treatment, physical and mental health status examinations, as well as a routine assessment of history of infectious diseases. It may also be valuable to conduct laboratory investigations, including urine drug screen, and testing for HIV, hepatitis or tuberculosis. In all cases patients should be informed about how to identify and manage overdose, and also receive information on other treatment, support and care options.

149.   Trained staff may apply standardized assessment tools to obtain a more detailed assessment of patients (see section B1 for a list of assessment tools).

150.   Once admitted into short-term inpatient treatment, patients should be monitored multiple times per day for withdrawal symptoms and any acute psychiatric or physical health problems. Once the acute problems are stabilized or resolved, daily monitoring should focus on the patient's psychiatric and physical health status, as well as their motivation and the development of their treatment goals and plans upon discharge.

151.   Criteria for programme completion and indicators of effectiveness: successful completion of short-term inpatient treatment can be evaluated for each patient on the basis of several factors including:

(a)   Resolution of withdrawal symptoms;

(b)   The patient's understanding of substance use disorder and related problems;

(c)   Engagement in follow-up treatment after discharge from long-term residential treatment or outpatient treatment;

(d)   Improvement in physical and mental health, and;

(e)   Reduced craving for drugs and the development of skills to gain control over triggers (thoughts, emotions and behaviours) that lead to drug use.

152.   Outcome indicators can help evaluate the effectiveness of short-term inpatient treatment programmes. The indicators include the proportion of patients who engage in follow-up treatment after discharge, or patients who abstain from or reduce their substance use based on a longer-term follow-up, for example six months (although this type of outcome indicator requires tracking and long-term follow-up of patients).

153.   Key requirements for short-term inpatient treatment settings:

(a)   All available treatment services, procedures, policies and regulations, as well as the patient's expectations of the programme, should be clearly outlined and accessible (with the patient's consent);

(b)   Patients must have individual treatment plans that are regularly reviewed and modified by staff, in conjunction with the patient, to ensure appropriate management of drug use disorders and comorbid health conditions;

(c)   The choice of treatment and the development of an individualized treatment plan for a patient with drug use disorders should be based on: a detailed comprehensive assessment of his or her drug and other substance use; health status and psychosocial issues; treatment needs; the appropriateness of treatment to meet the needs, and; the patient's acceptance of the treatment and its availability;

(d)   Clearly defined protocols should exist for prescribing medications, psychosocial and other interventions appropriate to the patient's specific needs, and they should be anchored in research findings or respect recognized good clinical practices;

(e)   Protocols must be in place for the management of specific risk situations (including intoxication and suicide);

(f)   On-site or off-site laboratory and other diagnostic facilities should be available;

(g)   Emergency support or transport must be available in the event of life-threatening complications of withdrawal syndromes or other health conditions;

(h)   When a procedure with known risks is under consideration, a careful risk/benefit evaluation must be carried out, leading to the selection of the least risky option;

(i)   Access to self-help and other support groups should be available. Whether the individual's treatment goal is abstinence or not, measures must be in place to reduce the harm of continued drug use. (Among other things the measures concern health, diet, sterile injection equipment, overdose prevention and the supply of naloxone.)

(j)   Treatment plans must ensure the continuity of the patient's care in outpatient treatment, long-term residential treatment or recovery management;

(k)   Treatment programmes for drug use disorders must be linked to other services that support interventions with patients' children and other family members who may need them;

(l)   The process and outcomes of the treatment provided must be subjected to periodic or continuous evaluation;

(m)   The structure and management of the treatment organization or programme must be defined, spelling out the roles and competences of individual positions, and ensuring that staff hiring and training methods reflect valid legal norms and established internal rules;

(n)   Written or electronic patient records must be kept in a manner that respects patient confidentiality;

(o)   The service should have policies on safe working conditions and ways to manage unsafe situations;

(p)   Cases involving the violation of a patient's rights by an employee should be documented in personnel records, as needed, along with the appropriate measures taken;

(q)   Specialized inpatient short-term treatment for drug use disorders must only be administered by personnel with the relevant qualifications and licences (for example in the medical, psychological, psychotherapeutic, social and educational fields).

A.5 Specialized long-term or residential treatment

154. Description: long-term or residential treatment typically offers services for individuals with drug use or other substance use disorders, living in a communal environment with other people who have similar health conditions. These individuals have an explicit commitment to abstain from drug, alcohol and other psychoactive substance use. They stay in a residential setting and participate in an intensive daily programme. The programmes provide a diverse range of interventions delivered in a variety of places. These may include: community meetings and group work; individual psychosocial interventions; family psychosocial interventions; mutual aid and self-help; active participation in community life, and; gaining life skills and vocational training. Admission to the treatment programme normally requires acceptance of the rules and regulations of the treatment setting.

155. Long-term or residential treatment differs from supported accommodation that primarily functions as a housing intervention without providing treatment interventions on-site, although residents may attend outpatient treatment programmes. Additionally, long-term or residential treatment settings differ from compulsory or detention centres for drug users, where people using drugs are confined without their consent, and often without due processes of diagnostic assessment and evidence-based and ethical treatment for substance use disorders.

156. Staying long-term in a residential setting or hospital (usually for three months and often far longer, depending on the patient's needs) helps remove patients from the sometimes chaotic and stressful environments that may have contributed to their drug use. The "substance-free" therapeutic environment is designed to reduce exposure to the usual cues that trigger drug-seeking behaviour and help patients or residents maintain abstinence and work towards recovery. Although traditional models of long-term residential treatment include only psychosocial treatment methods, modern approaches may involve the use of medications to decrease drug cravings and manage comorbid psychiatric symptoms.

157. Long-term residential programmes, especially therapeutic communities, use the programme's entire community, including other residents, staff and the social context, as active components of treatment and recovery management. Long-term residential treatment programmes have rules and activities designed to help residents develop better self-management skills. Programmes help patients or residents acquire skills to control cravings and prevent relapse to substance use, develop improved impulse control, delay gratification and develop new interpersonal skills. Additionally, they help develop personal accountability, responsibility, as well as the ability to cope with stress and improve self-esteem. The residential treatment setting offers comprehensive services, including vocational skills training, employment training, psychosocial support and sometimes treatment for mental health disorders.

158. The intensive and supportive environment that patients experience in residential treatment settings can offer an appropriate response to their personal history often characterized by poor parental care, emotional neglect, physical or sexual abuse, trauma, interpersonal violence and social exclusion.

159. Target population: long-term or residential treatment programmes are best suited for individuals who are not using drugs at the time of admission, but who require intensive and continuing treatment and care for drug use disorders to address complex health and psychosocial problems associated with drug use disorders. (The individuals include people who have stopped using drugs after inpatient or outpatient withdrawal management.) These are patients who have serious difficulty maintaining abstinence in a community setting or in outpatient treatment and wish to voluntarily participate in a structured residential programme. This is an opportunity for them to begin changes in various areas of their lives and to learn new skills to help in their recovery process, thereby improving the quality of their lives and their social integration.

160. Residential treatment services are typically indicated for individuals:

(a) Experiencing drug use (or polysubstance use) disorder of a significant severity that affects their education, employment and social integration process;

(b) Experiencing severe co-occurring physical and mental health disorders that have an impact on their security and well-being outside of structured environments (and who usually require hospitalization);

(c) With a history of unsuccessful treatment, who have not responded to interventions or repeatedly relapsed after short-term inpatient or outpatient treatment;

(d) With limited personal and/or economic resources (including income and housing);

(e) With social and family problems and limited social support;

(f) Who are socially isolated or deprived;

(g) Who, in order to achieve treatment objectives, need to change their environment and distance themselves from social networks and groups associated with drug use-related activities, and;

(h) Who voluntarily want to abstain from substance use, recognize their needs and are prepared to make significant life-style changes and acquire new skills in a residential setting.

161. Goals: the primary goal of long-term or residential treatment is to reduce the risk of returning to active drug use, maintain abstinence from drug use, improve health and personal and social functioning, as well as facilitate rehabilitation and social reintegration. Specific objectives of long-term residential treatment are to:

(a) Reduce the risk of a relapse to substance use;

(b) Develop skills to cope with cravings and life stressors without drugs;

(c) Provide treatment and care for co-occurring psychiatric and substance use disorders, using psychosocial therapy and, in some settings, pharmacological treatment;

(d) Improve health, personal and social functioning, including in work environments;

(e) Develop effective interpersonal relationships with other people, as well as the interpersonal and communication skills required to build a network of peers who do not use drugs;

(f) Build a healthy family environment and relationships within the family, including parents-child ties;

(g) Reintegrate into communities and facilitate social connectedness;

(h) Acquire new social skills and gain self-confidence as well as appreciation for positive behaviours;

(i) Acquire a healthier lifestyle, including good nutrition, a stable sleep/wake routine, regular health monitoring and adherence to treatment, and;

(j) Advance education and develop vocational skills to progressively regain control over one's life upon completion of treatment.

162. Models and components: long-term treatment programmes may differ in their treatment approaches. Patients are required to abstain from substance use and, whenever necessary, should receive treatment for withdrawal syndromes. This can be delivered within the same treatment setting or in specialized inpatient or outpatient settings in accordance with the relevant sections of this document (see sections B 3).

163. A variety of models of long-term residential treatment have evolved in different settings. The settings include stand-alone long-term residential treatment centres or

rehabilitation units set up specifically for drug use disorders. The units tend to have particular philosophies or treatment approaches that are not mutually exclusive. The philosophies or approaches include formal therapeutic communities, 12-step mutual aid programmes, faith-based programmes and vocational programmes. Hospital-based programmes (typically in a dedicated ward or building of a psychiatric hospital) may be focused solely on drug use patients or patients with comorbid drug (or polysubstance) use and psychiatric disorders. Such programmes may be therapeutic communities or hospital rehabilitation programmes and may feature both pharmacological and psychosocial interventions.

164. Detained individuals with drug use disorders can benefit from prison-based long-term residential treatment programmes. These may be organized as therapeutic communities or specific rehabilitation programmes for offenders with substance use disorders, typically in a dedicated section of a prison. See Section 5.4 for detailed information on treatment for people in contact the criminal justice system.

165. Admission: different types of long-term or residential treatment programmes may have different admission criteria. All should feature the patient's voluntary request for or consent to placement in a long-term residential programme. Some services may require the patient to visit the unit, and acceptance by the community group. In other services, the decision may depend on the staff and the patient.

166. Every programme should have a written intake policy to ensure that admission is voluntary, and the patient should confirm this with written consent. Such a policy should clearly describe the eligibility and exclusion criteria. Additionally, programmes should have a written intake/orientation procedure that applies to all incoming residents. During admission, new residents should receive adequate briefing as well as documentation on the programme, including its objectives, treatment methods and rules. It is important to inform patients about their obligations and rights, privacy, non-discrimination and confidentiality. There is a need to inform patients about the role of the staff, the programme's underlying philosophy and regulations on communication with visitors and people outside the programme. It is necessary to discuss administrative details, such as the programme's cost and payment methods. Intake policies and procedures should be well known by the staff. Lastly, there is a need to discuss and sign a treatment "contract" that clearly outlines all treatment services, procedures, policies and regulations as well as the patient's expectations of the programme.

167. If a programme does not accept a potential patient or resident, it should give them and the referring agency a comprehensive explanation verbally and in writing, without breaching confidentiality. It is important to make an appropriate on-ward referral for any person not accepted into the programme. The staff who conduct assessments, working with a pre-existing network of services, must be familiar with appropriate alternative services for referrals.

168. Certain people with special treatment and care needs may require separate long-term inpatient facilities. They include women, children and adolescents, individuals with dual diagnoses and people with developmental disabilities. If possible, they should have access to specialized long-term residential treatment programmes. See V for further details ways to adapt programmes to populations with special needs.

169. Assessment: some services may use an initial phone-based interview prior to the in-person assessment. Long-term residential treatment programmes should conduct a comprehensive psychosocial and medical assessment of every incoming patient to determine their individual needs and suitability for the programme. It may be necessary to place patients with significant mental and physical health problems in a setting that provides the appropriate level of medical and psychiatric care. This requires the patients' informed consent.

170. An initial meeting serves to familiarize the staff with the prospective resident, and the latter with the residential programme. It is the first step in the development

of a therapeutic alliance. The meeting usually enables prospective residents to decide whether to enter the programme, and the latter to decide whether to admit the prospective residents.

171. Following a patient's consent, it is necessary to discuss individual needs and medications with the referring agencies and the patients' medical practitioners. Discussions should include a plan on how to manage withdrawal, if needed.

172. Treatment plans should be developed based on comprehensive assessments, preferably involving standardized instruments and procedures, such as the Addiction Severity Index or a Composite International Diagnostic Interview–Substance Abuse Module.

173. The following areas are important for the assessment:

(a) Previous short- and long-term treatment and perception of previous treatment;

(b) General health, including current health concerns and physical, sensory or cognitive disabilities;

(c) Mental health, including trauma and abuse history (physical, emotional and sexual), violence and suicide risk, current psychological and interpersonal functioning;

(d) Current living conditions, including safe accommodation and housing and a support system at home;

(e) Family life, including relationships with the family of origin, intimate relationships and dependent children;

(f) Friendships, including networks of peer relationships, positive or negative influences and people supporting long-term sobriety;

(g) Education and work, including school and work history, vocational training level and needs, income (legal and otherwise

(h) Legal problems, including involvement in criminal activities associated with drug use, and;

(i) Leisure activities and hobbies.

174. The long-term period and the residential setting create an opportunity for more thorough continuous assessment. It also allows assessment after an initial period of abstinence from substances, and thereby prevents effects of drug intoxication or withdrawal from influencing the diagnosis of disorders. Additionally, it can provide assurance that patients fully understand the nature of treatment and are able to fully consent to it. Living with peers and the staff can also allow the on-going assessment of personality traits and functioning that can be very useful in individualizing the treatment.

175. Treatment engagement: higher levels of treatment engagement can influence treatment outcomes positively. Variables that foster treatment retention include:

(a) The level of motivation for treatment;

(b) Levels of drug or alcohol use before treatment;

(c) History of contact with the criminal justice system;

(d) The strength of the therapeutic relationship;

(e) Perceived helpfulness of the treatment service and usefulness of the treatment;

(f) Empathy of the staff.

176. During the first three weeks and in particular the initial days of a long-term residential treatment, the risk of dropping out and relapsing is highest. Therefore, it

is important that residents receive appropriate attention and individualized care focused on enhancing motivation to remain in treatment. Especially during this period, many residents may continue to experience psychological distress related to protracted withdrawal symptoms (insomnia, anxiety, irritability and drug cravings). They may feel ambivalent about giving up drug use and find it difficult to adapt to the programme's rules.

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

(a)　Provide a friendly and welcoming atmosphere;

(b)　Establish a therapeutic alliance built on trust, early in the process;

(c)　Respond quickly to requests for treatment to maximize patients' treatment engagement;

(d)　Provide information on the programme's philosophy, expectations, approach to treatment and recovery, retention and health outcomes, and concerns that residents frequently encounter early in the treatment;

(e)　Focus on the client's immediate concerns, rather than the programme's;

(f)　Beef up support in the first 72 hours of treatment through closer observation, increased general interaction and the use of a "buddy system" (the pairing of new residents with an established resident);

(g)　Develop realistic and individualized treatment plans and goals that reflect the client's needs and that are flexible enough to adapt to his or her progress;

(h)　Create awareness of the heterogeneity of clients, particularly in group treatment processes;

(i)　Be caring and respectful in all aspects of the treatment programme, as confrontation often results in anger and early abandonment of treatment;

(j)　Give objective feedback about the problems and processes of change in order to foster credibility and trustworthiness, and;

(k)　Develop motivational strategies that focus on the individual patient.

178. Therapeutic interventions: at a minimum, long-term residential treatment should provide drug- and alcohol-free environments, individual psychosocial support, interventions to help acquire life-skills and a variety of regular group meetings. These involve morning meetings, non-confrontational groups, gender specific groups, mutual help groups and peer support. Hospital-based residential programmes should also provide medical and psychiatric care, individual and group therapy and interventions involving family members. While some long-term residential treatment programmes provide only psychosocial treatment, others may offer pharmacological support, including opioid agonist maintenance treatment, if indicated.

179. Long-term residential programmes may include a broad range of therapeutic modalities, such as individual and group psychosocial interventions, life skills training, vocational and educational training and recreational activities. Evidence-based interventions routinely used in outpatient treatment can be adapted and applied to long-term residential treatment as well. Applicable specific psychosocial treatment methods include: cognitive-behavioural therapy; contingency management, motivational enhancement therapy; family or behavioural couple therapy; social skills training, and; other methods described in the section on treatment interventions (see section 4.2). Structured relapse prevention programmes are essential in preparing residents for re-integration into the community. Therapeutic interventions, such as art and creative therapy, movement therapy, meditations, relaxation and physical activity (for example exercise and group sports) can help patients discover and develop new free-time and recreational activities. This can support recovery if continued when patients return to the community.

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

181. Like in any other treatment setting, harsh verbal confrontation or shaming techniques should be avoided. Likewise, it is important to shun punitive or restrictive techniques (including physical restraint) and any other intervention that compromises individual safety or dignity.

182. Patient documentation: written or electronic patient records should be kept confidentially in a secure location, only available to the staff directly involved in the treatment. Proper documentation should include at a minimum:

(a) Signed consent to treatment and agreement on programme rules;

(b) Signed confidentiality and ethics policy;

(c) Patient assessment;

(d) Patient treatment and management plans for each resident;

(e) Regular reviews or updates of treatment plans with details of treatment, progress and any changes to the original goals, and;

(f) Patient discharge records with a completion summary of the patient's treatment.

183. Length of treatment: long-term residential treatment should last at least three months and most likely far longer, depending of the patient's needs. A treatment of sufficient length and intensity increases the resident's chance of consolidating and internalizing any behavioural change and their preparedness to live a drug-free life in their communities. The duration of treatment necessary to reach this point varies for each resident.

184. Discharge and follow-up: Many patients need continuous pharmacologic and psychosocial support once discharged from long-term residential treatment. Effective management of referral to aftercare (or continuous care) should be in place to follow up people after discharge. See section B6 for more details on Recovery management.

185. Staffing: the staffing of long-term or residential treatment facilities depends on the type of service and category of patients. Based on the size of the treatment programme, the delivery of optimal care usually requires a multidisciplinary team of trained professionals and volunteers.

186. Therapeutic communities and other long-term residential treatment services require some degree of medical supervision. Medical doctors, including psychiatrists if possible, should be on call or available for a certain number of hours every week. Residential treatment facilities for people with severe comorbid conditions need to have medical care services on site during the day and on call during the night.

187. Counsellors, nurses and social workers should be present at the programme site at all times. Former residents and individuals, who are recovering from drug use disorders and work as staff, can be valuable role models for residents. Preferably they should have worked outside a treatment programme and have professional training as counsellor or group worker. For professionals starting to work in a long-term residential programme, it is advisable to spend time in the programme before being hired or immediately thereafter.

188. Safety considerations: all residential treatment programmes must provide safe conditions to staff and residents to ensure a psychologically and physically safe living and learning environment.

189. The programme facility's physical environment and appearance matter greatly as residents may stay in the programme for several months. The facility should be like a home rather than a prison or a hospital. It is important to place and maintain a ban on alcohol and drugs. However, residents need not stop taking prescribed psychoactive medications, such as antidepressants, methadone or buprenorphine, used under medical supervision to treat psychiatric or substance use disorders, unless otherwise medically indicated. Procedures, including for the storage, dispensing and administering of medications, should be in place for the management of prescribed medications.

190. Unacceptable behaviour, such as the use of drugs or alcohol, violence, theft and sexual activities between residents, may result in removal from the programme. Urine toxicology screening, which residents undergo regularly on returning to the treatment setting from temporary leave and when drug use is suspected, can help maintain a drug-free environment. Procedures should be in place to report and manage unsafe incidents, such as physical or sexual abuse. There must be clear procedures to handle breaches to programme rules and values in a manner that is proportional to the specific circumstances. Contact with visitors should be restricted, monitored or supervised, particularly in the early stages of treatment.

191. If a person is discharged or not admitted to treatment, they should be informed about how to identify and manage overdose, as well as receiving information on other treatment, support and care options.

192. Criteria for the completion of the programme and indicators of its effectiveness: the evaluation of an individual's treatment success and their readiness for discharge should take into account several factors including their:

(a) Physical and mental health;

(b) Motivation to continue treatment, and recovery maintenance upon discharge;

(c) Ability and motivation to engage in work or education and to contribute to the community;

(d) Improved self-management skills and ability to regulate emotions;

(e) Understanding of factors and triggers that may contribute to drug use and relapse as well as demonstrated ability to recognize them and manage drug cravings;

(f) Improved social connectedness, functioning and willingness to move away from drug-using networks towards social networks which value abstinence and recovery, and;

(g) Development of new skills, hobbies and interests that can be continued after discharge.

193. Some long-term residential treatment programmes offer a transitional or re-entry treatment phase to prepare residents for discharge. During this phase residents may gradually spend an increasing amount of time outside the community (pursuing education or work) while still participating in the programme as a resident. This is a period of increased contact with the wider community while the residents still benefit from the safety, stability and support provided by programme services. It allows them to practise newly acquired skills, maintain abstinence, develop new relationships and supportive friendship networks and, where appropriate, to re-establish ties with their immediate families.

194. The overall functioning and effectiveness of a long-term residential treatment programme can be evaluated by a combination of process indicators (including what services are delivered or what goals are met by patients during the treatment stay) and objective measures of patients' long-term outcomes after discharge. The indicators may include the proportion of patients who:

(a) Complete treatment;

(b)   Engage in follow-up treatment or recovery management after discharge, for example, the proportion of patients who engage in follow-up treatment after discharge;

(c)   Complete treatment and maintain abstinence from drug use at follow-up (for example, at six-monthly intervals), evidenced by self-reports and other markers of recovery.

195.   Key requirements for long-term or residential treatment settings:

(a)   The long-term residential treatment setting has a planned therapeutic programme;

(b)   All patients undergo a comprehensive assessment;

(c)   All patients have a written individualized, regularly reviewed treatment plan, based on their assessment;

(d)   There is a structured and consistent daily schedule of group activities;

(e)   The treatment programme has a clear chain of clinical accountability;

(f)   There are clearly defined privileges with a rationale and process for allocating them;

(g)   The service takes responsibility for improving and maintaining the patient's physical health;

(h)   There are written policies, procedures and adequate clinical oversight for the pharmacological therapy and management of prescribed medications;

(i)   The service is equipped to prepare residents for independent living in the wider community;

(j)   Registered care homes and other long-term treatment facilities meet national minimum standards for residential settings;

(k)   There are defined criteria for the expulsion of patients, among other things, for the violation of treatment service rules, violence and continued use of non-prescribed drugs;

(l)   There is a strict code of ethics for staff. It is advisable to establish an external board to provide oversight, thereby ensuring that directors and staff of long-term residential treatment settings comply with good practice and ethics and refrain from abusing their power;

(m)   There are defined criteria for the management of specific risk situations (such as intoxication and suicide risk);

(n)   Discharge is based on a consideration of the patient's recovery status;

(o)   Attention is paid to further treatment and (family, social or other) support that may be required, based on the patient's diagnosis, goals and resources;

(p)   Care plans are explored that 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;

(q)   The service has policies for safe working conditions and the management of unsafe situations;

(r)   The structure and management of the long-term treatment programme is defined, spelling out the roles and competences of individual positions, and ensuring that staff selection, hiring and training methods comply with valid legal norms and established internal rules;

(s)   Written or electronic patient records are kept in a manner that respects patient confidentiality;

(t)   Cases involving the violation of a patient's rights by an employee are documented, as needed, in personnel records, along with the appropriate measures that were taken;

(u)   Specialized treatment for drug use disorders is only administered by personnel with the relevant qualifications and licences (such as in the medical, psychological, psychotherapeutic, social and educational fields), and always with the patient's consent.

B.   Treatment modalities and interventions

B.1   Screening, brief interventions and referral to treatment

196.   Description: screening, brief intervention and referral to treatment or screening and brief interventions is an evidence-based intervention used to identify, reduce and prevent drug use disorders, particularly in health settings that are not specialized in the treatment of drug use disorders (WHO, 2016). All health professionals can benefit from SBIRT training, particularly personnel working in populations with a high prevalence of substance use or with people who have substance use disorders.

197.   Screening: screening is a brief process to identify indicators for the presence of a specific condition. The indicators reflect an individual's need for treatment and determine whether a thorough assessment is warranted (SAMHSA, 2015). Screening tools used for these purposes can be grouped in two categories:

(a)   Self-report tools (interviews, self-report questionnaires);

(b)   Biological markers (blood alcohol levels, the presence of drugs in saliva, serum or urine).

198.   Self-report tools have the advantages of being physically non-invasive and inexpensive. A good self-report screening tool should be brief, easy to administer and to interpret, address alcohol and other drugs as well as be clinically sensitive and specific enough to identify people who need a brief intervention or referral for treatment.

199.   To enhance the accuracy of a self-report tool, it is important to assure the patient of confidentiality, interview them in a setting that encourages honest reporting and ask them clearly worded and objective questions.

200.   A range of validated tools exists for screening drug use disorders. The tools include the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), an evidence-based screening tool developed and recommended by the World Health Organization (WHO, 2010a). ASSIST consists of eight questions about alcohol, tobacco and drug use (including injecting drug use). The questions identify an individual's hazardous, harmful or dependent use. Developed specifically for a primary care setting, it is recommended for interview or self-completion.

201.   Following screening, additional tools can be used to obtain a more detailed assessment of patients, such as the Addiction Severity Index (ASI) (McLellan, Luborsky & Woody, 1980), which evaluates the severity of drug and other substance use disorders and associated problems (including psychiatric, physical health and family issues). When the patient is not in acute withdrawal, it is possible to consider a structured interview for psychiatric disorders. Tools for this include the Mini-International Neuropsychiatric Interview (MINI) (Sheehan et al, 1998; Sheehan, 2016), Structured Clinical Interview for DSM-5 (SCID) (First et al, 2015) or the Composite International Diagnostic Interview–Substance Abuse Module (CIDI-SAM) (Cottler, 2000). These are particularly useful for diagnosing drug use disorders as well as identifying co-occurring psychiatric conditions.

202.   While biological markers may be useful within the SBIRT framework when a patient is unable to respond to an in-person interview (for instance while unconscious

in intensive care), information is required to attain a screening result. However, it is preferable to use a self-report screening tool for conscious patients.

203. Brief interventions: a brief intervention is a structured therapy of short duration (typically 5-30 minutes) whose aim is to help an individual cease or reduce the use of psychoactive substances or (less commonly) to deal with other life issues. It is designed primarily for general practitioners and other primary health care workers (WHO, 2001; WHO, 2010b). Following a client-centred and strength-based approach, patients are empowered and motivated to take responsibility and change their substance use behaviour. If available and necessary, brief interventions may be extended for one or two sessions to help patients develop the skills and resources required to change, or for a follow-up to assess if further treatment is required.

204. An effective brief intervention requires several basic steps. Firstly the practitioner broaches the topic of drug use with respect to the patient's health and wellbeing and how this relates to the situation in which they find themselves. The discussion centres on the patient, with strategies, such as summarizing and reflection being used to provide feedback. Patients are asked to talk about change and to set realistic goals. The session ends with the practitioner making a summary and providing positive feedback to empower patients to take responsibility for changing their behaviour.

205. The components of effective brief interventions can be summarized in the FRAMES framework:

(a) Feedback is given to the individual about personal risk or impairment;

(b) Responsibility for change is placed on the individual;

(c) Advice to change is given by the provider;

(d) Menu of alternative self-help or treatment options is offered;

(e) Empathic style is used in counselling;

(f) Self-efficacy or optimistic empowerment is engendered.

206. WHO recommends the following nine-step approach to brief interventions following the ASSIST screening (WHO, 2010b):

(a) Asking clients if they are interested in seeing their ASSIST questionnaire scores;

(b) Using the ASSIST feedback report card to provide personalized feedback to clients about their scores;

(c) Giving advice about how to reduce risk associated with substance use;

(d) Allowing clients to take ultimate responsibility for their choices;

(e) Asking clients how concerned they are by their scores;

(f) Weighing up the good things about substance use against the less good things about it;

(g) Summarizing and analysing clients' statements about their substance use, with emphasis on the "less good things";

(h) Asking clients how concerned they are by the "less good things"; and

(i) Giving clients take-home materials to bolster the brief intervention.

207. Referral to treatment: once the screening and subsequent assessment of an individual confirm that they have a clinically significant drug use disorder or a serious polysubstance use, or co-occurring psychiatric or physical health condition, they should be referred to the most appropriate facility for treatment without delay. It is possible to speed up referrals by making the appointment at the treatment centre in the patient's presence, using "patient navigators" who accompany the patient to the treatment centre, and by following up with the patient on their enrolment in the

treatment programme. The most efficient referral method involves initiating and providing treatment for drug use disorders at the setting that conducts the SBIRT.

Recommendations (mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings, 2012):

- 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 individualized feedback and advice on reducing or stopping cannabis / psychostimulant consumption, and the offer of follow-up.

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

B.2 Evidence-based psychosocial interventions

208. Description: psychosocial interventions should be used in outpatient treatment programmes to address motivational, behavioural, psychological and other psychosocial factors related to drug use disorders. These interventions have proved effective in reducing drug use, promoting abstinence and preventing relapse. Psychosocial interventions can also serve to increase adherence to treatment and medications. Different drug use disorders require other interventions, the following of which have proved effective: psychoeducation; cognitive behavioural therapy; motivational interviewing; the community reinforcement approach; motivational enhancement therapy; family therapy; contingency management; dialectical behavioural therapy; mindfulness-based cognitive therapy; acceptance and commitment therapy; trauma-focused cognitive behavioural therapy; mutual help groups (including 12-step groups), and; housing and employment support, among others (WHO, 2016).

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

210. Contingency management: CM involves giving patients concrete rewards to reinforce positive behaviours, such as abstinence, treatment attendance, compliance with medication or a patient's own particular treatment goals. The effectiveness of CM requires an agreed positive outcome with an objective measure (typically toxicology testing of urine and a negative drug screening result) and immediate feedback. Drug test results provide an indicator of treatment progress and they may be discussed in therapy sessions to heighten understanding of the patient's condition. A CM approach, which can be combined with CBT, is often used as part of treatment that focuses on reinforcing new behaviours that are competing with drug use.

211. Patients treated with CM–unlike those using other treatments–often show greater initial reductions in drug use. However, it is doubtful whether these effects can last without using CM in combination with other treatment approaches. CM has proved particularly useful in treating patients with amphetamine and cocaine use disorder, helping reduce treatment abandonment and drug use. Other studies found that when CM used vouchers to reward patients for significant achievement in their treatment, this actually increased the level of employment among them. Although many of the research trials use monetary reinforcement, it is important to adapt contingency management to the culture and population, with input from patients.

212. Community reinforcement approach: the community reinforcement approach is a behavioural approach to reducing drug use in which people with drug use disorders seek to modify the way they interact with their "community" in order to gain more positive reinforcement from such interactions. Practitioners of the community reinforcement approach encourage clients to progressively build up a range of enjoyable non-substance related activities, such as positive family interactions, healthy social activities or employment. Community reinforcement approach strategies include: developing the skills (such as communication, social, job, problem solving, drug refusal and relapse prevention skills) of people with drug use disorders; encouraging clients to look at every aspect of their life that is important to their happiness, as well as; working with family members and other members of the client's community to encourage their interactions to be more positive.

213. Motivational interviewing and Motivational Enhancement Therapy: motivational interviewing is psychosocial intervention to increase motivation to change a behaviour. It is collaborative, evocative and recognizes the autonomy of the patient. The clinician assumes an advisory, rather than authoritative, role and seeks to understand what the patient values. This builds empathy and fosters a therapeutic alliance that could prompt behavioural change. The patient may come to realize that their drug use behaviour is inconsistent with the things that matter to them. Motivational interviewing is also promising as an approach to reducing high-risk behaviours, such as unprotected sex and sharing needles. One or two sessions of motivational interviewing are adequate in mild forms of drug use. This may be extended to six or more sessions (where the approach is called motivational enhancement therapy) to treat more severe drug use disorders.

214. Family orientated treatment approaches: Formal family-oriented treatment approaches are a collection of methods that recognize the importance of family relationships and cultures on behaviour. The approaches harness or utilize family systems or relationships to positively influence the behaviour of family members with drug use disorders. The concept of family may include many familial relationships: married couples without children, traditional nuclear or extended families, co-habiting partners with or without children, single-parent families, and "blended" families featuring partners with children from previous relationships.

215. Family-oriented treatment approaches have proved to be effective in improving engagement with treatment, reducing drug use and boosting participation in aftercare when compared to care focused on the individual patient. Family-oriented approaches are particularly useful in educating patients and their families about the nature of drug use disorders and the recovery process. Family-oriented approaches identified as effective for different drug use disorders include: behavioural couples therapy; brief strategic family therapy; functional family therapy; multisystemic therapy, and; multidimensional family therapy.

216. Multidimensional family therapy appears particularly effective in treating cannabis dependence in adolescence. Behavioural couples therapy has been examined more as part of treatment for alcohol dependence and of patients with opioid and cocaine use disorders and may also apply to the management of other drug use disorders.

217. Working with the family can also help when the patient refuses to participate in treatment using approaches such as unilateral family therapy or community reinforcement and family training. UNODC developed family therapy training materials, which are in the public domain, for the treatment of substance use disorders among adolescents.

218. Whenever possible and appropriate, families and caregivers of people with drug use disorders should participate in and support treatment processes, while respecting patient confidentiality. This includes: sharing correct information about drug use disorder and its treatment (keeping in mind issues of confidentiality); assessing personal, social and mental health needs, and; facilitating access to support groups for families and carers (if available) and other social resources.

219. Mutual help groups: mutual help groups such as Narcotics Anonymous, 12-steps peer-support programmes and other peer-driven and mutual help groups, can support individuals with drug use disorders. Such groups provide information, structured activities, and peer support in a non-judgmental environment. There is a need to provide patients with information about local mutual help groups as well as their contact details. Service providers can also facilitate patient engagement by directly referring them to or helping them durable contacts with representatives of locally available peer-support initiatives.

> **WHO Recommendations (mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings, 2016):**
>
> - Psychosocial interventions including contingency management, and cognitive behavioural therapy (CBT) and family therapy can be offered for the treatment of psychostimulant dependence.
>
> - Psychosocial interventions based on cognitive behavioural therapy or motivational enhancement therapy (MET) or family therapy can be offered for the management of cannabis dependence.
>
> - Behavioural interventions for children and adolescents, and caregiver skills training, may be offered for the treatment of behavioural disorders.
>
> - Psychosocial interventions including cognitive behavioural therapy (CBT), couples therapy, psychodynamic therapy, behavioural therapies, social network therapy, contingency management and motivational interventions, and twelve-step facilitation can be offered for the treatment of alcohol dependence.

B.3 Evidence-based pharmacological interventions

220. Description: medications can be very helpful in managing and/or treating a variety of disorders due to drug use, such as intoxication, overdose, withdrawal, dependence and drug-induced or drug-related psychiatric disorders. Pharmacological interventions should be administered alongside psychosocial interventions.

221. Pharmacological interventions for the management of drug withdrawal: unrecognized and untreated withdrawal runs the risk of driving a patient out of treatment. The management of withdrawal, also known as "detoxification", is typically the foremost concern if the patient has a recent history of severe and often protracted opioid, alcohol, benzodiazepine, barbiturate or polysubstance dependence. This calls for evidence-based withdrawal protocols, usually employing pharmacotherapy combined with rest, nutrition and motivational counselling

222. Opioid withdrawal: pharmacological treatment of opioid withdrawal involves: short-term treatment with methadone and buprenorphine, or; alpha-2 adrenergic agonists (clonidine or lofexidine). If neither of these is available, another option would be to use decreasing doses of weak opioids, as well as medications to treat the specific symptoms that appear. However, people with opioid dependence generally respond better to long-term opioid agonist treatment because, on its own, detoxification leaves them at greater risk of overdose.

223. The main goal of withdrawal treatment is to stabilize a patient's physical and psychological health while managing the symptoms of cessation or reduction of drug use. It is necessary to manage withdrawal before starting subsequent treatment with opioid antagonists. However, patients are particularly vulnerable at this point. The reason is that recent periods of abstinence are major risk factors for fatal opioid overdose due to reduced tolerance and the great danger of miscalculating opioid dosage. Where available, it is safe and effective to treat opioid detoxification using diminishing daily, supervised doses of methadone and buprenorphine over a period of one–two weeks. Otherwise, low doses of clonidine or lofexidine, or gradually reduced weaker opioid medications can be used, along with specific medications, to treat the symptoms of opioid withdrawal as they emerge. Clinicians should only

prescribe sedating medications for short periods and closely monitor treatment response as longer-term use of some medications may carry the risk of tolerance and medication misuse. The effectiveness of treatment is greater when psychosocial assistance is made available during withdrawal management

224. If available, naloxone should be given to people with opioid dependence and their families to take home in case of an opioid overdose, and they should be trained to manage opioid overdoses.

WHO Recommendations (WHO Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence, 2009):
- Opioid withdrawal services should be structured such that withdrawal is not a stand-alone service but is integrated with ongoing treatment options.   - Opioid withdrawal should be planned in conjunction with ongoing treatment.   - For the management of opioid withdrawal, tapered doses of opioid agonists (methadone or buprenorphine) should preferably be used, although alpha-2 adrenergic agonists may also be used.   - Clinicians should not use the combination of opioid antagonists with heavy sedation in the management of opioid withdrawal.   - Clinicians should not routinely use the combination of opioid antagonists and minimal sedation in the management of opioid withdrawal.   - Psychosocial services should be routinely offered in combination with pharmacological treatment of opioid withdrawal.

225. Sedative, hypnotic or anxiolytic withdrawal: patients admitted to the treatment programme should be asked about polysubstance use, including alcohol and sedative use, and monitored for the onset of withdrawal symptoms, or treated prophylactically if deemed high-risk regarding potential sedative, hypnotic or anxiolytic withdrawal (heavy or protracted use, or a history of past withdrawal episodes). Sedative, hypnotic or anxiolytic withdrawal can be effectively treated with long-acting benzodiazepines, starting with a dose sufficient to relieve withdrawal symptoms and tapering slowly over a period of days or weeks. There is a need to monitor patients for the onset of severe symptoms of alcohol or sedative-hypnotic withdrawal, including seizures, cardiovascular instability and delirium. It is important to ensure that the treatment is not merely prolonging sedative-hypnotic use.

226. Stimulant withdrawal: stimulant withdrawal (the "crash") is less well defined than syndromes of withdrawal from substances that cause central nervous system depression. Nevertheless, in stimulant withdrawal, depression is prominent and accompanied by malaise, inertia and mood instability. Pharmacological treatment of stimulant withdrawal, if indicated, should be symptomatic or focused on managing symptoms.

227. Cannabis withdrawal: a cannabis withdrawal syndrome typified by insomnia, headaches, depressed mood and irritability, can occur in heavy users. Pharmacological treatment of cannabis withdrawal, if indicated, should be symptomatic or focused on managing symptoms.

228. Other substances: The management of withdrawal from other psychoactive drugs, including new psychoactive substances, should be based on (emerging) scientific evidence on best practices.

WHO Recommendations (mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings, 2012):
• Withdrawal from cannabis, cocaine or amphetamines is best undertaken in a supportive environment. No specific medication is recommended for the treatment of withdrawal from these drugs.   • Relief of symptoms (e.g. agitation, sleep disturbance) may be achieved with symptomatic medication for the period of the withdrawal syndrome. Less commonly, depression or psychosis can occur during withdrawal, in these cases the individual needs to be monitored closely and advice sought from relevant specialists, if available.   • Withdrawal from benzodiazepines is best undertaken in a planned (elective) manner, using a gradually tapering dose over 8-12 weeks and with conversion to long-acting benzodiazepines, rather than using short-acting ones. Psychosocial support is helpful for individuals undergoing a tapering regime. Benzodiazepine withdrawal syndrome, if uncontrolled, can be severe; if a severe withdrawal develops (or occurs in an unplanned way on sudden stoppage of these drugs), specialist advice should be obtained regarding starting a high-dose benzodiazepine sedation regime and hospitalization.   • In individuals withdrawing from benzodiazepines, the presence of physical comorbidity (such as seizures or chronic pain) or psychiatric comorbidity may be an additional indication for hospitalization.

229. Pharmacological interventions for the management of opioid dependence: given that opioid dependence generally has a chronic and relapsing course, there is a need to implement long-term relapse-prevention treatment for individuals who stop their non-medical use of opioids. Relapse-prevention treatment should include a combination of pharmacological treatment and psychosocial interventions. Treatment that relies solely on psychosocial approaches achieves inferior outcomes compared to treatment that also incorporates appropriate medication.

230. There are two main pharmacological therapeutic strategies used to address opioid dependence (WHO, 2009).

(a) Opioid agonist maintenance treatment (OAMT) with long-acting opioids (methadone or buprenorphine), which is combined with psychosocial assistance, is the most effective pharmacological intervention for opioid dependence;

(b) Detoxification, followed by relapse-prevention treatment using opioid antagonist (naltrexone), is particularly useful for patients who are motivated to abstain from opioid use.

231. Opioid agonist maintenance treatment: the primary aim of OAMT is to reduce or end the non-medical use of opioids and associated risks and support abstinence by preventing withdrawal symptoms, as well as minimizing drug craving and the effects of other opioids, if they are consumed.

232. All patients receiving OAMT should have access to psychosocial interventions and support in recovery. Links between different treatment modalities should be in place to make such support possible. Non-compliance with a treatment programme rules alone should not generally warrant involuntary discharge. The need to ensure the safety of staff and other patients may justify involuntary discharge from treatment. However, before a patient is discharged involuntarily, reasonable measures should be taken to improve the situation, including by re-evaluating the treatment approach used. If the discharge is inevitable, it is important to make every effort to refer the patient to other facilities or branches of care and prevent overdose.

233. Methadone maintenance treatment: compared to treatment without medication, methadone-treated patients show marked reductions in heroin and other drug use.

They have lower mortality rates, fewer medical complications, lower rates of HIV and hepatitis transmission, decreased involvement in criminal activities and improved social and occupational functioning.

234. It is important to follow the general rule to "start low, go slow", when initiating methadone use. Once inducted safely, the treatment's goal is to achieve an optimal dose for longer-term maintenance to prevent craving and the use of illicit opioids. There is a need to gradually adjust the initial dose upwards to the ideal dose that eliminates opioid cravings, without inducing sedation or euphoria, and allows patients to function optimally in all areas of their life. The clinician should adjust the dose upwards if the patient is using heroin and downwards if they are under any sedation, or ready to cease treatment.

235. The effectiveness of methadone-maintenance doses depends on individual factors, such as the ability to metabolize medication and metabolic interferences by other medications (for instance, for the treatment of HIV or TB infections, psychiatric or cardiovascular disorders) that can change the blood level of methadone. To maintain adequate plasma levels and avoid opioid withdrawal it is important to administer methadone daily and monitor patients regularly for adherence to their medication regime. At the start of treatment, methadone should be administered under supervision. Once the patient is stabilized, take-home doses can be introduced, taking it account local laws and an individual risk-benefit assessment.

236. One of the ways to reduce the diversion of methadone is to dilute the supervised dose or "take-home" dose of the medication to the point where it is least likely to be injected.

237. Buprenorphine and buprenorphine/naloxone combination: buprenorphine maintenance treatment and methadone maintenance treatment have similar aims and principles. However, while the premise for methadone induction is to "start low, go slow", buprenorphine induction can proceed fairly rapidly to effective dosage once the first dose proves to be well tolerated. This is because in buprenorphine induction the risk of toxicity is relatively low owing to the medication's partial agonist action.

238. Compared to methadone, buprenorphine interacts less with other commonly administered medications. As with methadone, buprenorphine doses should be administered under supervision until the patient is stable. It is then possible to introduce take-home doses, taking into local laws and an individual risk-benefit assessment.

239. To prevent non-medical use of buprenorphine, including injecting or the diversion of buprenorphine tablets, the medication also exists in a buprenorphine-naloxone combination. This combination makes it less attractive for non-medical use, and its use may trigger withdrawal symptoms if injected. Since the sublingual formulation can take up to 15 minutes to fully dissolve in the mouth, a film formulation has also been developed which solidifies on contact with water and makes injecting much more difficult.

240. Opioid antagonist treatment with naltrexone: treatment with the long-acting opioid antagonist, naltrexone, can only be initiated following detoxification in individuals who have abstained from opioid use for a week or more (typically, those leaving residential treatment). Naltrexone is used to prevent relapse; it blocks the effects of opioids for one – two days. Unless the patients are sufficiently motivated, treatment abandonment rates can be high.

241. Naltrexone can be useful to patients who:

(a) Lack access to treatment with agonists;

(b) Are highly motivated to abstain from all opioids;

(c) Are unable to take agonist treatment owing to adverse effects; or

(d) Have been successful on agonist treatment but want to discontinue while being protected against relapse.

242. Naltrexone is available as an oral tablet that can be taken daily or three times a week to maintain the blood levels of the medication required to produce therapeutic effects. Naltrexone is also available in extended-release depot preparations (given as injection or as an implant), a single dose of which can maintain therapeutic levels of the medication for three–six weeks. A number of naltrexone implant formulations that report even longer durations of opioid blocking are in circulation.

WHO Recommendations (WHO Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence, 2009):

- Psychosocially assisted pharmacological treatment of opioid dependence should not be compulsory.

- Treatment should be accessible to disadvantaged populations.

- Pharmacological treatment of opioid dependence should be widely accessible; this might include treatment delivery in primary care settings. Comorbid patients can be treated in primary health-care settings if there is access to specialist consultation when necessary.

- At the time of commencement of a treatment service, there should be a realistic prospect of that service being financially viable.

- 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.

- To achieve optimal coverage and treatment outcomes, treatment of opioid dependence should be provided free of charge, or covered by public-health insurance.

- Pharmacological treatment of opioid dependence should be accessible to all those in need, including those in prison and other closed settings.

- 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.

- 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.

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

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

- 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.

- 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.

- To maximize the safety and effectiveness of agonist maintenance treatment programmes, policies and regulations should encourage flexible dosing structures, with low starting doses and high maintenance doses, and without placing restrictions on dose levels and the duration of treatment.

- Patients should be monitored with clinical assessment and drug testing.

- Psychosocial support should be available to all opioid dependent patients, in association with pharmacological treatments of opioid dependence.

- Up-to-date medical records should be kept for all patients. These should include, as a minimum, the history, clinical examination, investigations, diagnosis, health and social status, treatment plans and their revisions, referrals, evidence of consent, prescribed drugs and other interventions received. Confidentiality of patient records should be ensured.

- 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.

- Health authorities should ensure that treatment providers have sufficient skill and qualifications to use controlled substances appropriately. These requirements may include postgraduate training and certification, continuing education and licensing and the setting aside of funding for monitoring and evaluation.

- Documented processes should be established to ensure the safe and legal procurement, storage, dispensing and dosing of medicines, particularly of methadone and buprenorphine.

- There should be a system for monitoring the safety of the treatment service, including the extent of medication diversion.

243. Pharmacological interventions for the management of disorders due to psychostimulant use: psychostimulants, such as amphetamines and cocaine, are among the most frequently used and problematic psychoactive drugs in many parts of the world. To date no medication has proved to be consistently efficacious in treating psychostimulant use disorders. Medications in use primarily serve to manage co-occurring psychiatric disorders and withdrawal symptoms.

244. Symptoms of a stimulant withdrawal syndrome can be treated with symptomatic medications, as required. However, clinicians should prescribe psychoactive medications with caution, for short periods only, and monitor the treatment response closely as prolonged use may raise the risk of tolerance and medication misuse.

245. Antipsychotic and sedative medications may be used to manage psychotic symptoms caused by acute psychostimulant intoxication. Given that many patients with a psychostimulant use disorder have a co-occurring serious psychiatric disorder, (such as major depressive disorder, bipolar disorder or schizophrenia), appropriate psychotropic medications play a major role in treating such patients. Patients with a psychostimulant use disorder are often polysubstance users and may have disorders (including alcohol or opioid dependence), caused by other substance use, that should be treated using pharmacological as well as psychosocial approaches.

WHO Recommendations (mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings. Version 2.0, 2016):

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

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

246. Pharmacological interventions for management of disorders due to cannabis use. To date there is no approved pharmacological treatment for cannabis use disorders and psychosocial treatment remains the primary approach. In the event of a cannabis withdrawal syndrome, symptomatic medications can be used to manage withdrawal symptoms, as required. However, clinicians should only prescribe psychoactive medications for short periods and closely monitor the treatment response, as prolonged use may raise the risk of tolerance and medication misuse.

> **WHO Recommendations (mhGAP Intervention Guide for mental, neurological and substance use disorders, Version 2.0, 2016):**
>
> 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

B.4 Overdose identification and management

247. Opioid overdose: opioids are potent depressants of respiratory function, and opioid overdose resulting in respiratory depression and death is a leading cause of fatalities attributable to opioid use. People with opioid dependence are the group most likely to experience an overdose, particularly if the opioids are administered by injection or used in combination with other sedating substances with the potential for respiratory depression (such as alcohol, benzodiazepines or barbiturates). Lowered tolerance after a period of abstinence significantly increases the risk of opioid overdose. High-risk periods include the initial weeks following: discharge from inpatient or residential detoxification or after cessation of drug dependence treatment using naltrexone, and; release from incarceration.

248. Opioid overdose can be identified by a combination of three symptoms: pinpoint pupils; unconsciousness, and; respiratory depression. Emergency basic life support resuscitation and/or the timely administration of naloxone can avert death from an opioid overdose. The opioid antagonist, naloxone, is a lifesaving treatment that can completely reverse the effects of opioid overdose within minutes, and is included in the WHO Model List of Essential Medicines. With a long history of clinical success and extremely rare adverse effects, naloxone should feature in all settings described in this document and all health care facilities that may be requested to respond to opioid overdose. While access to naloxone is often restricted to health professionals, people likely to witness an opioid overdose, such as outreach workers, the police, peers, close friends and family members, should have access to naloxone and be instructed on how to administer it in the emergency management of a suspected opioid overdose (WHO, 2014a).

249. Naloxone can be injected intramuscularly, subcutaneously and intravenously, or administered intranasally. Intranasal formulations of naloxone are more concentrated than those for injection, as the nasal mucosa has a limit to the amount of liquid it can absorb at a time, and the doses used in intranasal administration may need to be higher than those delivered intramuscularly.

250. In addition to the administration of naloxone, the management of opioid overdose includes airway management, resuscitation techniques (such as assisting ventilation and rescue breathing), calling an ambulance and staying with the person until they are fully recovered.

251. Stimulant overdose: a stimulant overdose is manifested by symptoms and signs of severe acute stimulant intoxication, with behavioural and physiological features of the overactivation of the sympathetic nervous system caused by increased catecholamine neurotransmitter activity that may be life threatening. Clinical features include agitation, severe anxiety, paranoia, impaired judgement and inappropriate behaviour, grandiosity, seizures and often full-blown psychotic conditions associated with hyperthermia, severe tachycardia, hypertension, cardiac arrhythmias or

myocardial infarction and rhabdomyolysis. The features usually develop following the administration of high doses of cocaine, amphetamines or other stimulants.

252. The treatment of stimulant overdose focuses on managing syndromes and symptoms of overdose by using benzodiazepines and (sometimes antipsychotic medications) to sedate and monitor the patient. Meanwhile, it maintains and restores their vital functions, with particular attention to cardiovascular functions and hydration.

WHO Recommendations (WHO guidelines on community management of opioid overdose, 2014):

- People likely to witness an opioid overdose should have access to naloxone and be instructed in its administration to enable them to use it for the emergency management of suspected opioid overdose.

- Naloxone is effective when delivered by intravenous, intramuscular, subcutaneous and intranasal routes of administration. Persons using naloxone should select a route of administration based on the formulation available, their skills in administration, the setting and local context.

- In suspected opioid overdose, first responders should focus on airway management, assisting ventilation and administering naloxone.

- After successful resuscitation following the administration of naloxone, the level of consciousness and breathing of the affected person should be closely observed until full recovery has been achieved.

B.5 Treatment of co-occurring psychiatric and physical health conditions

253. Comorbid mental disorders: Co-occurring psychiatric disorders, including mood, anxiety or fear-related disorders, those specifically associated with stress (such as post-traumatic stress disorder), schizophrenia or other primary psychotic disorders may complicate the natural cause of drug use disorders and compromise engagement in treatment. The use of different psychoactive drugs and alcohol may have the effect of aggravating or exacerbating the psychiatric disorders' symptoms and syndromes. These include depression or manic symptoms, anxiety and psychotic symptoms, such as delusions or hallucinations. The effect may wear off or diminish significantly with the cessation of drug use. It is important to screen all patients with drug use disorders for comorbid mental disorders. Initial screening can be conducted in any treatment setting, but more rigorously in outpatient and inpatient settings. Abstinence from substance use cannot be a condition for initiating treatment of comorbid mental disorders: all patients with drug use disorders should have access to mental health evaluation and treatment, while respecting the patients' informed consent and confidentiality.

254. In order to accurately evaluate symptoms of other mental disorders among patients with drug use disorders, it is critically important first to distinguish independent psychiatric disorders from substance-induced disorders that resolve with abstinence. Short-term inpatient treatment can provide an opportunity to conduct a comprehensive diagnostic assessment and establish whether psychiatric symptoms resolve or diminish when drug use ceases. It is also a chance to initiate medical or psychosocial treatment for co-occurring disorders that will persist beyond abstinence from substance use.

255. It may be helpful to conduct structured psychiatric interviews using diagnostic instruments, such as the Mini International Neuropsychiatric Interview for DSM 5, Composite International Diagnostic Interview or the Structured Clinical Interview for DSM 5, and use other diagnostic tools for mental disorders. The interviews will assist in diagnosing comorbid conditions, such as major depression, bipolar disorders and anxiety disorders. More detailed guidelines on how to manage mental disorders can be found in the mhGAP Intervention guide (WHO, 2016).

256. Assessing and managing self-harm and/or suicide risk: suicide is the act of deliberately killing oneself, whereas self-harm is a broader term referring to intentional self-inflicted poisoning or injury, with or without an intent of death or fatal outcome. It is important to recognize the risk for self-harm and/or suicide in people with drug use disorders. During initial assessment, and periodically, as required, each person with drug use disorders should be asked to disclose thoughts or plans of self-harm they have had in the last month, or acts of self-harm they have carried out in the last year.

257. When conducting a self-harm and/or suicide-risk assessment, the following factors are important:

(a)   Assessment of imminent risk, in other words current or recent (within the previous month) acts, thoughts or plans of self-harm and/or suicide, as well as extreme agitation, violence, distress or lack of communication;

(b)   History of previous acts of self-harm (as well as history of injury or poisoning);

(c)   Presence of any comorbid physical or mental conditions;

(d)   Presence of chronic pain;

(e)   Severity of emotional symptoms; and

(f)   Availability of social support.

258. If the individual has previously had thoughts, plans or acts of self-harm, a number of preventive strategies should be in place (WHO, 2016).

(a)   It is important to advise the individual, their family and relevant others to restrict access to means of self-harm (such as pesticides and other toxic substances, medication or firearms);

(b)   There is a need to establish regular contact (telephone calls, home visits, letters, contact cards and brief intervention contact) with the non-specialized health care provider. The contact should be frequent initially and then become less frequent as the individual improves. The individual's condition determines the intensity and duration of the contact;

(c)   If human resources allow, a structured problem-solving approach is the recommended treatment for individuals who have carried out acts of self-harm in the previous year;

(d)   Social support (from available informal and/or formal community resources) should be accessible for individuals who volunteer information about thoughts of self-harm or who are identified as having had plans of self-harm in the last month or acts of self-harm in the last year;

(e)   Individuals at risk of self-harm should not be routinely hospitalized in non-psychiatric services of a general hospital in an effort to prevent acts of self-harm. However, it may be necessary to admit them to general hospital so as to manage the medical effects of an act of self-harm; in such cases it is important to closely monitor the individual's behaviour so as to prevent subsequent self-harm while in the hospital;

(f)   In the event that the health worker is concerned about imminent risk of serious self-harm (for example, when the individual is violent, extremely agitated or uncommunicative), it is crucial to consider emergency referral to a mental health service. In the absence of such a service, family, friends, concerned individuals and other available resources should be mobilized to keep a close eye on the individual for as long the imminent risk persists;

259. In all the cases above it is vital to assess and adequately manage comorbid mental and medical illnesses.

WHO Recommendations (mhGAP Intervention Guide for mental, neurological and substance use disorders, Version 2.0, 2016):

- Non-specialist health care providers should ask individuals over 10 years of age suffering from depression, bipolar disorder, schizophrenia, epilepsy, alcohol use disorders, illicit drug use disorders, dementia, children diagnosed with mental disorders, or individuals, who present with chronic pain or acute emotional distress associated with current interpersonal conflict, recent loss or other severe life event, about thoughts or plans of self-harm in the last month or acts of self-harm in the last year at initial assessment and periodically as required.

260. Depression: major depression is the most common comorbid mental disorder among people with substance use disorders (Torrens et al, 2015). People with depression experience a range of symptoms, including depressed mood, loss of interest or the ability to enjoy activities that were previously pleasurable, decreased energy or increased fatigability for at least two weeks.

261. The relationship between substance use and depression is complex: substance use disorders contribute to the development of depression and substance use can compromise its treatment outcomes; depression, in turn, may increase substance use and hasten the progression of substance use disorders (WHO, 2004). Depressive symptoms may occur during substance withdrawal and lead to abstinence, but they can also persist long after the discontinuation of substance use. Therefore, patients should undergo frequent assessment. In the event that depressive symptoms persist and a depressive episode is diagnosed, it is crucial to treat both disorders simultaneously using the integrated treatment model. Importantly, substance use or substance use disorders should not preclude treatment for depression.

262. Once the patient is adequately assessed there is a range of pharmacological and psychosocial options. The patient may require pharmacological treatment with antidepressants if depressive symptoms persist and interfere with daily functioning. Psychosocial intervention for depression includes psychoeducation, stress-management, cognitive behavioural therapy, behavioural activation, relaxation training, group interpersonal therapy and the strengthening of social support. More detailed guidelines on the management of major depression in non-specialized health settings can be found in the mhGAP Interventions Guide (WHO, 2016).

263. Anxiety: soon after ceasing the use of drugs, many patients experience anxiety or insomnia, which may be treated with symptomatic medications. However, sedative-hypnotic medications, such as benzodiazepines, should be used with caution as a first line of treatment because of their high dependence potential. Additionally, they can increase the risk of fatal overdose if the patient uses drugs that can cause respiratory depression (such as opioids). Alternative medications, such as antidepressants, should be considered along with psychosocial and behavioural treatment.

264. Psychotic disorders: people with drug use disorders can also present with schizophrenia or other primary psychotic disorders. Psychotic disorders are characterized by distorted thoughts and perceptions, as well as disturbed emotions and behaviours. Incoherent or irrelevant speech may also be present. There might be symptoms, such as hallucinations, delusions, severe behavioural abnormalities (disorganized behaviour, agitation, excitement, inactivity or hyperactivity) as well as mood and emotional disturbances.

265. Psychosis may develop during intoxication or withdrawal from certain psychoactive substances. However, it can also occur in abstinence due to independent comorbid mental disorders. It is important to distinguish between psychotic symptoms associated with substance use (which resolve with abstinence) and independent psychotic disorders. Acute or persistent psychotic symptoms may necessitate consultation with, and/or referral to mental health professionals to initiate pharmacological and psychosocial treatment. This may include indication for

antipsychotic and/or mood stabilizing medications, psychoeducation, family interventions, cognitive-behavioural therapy, life skills and social skills training and supported employment. More detailed guidelines on the pharmacological and psychosocial management of psychosis can be found in the mhGAP Interventions Guide (WHO, 2016).

266. Polysubstance use: some people with drug use disorders may use multiple psychoactive substances, mixing opioids, stimulants, alcohol, cannabis and other substances. This may hinder diagnostic and treatment processes and increase the risk of complications caused by pharmacological interactions. For example, consuming substances with a sedative effect increases the risk of opioid overdose. Initial assessment should include enough detail on all substances used, frequency and intensity of use, as well as screening for other medical and psychiatric comorbidities.

267. Alcohol use disorders: alcohol use disorders are frequently comorbid with drug use disorders. The diagnosis and assessment of the severity of the alcohol use disorder is important because it points to the treatment interventions required. Acute withdrawal from alcohol in people with alcohol dependence may require medical management as it may lead to seizures, acute psychosis (delirium tremens) and, in some instances, death.

268. During initial assessment it is important to examine the history of alcohol use, presence of comorbid alcohol use disorders and the need for alcohol withdrawal management. Questionnaires, such as the Alcohol, Smoking and Substance Involvement Screening Test (WHO, 2010a) and Alcohol Use Disorder Identification Test (WHO, 2001) are useful for screening patients as part of subsequent diagnostic assessment. The Severity of Alcohol Dependence Questionnaire (Stockwell et al., 1979) and Alcohol Problems Questionnaire (Drummond, 1990) may assist in assessing the severity of alcohol dependence and other related problems.

269. If it becomes necessary to manage alcohol withdrawal and treat comorbid alcohol use disorders, this should be carried out under the supervision of trained staff in accordance with appropriate guidelines.

270. Comorbid physical health conditions: every acute medical condition seen on admission may need to be managed before or during any further treatment or care. Among others the conditions can include: fever, acute pain, gastrointestinal or other bleeding, seizures, pneumonia and acute cardiovascular conditions.

271. Depending on local conditions, the treatment of drug use disorders, including opioid dependence, should be combined, if necessary, with treatment for TB, HIV, hepatitis and other infectious or non-communicable health conditions (WHO, 2012b). A short-term inpatient or residential treatment programme may not have sufficient medical resources, expertise or the time to initiate such treatment, but consultation and referral to appropriate services should be available.

272. Hepatitis B is common in many drug-using populations, particularly (but not exclusively) among those who inject drugs. Short-term inpatient treatment can be an opportunity to vaccinate against hepatitis B. Depending on the length of the treatment, people who have not previously had a complete course of hepatitis B vaccination may benefit from an accelerated vaccination schedule, consisting of two or three doses, without necessarily undergoing serological testing beforehand (WHO, 2012a).

273. Chronic pain is another common problem that may contribute to the use of illicit drugs, particularly opioids, and to the risk of relapse and overdose. It is necessary to refer the patient for further evaluation of the source of the pain, and draw up specific pain management strategies.

> **WHO Recommendations (Guidelines on management of physical health conditions in adults with severe mental disorders (WHO, 2018):**
>
> - For people with severe mental disorders and comorbid substance use disorders (drug and/or alcohol) interventions should be considered in accordance with the WHO mhGAP guidelines.
>
> - Non-pharmacological interventions (e.g. motivational interviewing) may be considered and tailored to the needs of people with severe mental disorders and substance use disorders.
>
> - Prescribers should take into account the potential for drug-drug interactions between medicines used for treatment of substance use disorders and severe mental disorders.

B.6 Recovery management

274. Description: recovery management, also known as recovery-oriented "aftercare", "continuing care" or social support, describes a long-term process of increasing patients' health and wellness, as well as supporting them in recovery from drug use disorders. Recovery management is an evolving approach to the long-term treatment of drug use disorders that goes beyond a single treatment episode, or a short-term aftercare programme. It should support patients throughout their treatment process in different treatment settings and modalities. Once patients have stabilized during abstinence achieved through outpatient or residential treatment, recovery management should follow. It focuses on reducing the risk of relapse to substance use by comprehensively supporting social functioning, well-being, as well as social reintegration into the community and society. In line with the life course perspective, recovery management helps to improve health and wellness, while stabilizing and strengthening recovery. Additionally, it helps improve patients' social functioning by enabling them to build on their strengths and resilience while keeping the focus on personal responsibility in managing their drug use disorder. Sustainable recovery however is possible, and about 50% of patients with drug use disorders achieve it (White, 2012).

275. Ideally, after long-term residential and intensive outpatient treatment, patients should transfer to a less intensive level of care or long-term recovery management. This is in contrast with a common scenario of repeated brief episodes of treatment, with no continuity, and recurrent relapses, that is associated with poorer outcomes and increased risks of overdose, among other things. Recovery-oriented continuing treatment and care are an approach to the long-term management of patients within the network of community-based support resources and services. Professionally directed recovery management, like the management of other chronic health disorders, shifts the focus of treatment from one that seeks to "admit, treat and discharge" to a sustained health-management partnership between services and the patient. In this model, post-stabilization monitoring, recovery education, recovery coaching, active linkage to recovery communities (such as 12-step peer support), resource development and rapid access back to treatment, when needed, take the place of the traditional discharge process.

276. Longitudinal studies have repeatedly demonstrated that the treatment of drug use disorders plays a role in substantially reducing substance use, drug-related problems and costs to society. However, post-discharge relapse and eventual re-admission are very common. Indeed, most patients admitted to treatment have received treatment before. The risk of relapse appears to decrease, but not until four to five years of successful abstinence (Dennis, Foss and Scott, 2007). Therefore, all patients regardless of the stage of their recovery should be informed about how to identify and manage overdose and associated risks.

277. The focus on long-term management, as opposed to single-episode treatment, is supported by the evidence that drug dependence is best understood and managed as a

chronic and often relapsing disorder, similar to other multifactorial diseases like hypertension, asthma and diabetes, rather than as an acute illness or episode (DuPont, Compton and McLellan, 2015). As such, individuals with drug use disorders should have lifetime access to medical and psychosocial interventions, with the intensity matching the severity of their symptoms. Recovery-management approaches should include long-term pharmacological, psychosocial and environmental interventions aimed at reducing substance use and criminal behaviour while helping improve overall physical and mental health, wellbeing and social functioning. There is evidence that recovery-management interventions are effective (McCollister et al., 2013), and that involvement in 12-step peer support helps patients abstain from illicit drugs and alcohol, leading to fewer problems (Donovan et al., 2013; Hai et al., 2019). Healthcare professionals can improve involvement in peer support by encouraging attendance.

278. To provide effective recovery management, it is necessary to involve the whole system, integrating all treatment modalities and the participation of stakeholders outside the health sector. Multiple stakeholders in communities play a role and should be engaged in the recovery process. These include families and caregivers, friends, neighbours, mutual self-help groups, spiritual and community leaders, stakeholders from the educational sector, the criminal justice system as well as sports and recreational facilities.

279. Stigma and discrimination towards people with drug use disorders may hinder access to and mitigate success in treatment and rehabilitation. All efforts should be taken to raise awareness, promote non-stigmatizing attitudes and address structural discrimination towards people with substance use disorders.

280. Target population: following initial treatment for drug use disorders, most patients require some degree of long-term recovery management, whose intensity reflects the individual patient's needs. Patients with a history of multiple relapse episodes, physical and mental health disorders, poor family and community support, financial, legal and/or housing problems, are in special need of recovery management. Patients with serious disorder complexity, in particular those with an early onset of drug use disorders and severely impaired functioning, poor life skills and limited ways and means of coping with stress, need more intensive recovery-management programmes. Crucially, patients who are highly vulnerable to relapse should benefit from appropriate and personalized components of recovery management before discharge from long-term residential or intensive outpatient treatment.

281. Goals: the primary goal of recovery management is to maintain benefits obtained in other treatment modalities by providing continuous support individualized to the patient's needs. Recovery-oriented care minimizes risks associated with drug use, maintains abstinence or reduced levels of drug use and controls drug-seeking behaviour during intensive treatment stages. Subsequently, it seeks to help develop and consolidate personal and social assets that the patient requires to cope with external circumstances and maintain a healthy lifestyle. This includes the continuous journey to personal and social recovery as a part of living a drug-free life, improvement of self-care for physical and psychological well-being, reclaiming of personal dignity, self-worth, and spiritual growth and social re-integration.

282. Recovery can benefit from continuing treatment (including pharmacological and psychosocial treatment interventions) and/or staying engaged with a broader recovery community, such as mutual aid or peer-support groups (including Narcotics Anonymous and 12-step groups). Recovery-oriented care supports the development of skills to manage daily stress related to maintaining 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 this, recovery-oriented treatment and recovery-management interventions boost focus on reducing stressful stimuli that may trigger the recurrence of compulsive drug seeking. In general,

recovery-oriented care helps patients improve and stabilize a good quality of life and opportunities for social reintegration in the community.

283. Models and components: Continuing care and recovery management is an opportunity for patients to sustain contact with the health care system, social services and treatment facilities. Commonly a counsellor or other professional (social worker or a nurse) coordinates case management, meets the patient frequently, provides positive support, encourages engagement in the community and helps manage stressful situations that arise. A counsellor helps the patient to connect with other professionals who can support the patient's social reintegration. In response to specific needs, a counsellor refers patients notably to social workers and psychologists, medical practitioners, sex and reproductive health professionals and legal support officers.

284. Many patients with drug use disorders need continuous pharmacological and psychosocial treatment and support. This includes proper referral, aftertreatment in any form and aftercare support. It is necessary to establish links between different branches of care to ensure that treatment and support function properly. As an example, patients with complex drug use disorders who lack social support need short-term inpatient treatment, followed by referral to long-term residential treatment. For patients with less severe drug use disorders and better social support, outpatient treatment is indicated. Patients should have support to navigate the social care system in order to access vocational training, stable housing and other services, as needed.

285. Principles of recovery management: the recovery management approach is characterized by a number of factors:

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

    (b)   Flexible rather than fixed programmes: Recovery-management programmes must respond to the changes that the patient goes through over time, by offering choices and providing a flexible range of support and services to meet the individual's changing needs;

    (c)   Consideration for the patient's autonomy: Recovery management is a self-directed approach that encourages and supports the patient in making informed choices about their life and treatment. The importance of incorporating the patient's choices has been stressed in other areas of medicine, especially in the management of chronic diseases, and has proved effective in increasing the individual's responsibility for their recovery;

    (d)   Community participation: Contrary to overcoming drug use disorders in isolation, recovery management implies involving family members, friends and the community to strengthen social aspects of recovery. Other people are encouraged to play a role in the patient's recovery using community resources, such as professional organizations, non-government organizations, mutual aid or peer support, faith-based organizations and schools and other educational institutions.

286. Recovery-management activities: recovery management combines a variety of interventions and activities that promote and strengthen internal and external resources to help patients voluntarily and actively manage drug-related problems and their drug use, if it recurs. Some of the activities may already exist in the patient's home, health facilities, neighbourhood and community while others need to be developed.

287. The following factors and activities increase social reintegration and improve chances of stable remission and recovery:

    (a)   Strengthening the individual's resilience, self-efficacy and self-confidence to manage daily challenges and stresses while maintaining commitment to recovery and avoiding relapse to substance use;

(b)   A supportive social network (such as partner, caregivers, family members and friends) that can monitor the stability of recovery, abstinence from drugs and compliance with treatment;

(c)   Educating patients about different factors that contribute to their drug use and equipping them with the strategies to create and maintain a supportive social environment that promotes health and recovery;

(d)   Educating patients about health and social care systems and navigating them through health and social services;

(e)   Providing them access to long-term pharmacological treatment if indicated;

(f)   Educating patients about, and providing them access to strategies and tools to prevent and manage drug overdose;

(g)   Educating patients on identification and management of drug overdose, including the use of naloxone for opioid overdose;

(h)   Engagement with individuals and social networks of friends and workmates that can provide support in maintaining abstinence and achieving recovery goals;

(i)   Meaningful and appreciated work;

(j)   Reduced burden of stigma and discrimination on the basis of health, age, gender, sexuality, class, race, cultural identity and so on;

(k)   Freedom from violence and abuse;

(l)   Social participation and integration in educational and vocational pursuits, including volunteering or community involvement;

(m)   Active involvement in self-help, mutual-help, spiritual or other support groups;

(n)   Social, cultural, political, humanitarian or spiritual involvement that provides a way to achieve a stronger purpose in life; and

(o)   Stable accommodation; and

(p)   Resolving legal and financial problems.

288. Criteria for programme completion and indicators of effectiveness: given its "life course" perspective, recovery management is open-ended and may continue for an entire lifetime. It embraces the chronic-disease management approach whose goal is to help individuals effectively manage their own health problems and thereby improve their health and well-being.

289. In evaluating the success of recovery-management activities and programmes, it is important to take into account their capacity to: lower the risk of relapse and overdose; reduce the use psychoactive substance and associated harms, as well as; improve physical and psychological health, well-being, social functioning and reintegration. The Addiction Severity Index and similar structured instruments that evaluate overall functioning in the context of substance use disorders can be used to assess progress in multiple aspects of health and functioning. In evaluating the effectiveness of recovery management it is necessary to concentrate on assessing progress in the "recovery capital" – the internal and external resources that can help initiate and sustain recovery.

290. Key requirements for recovery management:

(a)   Individual treatment plans are key to ensuring that every patient benefits from recovery-orientated treatment. The plans' development should be based on assessments conducted with the help of a team of professionals and with the patient's participation. Treatment plans should be specific to the individual and consistent with the management of other chronic illnesses and health conditions. Unlike intensive

care programmes, treatment plans in recovery-oriented care expand their focus from primarily medical care to social care, bringing in professionals from other fields. Ideally the professionals should function as a multi-disciplinary team (comprising social workers, psychologists, peer counsellors, and potentially, elders, spiritual leaders and other community leaders), and also including friends and supportive family members;

(b) Once a community-based outpatient, inpatient or residential treatment programme is completed, aftercare planning must be consolidated into individual recovery management plans. This should include personal strategies to: prevent relapse to drug or polysubstance use (with a high risk of overdose); maintain housing; secure or hold employment; establish or sustain positive social networks, and; re-integrate into the community. Plans should also include rapid access back to treatment if the patient relapses;

(c) Ideally recovery management involves regular monitoring or follow-up (check-ups) meetings or phone calls, undertaken by a drug treatment counsellor, psychologist, other professional or a primary care physician or nurse. The check-ups can help sustain recovery and prevent relapse. During the check-up, the patient may be asked to provide an update on their work performance, living conditions and mechanisms for coping with stress or maintaining healthy relationships. Recovery check-ups may include voluntary drug toxicology testing, with patients being offered the option to be screened in the community. The aim of the testing is to give patients the incentive to be "drug free", detect relapse and, if necessary, enable them to benefit from timely re-intervention. There is emerging evidence that recovery check-ups are effective methods of managing recovery over time, and that they are cost-effective and, potentially, cost-saving strategies for promoting abstinence and reducing substance use among people with chronic substance use disorders (White, 2007; McCollister et al., 2013; Miller, 2013; Dennis, Scott and Laudet, 2014; Garner et al., 2014).

V.   Treatment settings, modalities and interventions

291. The International Standards', recognize that a range of population groups have special treatment and care needs and may require consideration and tailored interventions to treat drug use disorders.

292. This chapter is not an exhaustive list of populations or groups with special treatment and care needs. A range of population groups may require special provisions for treatment and care. The groups include those concerned by: particular patterns of drug use (including polysubstance use); health needs (people with comorbid health conditions, such as those living with HIV, mental disorders and disabilities); age (such as children and adolescents and elderly people); social care and support needs (such as people who are homeless, socially marginalized, living in poverty, illiterate and those with limited education, and; place of residence (people living in remote and rural areas, migrants). Additionally, women and pregnant women, sexual minorities, sex workers, religious and ethnic minorities, indigenous populations and people in contact with the criminal justice system require tailored interventions and special provisions for treatment. Standard principles of treatment and care outlined in II apply to all people with substance use disorders. For most of the population groups mentioned above, a combination of stigma and discrimination often compounds barriers to treatment. Good clinical governance should guarantee all people equal access to treatment and care. There is a need to make a concerted effort to remove structural barriers to treatment, prevent social marginalization and promote non-stigmatizing attitudes.

293. V outlines treatment system considerations and needs assessments that facilitate the delivery of treatment to populations and groups with special treatment and care needs. Local treatment systems should be designed, planned and funded to provide

appropriate, accessible and affordable treatment and care in line with principles outlined in this document.

A. Pregnant women with drug use disorders

294. Description: women with drug use disorders who are pregnant represent a unique population in special need of treatment mainly for two reasons. Firstly, drug use may affect the mother and the foetus, while treatment may also adversely affect both members of the dyad. Providing treatment for drug use disorders to pregnant women may entail medical and ethical challenges. Secondly, like all parents, many pregnant women with a drug use disorder and their partners may benefit from parenting skills training and support around child care and development. Moreover, once the baby arrives it may need medical and other services, given the likelihood of its prenatal drug exposure. Additionally, the opportunity to provide treatment for drug (and other substance) use disorders to pregnant women has tremendous potential to make positive changes in the lives of the mother and the foetus if both receive services. As such, often two "dyads" participate in the treatment of pregnant women with substance use disorder – the mother-foetus dyad, and the mother-child dyad. Family dynamics and support play an important role in pregnancy and treatment outcomes. For this reason, the treatment of pregnant women with drug use disorders should include a significant component of family interventions.

295. Pregnant women with drug use disorders face similar issues as many other adults with drug use disorders. Several of the issues, such as lack of formal education or likely involvement with the legal justice system, are common to men, women and pregnant women. However, stigma, feelings of shame and lack of positive and supportive relationships may affect women more adversely and are the key reasons why women often refrain from seeking and entering treatment or engaging in it. Furthermore, few gender-sensitive treatment services exist for drug use disorders, which further limits access to treatment even for women who are ready to engage with treatment and support services. Women with drug use disorders are more likely than men to: have experienced child abuse and/or neglect; have been repeatedly exposed to interpersonal violence; be economically dependent on others for survival, and; to have lacked access to formal educational or vocational opportunities. With pregnancy, these issues may further intensify, hindering access to and engagement with treatment, and compromising treatment outcomes. Many pregnant women with drug use disorders may feel conflicted, ashamed and guilt-ridden about what they often see as their inability to control their substance-using behaviour.

296. Pregnant women with drug use disorders have the same right to treatment as women who are not pregnant, or who are but have no drug use disorders, and should not be excluded from treatment or prevented from receiving it because of pregnancy. Treating women with drug use disorders is not more complicated than treating other patients. Women with drug use disorders should not be forced to have abortions and sterilizations. Moreover, treatment programmes must have procedures and safeguards in place to prevent detention and forced treatment of pregnant women. Finally, women have better long-term outcomes when they receive treatment that focuses on issues more commonly found among women with drug use disorders compared to treatments that lack such a women-centred focus.

297. Models and components: screening and intake. Generally, all women of child-bearing age entering treatment services should be screened for pregnancy. This may involve history taking and urine testing. Services that provide treatment to pregnant women with drug use disorders and their children typically have a screening and intake procedure that helps determine suitability for admission into the programme. At a minimum, screening should assess three factors: acute medical conditions requiring urgent medical attention; a risk of withdrawal and need for withdrawal management and/or detoxification, and; a risk of harm to self and/or others. One or more of these three factors may indicate a need to refer or transfer a pregnant woman to a more specialized medical or psychiatric unit to manage the risks, at least

temporarily, before she is admitted into the specialized treatment programme for drug use disorders. As the first step in establishing a patient-provider relationship and a chance to build rapport, it is important to consider the pregnant woman's needs and how they fit with the services that the programme offers.

298. It is important to have a written policy on screening and intake procedures for pregnant women with drug use disorders (and comorbid conditions) and it should include the following elements:

(a) Description of the screening procedures and intake measures and/or interviews; as far as possible, all intake measures, instruments and assessment tools used in connection to pregnant women with drug use disorders should be validated;

(b) The training required by staff to conduct intake and screening, and;

(c) Policy on eligibility for admission to the programme and procedures for non-admission, including information about alternative services for pregnant women.

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

300. Assessment: Upon entering a programme, a pregnant woman with drug use disorders should undergo clinical assessment whose aim is to examine the relevant aspects of her life circumstances in detail for three purposes: accurate diagnosis; appropriate treatment placement, and; the development of appropriate treatment plans and goals. The primary purpose of an assessment is to evaluate current life circumstances and gather information on physical and psychological health, substance use, family support and social situation. This is crucial in developing a treatment plan that suits the pregnant woman's strengths and needs. Information that is specific to pregnancy, such as the due date, past pregnancies and delivery plans are also important. Ideally, an assessment should utilize multiple sources of information to obtain a complete medical history of the woman and the psychosocial context in which she lives. There is a need for an initial assessment that develops into a continuous process, with plans to carry out periodic assessments and reviews in the course of treatment. Given the changes in physical, psychological and social functioning that she faces, it is critical to assess and review the health status of a woman throughout treatment, adapting treatment plans to reflect changing needs and as she comes into recovery. The frequency of such assessments will depend on the clinical course of treatment and any setbacks encountered as treatment progresses. Assessment standards are similar to those applicable to screening and intake, as described above.

301. Treatment planning: programme staff should develop an individual treatment plan for the pregnant woman, based on assessment, taking into account her wishes and fully involving her in the planning and goal setting. Treatment plans should be reviewed regularly, especially given the rapid changes that occur throughout pregnancy and following delivery. A pregnant woman with a drug use disorder should not be seen as a passive recipient of information, but as an active participant of the treatment planning process. A woman should actively participate in treatment decisions that affect not only her but also the foetus. Treatment plans should include collaboration with obstetricians and gynaecologists. It may also be necessary to closely monitor foetal development.

302. Treatment approaches: treatment approaches for pregnant women with drug use disorders largely depend on the amount and patterns of psychoactive drug (and other substance) use. In certain circumstances, it may be appropriate for a primary care provider or obstetrician to deliver a brief intervention focusing on education and risk review. However, given the potential risks to the foetus, it is necessary to limit such interventions to selected cases. Treatment programmes for pregnant women using psychoactive substances should utilize evidence-based approaches.

303. Pregnant women may receive treatment for drug use disorders in outpatient, inpatient or residential settings. Treatment may include psychosocial interventions

and pharmacotherapy, depending on the type of substances used and severity or complexity of problems.

WHO Recommendations (Guidelines for identification and management of substance use and substance use disorders in pregnancy, 2014):

- Health care providers should ask all pregnant women about their use of alcohol and other substances (past and present) as early as possible in the pregnancy and at every antenatal visit.

- Health care providers should offer a brief intervention to all pregnant women using alcohol or drugs

- Health care providers managing pregnant or postpartum women with alcohol and other substance use disorders should offer comprehensive assessment, and individualized care.

- Health care providers should at the earliest opportunity advise pregnant women dependent on alcohol or drugs to cease their alcohol or drug use and offer, or refer to, detoxification services under medical supervision where necessary and applicable.

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304. Special considerations for pharmacological treatment during pregnancy: pharmacological considerations are especially important for women with opioid use disorder if medication is an essential part of the treatment. A woman with an opioid use disorder should not be denied treatment with opioid agonist medication because of her pregnancy. Opioid medication choices should be made on an individual basis, taking into account characteristics of the patient. Methadone or buprenorphine prescriptions are effective treatment options with a favourable risk-to-benefit ratio (but their effects may vary from patient to patient). Research evidence shows that buprenorphine exposure in utero causes less severe neonatal abstinence syndrome (or neonatal withdrawal syndrome) than methadone. However, neonatal abstinence syndrome is an easily identifiable and treatable condition. It is just one aspect of the complete risk–benefit ratio decision for a pregnant woman and her physician to consider when making medication decisions.

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

306. If a woman becomes pregnant while using methadone or buprenorphine, treatment should be continued on the same medication, especially when the response is good. Medical withdrawal from opioid agonist during pregnancy is not recommended. Withdrawal is associated with high rates of treatment abandonment and relapse, along with the attendant risk to the woman and the foetus. Additionally, opioid withdrawal increases the risk of miscarriage.

307. There is no sufficient evidence to support pharmacological treatment during pregnancy to manage dependence on amphetamine-type stimulants, cannabis, cocaine or volatile agents. However, pharmacological treatment can be used, as appropriate, to treat comorbid health conditions. Psychopharmacological medications may be useful in treating the symptoms of psychiatric disorders to manage withdrawal in pregnant women with stimulant dependence. However, the medications are not required routinely.

WHO Recommendations (Guidelines for identification and management of substance use and substance use disorders in pregnancy, 2014):
• Pregnant women dependent on opioids should be encouraged to use opioid maintenance treatment whenever available rather than to attempt opioid detoxification.   • Pregnant women with benzodiazepine dependence should undergo a gradual dose reduction, using long-acting benzodiazepines.   • In withdrawal management for pregnant women with stimulant dependence, psychopharmacological medications may be useful to assist with symptoms of psychiatric disorders, but are not routinely required.   • Pharmacotherapy is not recommended for routine treatment of dependence on amphetamine-type stimulants, cannabis, cocaine, or volatile agents in pregnant patients.   • Pregnant women with opioid dependence should be advised to continue or commence opioid maintenance therapy with either methadone or buprenorphine.

308. Comprehensive treatment: comprehensive women-centred treatment approach consists of treating the whole person and the mother-child dyad. This may include multiple and diverse interventions and services, such as trauma-informed group and individual treatment practices; childcare and parenting education; general medical care; obstetrics and gynaecological care; interventions and services for comorbid psychiatric disorders; early interventions; social support, including vocational rehabilitation, housing and transportation, and; legal aid. Providing these services is necessary but not sufficient to make a treatment women-centred. Women-centred treatment programmes for pregnant women who use drugs should be sensitive and deal with specific biological as well as cultural, social and environmental factors related to drug use and treatment in women. This will optimize the outcome of treatment.

309. There are other considerations that should be taken into account in the treatment of women with drug use disorders:

(a) Significant interpersonal relationships and family history play an integral role in initiating and continuing drug use;

(b) Stigma and limited availability of gender-sensitive treatment services deter women from entering treatment;

(c) Women often enter treatment for drug use disorders from a wide array of referral sources;

(d) Caregiver roles, gender expectations and socioeconomic hardships render women more susceptible to barriers in seeking help, entering treatment and during treatment. These barriers may delay treatment entrance until the disorder reaches a more severe stage, with additional medical and psychiatric pathology;

(e) Women are more likely to engage in help-seeking behaviour and in attending treatment after admission;

(f) Pregnant women may require adjusted pharmacological treatment and medication dosages;

(g) Women may require women-focused treatment in a safe single-sex setting to obtain maximum benefit;

(h) Women may need training and support on issues, such as sexual health, contraception, parenting and child care;

(i)   Women and children are more vulnerable to the risk of domestic violence and sexual abuse, and would benefit from linkages with social agencies that protect them;

(j)   Treatment services should be able to accommodate children to allow mothers to receive treatment.

310.   Baby delivery protocol: programmes that include the delivery of the baby of a pregnant woman with drug use disorders should have a written delivery protocol that specifies potential issues with both delivery and patient management. At a minimum, such issues as where the delivery will be conducted, who will be notified, what provisions she and her baby need and how she will get them should be addressed. Appropriate pain management procedures must also be in place. Many women with opioid use disorders are more sensitive to pain than women without such disorders. If untreated pain makes it impossible for the mother to care for her newborn, this can trigger drug use relapse and other adverse outcomes for the mother and the infant.

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

312.   Breastfeeding: although every effort should be made to encourage breastfeeding in mothers with drug use disorders, the decision about breastfeeding should be evaluated on a case-by-case basis. Breastfeeding may be contraindicated in the case of HIV-positive mothers and for mothers with other medical conditions who take certain psychotropic medications. Other contraindications or precautions regarding breastfeeding may emerge in the case of maternal use of inhalants, methamphetamines, stimulants, tranquilizers and alcohol. It is advisable that clinicians reach clear and preferably written agreements with mothers about their breastfeeding practices.

WHO Recommendations (Guidelines for identification and management of substance use and substance use disorders in pregnancy, 2014):
• Mothers with substance use disorders should be encouraged to breastfeed unless the risks clearly outweigh the benefits.
• Breastfeeding women using alcohol or drugs should be advised and supported to cease alcohol or drug use; however, substance use is not necessarily a contraindication to breastfeeding.
• Skin-to-skin contact is important regardless of feeding choice and needs to be actively encouraged for the mother with a substance use disorder who is able to respond to her baby's needs.
• Mothers who are stable on opioid maintenance treatment with either methadone or buprenorphine should be encouraged to breastfeed unless the risks clearly outweigh the benefits.

A.1   Management of newborn infants passively exposed to opioids in utero

313.   Description: the number of neonates born following intrauterine sustained exposure to opioids and other psychoactive substances is difficult to determine. But in all cases the health outcomes of newborn infants are enhanced if their mothers receive comprehensive medical, psychosocial and medication-assisted treatment. Failure to provide these services puts the newborn infant 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 or neonatal withdrawal syndrome (NWS). NWS is defined as transient alterations in the: central nervous

system (typified by irritability, high pitched cry, tremors, hypertonia, hyperreflexia and sleep disturbances); gastrointestinal system (for instance regurgitation, loose stools, increased sucking reflex, dysrhythmic sucking and swallowing and poor intake with weight loss), and; respiratory system (for example nasal stuffiness and tachypnea), and the autonomic nervous system (such as sneezing and yawning), that manifest in the days and weeks following birth in babies exposed to opioids or other sedatives in utero. Newborn babies develop NWS from maternal non-medical use of opioids purchased on the street or from prescribed opioid medication given by the mother's physician for her medical condition. This may include methadone or buprenorphine used to treat her opioid use disorder.

314. Treatment of neonatal withdrawal syndrome: the treatment of NWS should include non-pharmacological interventions followed by medication treatment (when needed) after comprehensive assessment. Supportive measures include: rooming-in, breastfeeding, offering a pacifier (non-nutritive sucking), swaddling snugly with hands available for sucking without overdressing and skin-to-skin contact with the mother. The newborn's naso-pharynx should be aspirated, and feeding should include frequent offerings (every two hours) of small amounts (if poor feeding persists) without overfeeding. The positioning should be right side lying to reduce aspiration, if there is vomiting or regurgitation (both are prominent symptoms of NWS).

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

WHO Recommendations (Guidelines for identification and management of substance use and substance use disorders in pregnancy, 2014):

- Health-care facilities providing obstetric care should have a protocol in place for identifying, assessing, monitoring and intervening, using non-pharmacological and pharmacological methods, for neonates prenatally exposed to opioids.

- An opioid should be used as initial treatment for an infant with neonatal opioid withdrawal syndrome if required.

- If an infant has signs of a neonatal withdrawal syndrome due to withdrawal from sedatives or alcohol, or the substance the infant was exposed to is unknown, then phenobarbital may be a preferable initial treatment option.

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316. Staff training: any staff member who has direct contact with patients (secretaries, office managers) must be knowledgeable about and sensitive to the issues pregnant women face. Staff should be trained on what to do when a woman goes into labour: who to contact, how to react and where to go for medical help. Many pregnant women with drug use disorders may feel conflicted, ashamed and guilt-ridden about what they often see as their inability to "control" their drug-using behaviour. Staff need to be aware of these feelings and concerns and prepared to respond appropriately in a supportive way. Shaming and stigmatizing women for drug use during pregnancy is not an effective treatment method for preventing drug exposure to the foetus or improving the health of the mother. On the contrary, it might lead to higher rates of treatment abandonment.

317. All health staff caring for infants should be trained to identify the signs and symptoms of neonatal withdrawal syndrome (or neonatal abstinence syndrome) as

well as the neonatal conditions that may present in similar ways as NWS (for instance septicaemia, encephalitis, meningitis, post-anoxic irritation of the central nervous system, hypoglycaemia, hypocalcaemia and cerebral haemorrhage).

318. Documentation: regardless of the type of setting or intensity of care provided, proper documentation of the treatment of pregnant women with drug use disorders should include all the regular documentation or patient records. These include treatment contract, assessment, individualized treatment and management plan. Equally essential are treatment reviews and changes to treatment, the management of treatment goals and a treatment completion summary. Services providing care to pregnant women with drug use disorders need to keep records of all medical, psychiatric and treatment services to ensure the implementation of all recommended care and close coordination between various care providers. Any assessment for neonatal withdrawal syndrome should be recorded along with the medication and non-medication interventions provided to minimize NWS.

B. Children and adolescents with substance use disorders

319. Description: use of psychoactive substances usually starts in adolescence (10–19 years old) and even childhood. The earlier substance use starts, the greater the risks for more rapid progression to heavy use and substance use disorders.

320. The majority of children and adolescents do not use psychoactive drugs. Children who use drugs usually are exposed to more risk factors and have fewer protective factors. They can be victims of neglect and physical, sexual and emotional abuse. They may have been exploited in war, terrorism and the drug trade, and can be subjected to many forms of violence. Such children may suffer deprivation, poverty, homelessness, famine, gender-based discrimination and frequent displacement. As a result, they can develop various mental and physical health conditions. If children are used in growing, manufacturing and distributing drugs, they can be kept illiterate and victimized at each point of the drug trade industry. Children whose families grow drug-producing plants and manufacture drugs can be exposed to toxic residues and second- and third-hand smoke. Children living in countries in conflict are made vulnerable to dire risks in multiple ways. Child soldiers often have easy access to drugs to keep them awake, fight and perform other terrifying actions as well as to cope with trauma.

321. Children and adolescents using psychoactive drugs may not identify substance use as a problem for themselves or others in their lives and may be oblivious to the significant harm that drug use causes to their brain and psychosocial development. Moreover, drug use in childhood and adolescence is associated with increased lifelong risk of substance use disorders and other mental health conditions. As a result, such children may subsequently have a higher probability to need substance use and mental health treatment services.

322. Childhood and adolescence are important developmental periods when brains are especially vulnerable to drug use and drug use disorders. Given the neurotoxic effects of drugs or alcohol on the developing brain, substance use needs to be identified and addressed as early as possible. Children and adolescents can also benefit from interventions for substance use even if they are not dependent on any specific substance. Disrupting exposure to the substance without delay may help minimize the risks for subsequent physical and/or psychological damage. Routine medical, school, or other health-related visits provide opportunities to ask children and adolescents about substance use. Adolescents will respond honestly if they face no repercussions for being honest. Family therapy is an evidence-based intervention for adolescents with substance use disorders as well as for adolescents with a history of delinquency.

323. Adolescents are not "older children" or "younger adults". Characterized by physiological maturation of all body systems and other life-changing transformations, including from childhood dependence on parents and caregivers to adult

independence, this period of life requires tailored health and education services, health protection and health promotion designed to reflect the adolescents' developmental stage and to meet their needs.

324. Adolescents face specific barriers in accessing health care and information. They often find public health care services unacceptable because of perceived lack of respect, privacy and confidentiality, fear of stigma, discrimination and health-care providers who impose moral values. Furthermore, health services often require the support or permission of parents and partners, including for sensitive issues such as sexual and reproductive health. Adolescents may lack parental support. They may be under the control of their parents or partners owing to socio-cultural and gender norms – a fact that is often reinforced by laws and regulations on consent. All this can further prevent them from seeking care.

325. As with other age groups, barriers including low-health literacy, poverty and marginalization also negatively affect adolescents' access, but likely with greater impact.

326. Models and components: children and adolescents who use drugs may reside with their families but may also live on the streets – after being orphaned or rejected by their family – or in correctional system institutions. Treatment circumstances and settings for these latter two groups of children and adolescents may differ substantially from traditional outpatient or residential treatment, and may involve more outreach and drop-in centres than is typically found in the management of substance use disorders among adults. Adolescents may be brought to treatment by their parents who are concerned about recent substance use.

327. Research on treatment for children and adolescents remains limited and, research findings from treatments provided to adults have in the past often guided treatment for children with drug substance disorders. While there is encouraging evidence that age-appropriate psychosocial treatment is effective in adolescence, very limited evidence is available on treatment for younger children. To treat children with substance use disorders, it is necessary to design psychosocial treatments to fit their level of cognitive development and life experiences. This may entail unforeseen problems, such as children responding differently to medications compared to adolescents and adults.

328. There are other issues to consider when providing treatment for children and adolescents with substance use disorders:

(a)   The legal status of children and adolescents regarding their competence and capacity to consent to treatment varies from country to country. There is a need to take this into account and seek parental consent or involvement, as required;

(b)   Children and adolescents using drugs have unique treatment and care needs that reflect their developing brain and cognitive functioning, as well as limited coping skills, given the stage of their psychosocial development;

(c)   Adolescents have high levels of risk taking and novelty seeking, and are very responsive to peer pressure;

(d)   Adolescents with drug use problems have a high prevalence of comorbid psychiatric disorders and family dysfunctions, which should be a focus of treatment;

(e)   Being more concrete in their thinking, less developed in their language skills, and perhaps less introspective than adults, children and adolescents may also be less likely to value discussing their problems;

(f)   There is a need to adapt behavioural treatment interventions, taking into account children and adolescents' limited cognitive abilities;

(g)   Children and adolescents may have different motivations than adults to participate in treatment and to share common treatment goals with a treatment provider.

329. The treatment of drug use disorders should be tailored to the unique needs of the adolescent and address the needs of the whole person, not merely the drug use. It is important to identify violence, child abuse and the risk of suicide and harm, at the earliest opportunity in the treatment, and to take action to safeguard or protect the child or adolescent. Monitoring substance use is key to the treatment of adolescents, where the goal is to provide the needed support and additional structure while their brains are developing. In treatment, adolescents need more and different support than adults do. Given the onset of sexual involvement and higher rates of sexual abuse among adolescents with drug dependence, voluntary testing for sexually transmitted diseases such HIV, as well as hepatitis B and C, is an important part of drug treatment for adolescents. Treatment should also include strategies such as: social skills training, vocational training, family-based interventions and sexual health interventions, including the prevention of unwanted pregnancy and sexually transmitted diseases.

330. Treatments should attempt to integrate other areas of social involvement of adolescents, such as families, school, sports and hobbies, and recognize the importance of positive peer relationships. Treatment for adolescents should promote positive parental involvement, where appropriate, and ensure access to child welfare agencies.

331. Substance use disorder and mental health treatment services should accommodate the unique characteristics of children and adolescents and be flexible in identifying and addressing their needs. This should be done within a framework that best protects the children and adolescents from harm while meeting their individual health needs.

332. Outreach services: The goal of outreach programmes is to identify children and adolescents who might be in need of health and social services. The programmes provide such services to the extent possible, given the constraints under which a child might be living (for example on the streets or incarcerated). As such, outreach staff should target children and adolescents known to be at risk, and then serve as a conduit for the necessary services. Such services should seek to address any of a variety of problems, including those of a mental, behavioural and social nature. In outreach cases, staff may carry out screening in order to collect sufficient information to determine the need for referral and treatment, and to play an active role in organizing the referral or treatment. Outreach services may also need to assess interfamily dynamics and vulnerabilities that lie therein. Initiating treatment for drug use disorders takes precedence over the cause and extent of the problem.

333. Screening and assessment: traditional outpatient and inpatient programmes that provide treatment to children and adolescents typically have screening and intake procedures that determine the suitability of the child or adolescent to enter the programme. It is necessary, at a minimum, to screen for three risk factors as part of the admissions process: the severity of the substance use disorder; risk of self-harm and harm to others, and; other safety issues, such as vulnerability to abuse (emotional, sexual and/or physical). A combination of risk factors as well as complication involving other co-occurring disorders might suggest the need to admit the child or adolescent to a more suitable inpatient treatment setting, if outpatient treatment cannot guarantee adequate support and safety. An assessment evaluates a child or adolescent's current life circumstances and gathers information on their physical, psychological, family and social history to determine specific treatment needs. This helps to develop a treatment plan that matches the child or adolescent's strengths and needs. Standards used in screening and assessing children and adolescents should be no different from those used for other patient populations.

334. Treatment planning: children and adolescents with substance use disorders need to be considered as integral to a treatment team that focuses on the physical and psychological well-being. It is important to view them, not merely as patients who are passively informed about their health status, but rather more accurately, as active participants in treatment decision making, along with the caregiver. Additionally,

early on in the planning process, case management can help with linkages to the relevant community services and – in the case of inpatient treatment – there is a need to decide about transitioning back to the community. Treatment planning also requires collaboration with the school system and should take into account the need for continued formal education.

335. Treatment approaches: treatment approaches for children and adolescents with substance use disorders largely depend on the substance(s) used. As with other patient populations, treatment should involve psychosocial interventions in combination with medication when appropriate. However, little research exists on the efficacy of pharmacotherapies for treating adolescents, and even less on child substance use disorders. As such, none of the medications is approved for use in this population group. There is some support for the use of opioid agonists, such as methadone and buprenorphine, to treat adolescents when they are able to give legal consent to such treatment. It should be used for adolescents with severe opioid dependence who are at a high risk of continuing drug use. Parents should also provide consent to any treatment of minors, as required by national legislation. Adolescents with a short duration of opioid use disorder, who have significant family and social support, may respond to opioid withdrawal management with or without a subsequent prescription of naltrexone as a relapse prevention strategy. Appropriate pharmacotherapy should also be used to treat co-occurring psychiatric disorders as a part of an integrated treatment plan that also involves psychosocial treatments.

336. Psychosocial approaches for the treatment of drug use disorders in children and adolescents should cover a wide range of their needs and use an individualized approach that takes into account their vulnerabilities and strengths as well as developmental history from birth to the present. Examples of treatment approaches for substance use disorders in children and adolescents include the life skills approach, family-based interventions and psychoeducation. Adolescents will benefit from training in self-control, social skills and decision making. When available and locally tested, the use of evidence-based digital technologies may also be introduced into treatment programmes.

337. Gender specific issues in the treatments of adolescents: recognition of gender differences should form an integral part of treatment in children and adolescents. Boys typically prefer mixed-gender groups, while girls may prefer girls-only groups, reflective of differences in both the socialization and substance use histories of girls and boys. Given the much higher rates of physical abuse, sexual abuse and the exchange of sex for drugs among girls than boys, at least part of a treatment programme should be gender specific and include components dealing with sexual and reproductive health. For girls, treatment may focus on specific vulnerabilities that affect girls, such as depression and a history of physical and sexual abuse, while for boys treatment may focus more on impulse-control issues, disruptions in the school and the community and a history of learning and behavioural problems. However, there will be a need to address many of these issues in all children and adolescents.

338. In summary, investing in drug treatment services specifically tailored for adolescents will also fuel economic growth by helping increase productivity, reduce health expenditure and disrupt the intergenerational transmission of poor health, poverty and discrimination.

C. Drug use disorders among people in contact with the criminal justice system

339. Description: the size of the prison population throughout the world is growing, placing an enormous financial burden on governments and at a great cost to the social cohesion of societies. It is estimated that more than 10.3 million people, including sentenced and remand prisoners, were held in penal institutions worldwide in October 2015. Although women only constitute 6.8% of the world's prisoners, the female

prison population has increased by 50% since 2000, while the equivalent figure for the male prison population is 18% (Walmsley, 2015).

340. Globally, an estimated one in three prisoners has used an illicit substance at some point while incarcerated (a median lifetime prevalence of 32.6%, based on data from 32 studies), with 20.0% reporting use in the past year (a median past-year prevalence from 45 studies) and 16.0% reporting current use (a median past-month prevalence from 17 studies). According to estimates, people with drug use disorders represent a high proportion of the prison population in many countries (UNODC, 2017: UNODC, 2019).

341. Numerous studies have shown that drug use, including injecting drug use, is highly prevalent in prisons, with the sharing of needles and syringes being commonplace. Unsafe injecting practices in prison, where rates of HIV are high, place people who inject drugs at an increased risk of HIV through the use of contaminated needles and syringes (UNODC, 2017).

342. Globally, an estimated 2.8% (2.05 – 3.65%) of prisoners have active tuberculosis, with the highest rates being in Eastern Europe and Central Asia (4.9%) and East and Southern Africa (5.3%). People who use drugs in prison have been shown to be at higher risk of contracting tuberculosis (UNODC, 2017).

343. It is important to screen for drug use and drug use disorders among people in contact with the criminal justice system. It is an opportunity to encourage a person that screened positive to receive appropriate support and, if necessary, treatment interventions with referral to treatment services for drug use disorders. This may require a coordinated response that involves the criminal justice as well as the health and social care systems. Evidence-based drug use disorder treatment has proved effective in reducing substance use and promoting recovery while breaking the vicious cycle of drug use and crime, and reducing re-offending and re-incarceration among people with drug use disorders who come into contact with the criminal justice system (Justice Policy Institute, 2008; Gumpert et al., 2010; Sun et al., 2015; Zhang et al., 2017)

344. Treatment for people with drug use disorders who come into contact with the criminal justice system may – depending on the offence – take place as an alternative to conviction or punishment or in parallel to sentencing or incarceration (in prison settings, for example).

345. International drug control conventions (UN, 1961, 1971, 1988) anticipate facilitating treatment as a partial or a complete alternative to conviction or punishment (or in parallel to conviction or punishment), mainly to be considered in appropriate cases of a minor nature committed by a person with a drug use disorder. Treatment as an alternative to conviction or punishment can be implemented along the criminal justice continuum throughout the pretrial, trial and post-sentencing stages.

346. Models and components: evidence-based treatment and care should be available to all people with drug use disorders independent of their legal status. Persons with drug use disorders who come into contact with the criminal justice system can be offered drug treatment services either as an alternative to conviction or punishment or in parallel, for example, within prisons, depending on the severity of the crime committed and the sentence that they may have received or not. In order to offer an effective response to anyone with drug use disorders, who is in contact with the criminal justice system, it is necessary to consider the severity of their drug use disorders and comorbid health conditions. In line with the United Nations Standard Minimum Rules for Non-Custodial Measures ("The Tokyo Rules") (UN, 1990), prison should always be a last-resort measure. Additionally, the special conditions of women in contact with the criminal justice system should be taken into consideration, in conformity with the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (The Bangkok rules) (UN, 2011).

347. When people with drug use disorders commit criminal offences that are considered minor (whether drug related or not), treatment can be offered as an alternative to conviction or punishment, in compliance with international conventions and norms. Offering evidence-based treatment for drug use disorders to people in contact with the criminal justice system is an effective public health and public safety response (Belenko, Hiller and Hamilton, 2013; UNODC and WHO, 2019).

348. People with drug use disorders, who cannot benefit from treatment as an alternative to conviction or punishment because they are serving a prison sentence, need to receive treatment and care, delivered in prison or other settings.

349. Screening and assessment in the criminal justice context: interaction with the criminal justice system could be an opportunity to encourage people with drug use disorders to voluntarily participate in treatment services. It is therefore critically important to screen for drug use and drug use disorders among those in contact with the criminal justice system, preferably as a part of a larger health screening.

350. All points of contact within the criminal justice system should offer opportunities to carry out screening and assessment for health disorders, including drug use disorders. It is necessary to establish, at the earliest point of their contact with the criminal justice system, whether offenders with drug use disorders are eligible for alternatives to conviction or punishment, and to implement the alternatives if applicable. The justice and health authorities should have the joint capacity to evaluate treatment to determine whether it can serve as an alternative to conviction or punishment. Additionally, they should establish which treatment options are available and most suitable for the person under consideration, taking into account both the offence committed and the healthcare needs.

351. Points of and opportunities for intervention to link drug users to services include: contacts with law-enforcement officers; initial detention and/or initial court hearings; jails and courts; re-entry into the criminal justice system, and; community correctional programmes, such as probation and parole, for offenders. Every actor at each point of intervention has an opportunity to identify signs of potential drug and other psychoactive substance use and substance use disorders, and to ensure prompt health screening for substance use disorders. Following a positive screening, trained health professionals should carry out a comprehensive assessment. That will make it possible to plan and implement consecutive health interventions. These are especially necessary in managing withdrawal syndromes to avoid unnecessarily suffering and, in some cases, dangerous and life-threatening complications among detained people with substance dependence. Screening for drug and other substance use disorders should form an integral part of standard health screening whenever the criminal justice system takes people into custody.

352. Assessment is a continuous process that different people in different settings at various stages of contact with the criminal justice system can undergo. For example, an initial assessment could be taken at the pretrial level, to be followed by another later on, in prison. There are several reasons why a reassessment might be required, such as changes in an individual's perceived need for treatment, motivation or health status. There is a particular need to consider the suicide risk at all stages of assessment.

353. Only trained personnel should conduct assessments for drug use disorders. The key issues to be addressed in the assessment are:

(a) Is there any immediate risk to life, including as a result of an overdose?

(b) Is the person in need of any immediate treatment, such as for drug withdrawal or psychosis?

(c) Does the pattern of drug use fit the pattern of harmful use or dependence?

(d) Is the person interested in receiving treatment for drug use disorders?

(e) What kind of treatments have they received in the past?

(f) What ranges of treatment interventions are likely to be effective?

(g) What kinds of treatment interventions are available?

(h) Are those interventions available for people receiving treatment as an alternative to conviction or punishment and/or in the prison system?

(i) Of these treatment interventions, which would the person be interested in pursuing?

(j) Are there concomitant medical problems (including psychiatric conditions) that need to be taken into consideration?

(k) What is the legal situation in case treatment is accepted or refused?

354. Based on a comprehensive assessment of the individual and their needs regarding treatment and other important life domains (health, social, legal), it is important to develop a treatment approach tailored to those needs. It is vital to avoid approaches that exclusively focus on punishment, or that lack structure. To be effective, treatment interventions for people with drug use disorders and a history of delinquency should address complex needs and the risk of problems, including the risk to reoffend.

355. Treatment of drug use disorders in the criminal justice context: the basic premise of delivering health services within the criminal justice system is that such services should observe the same principles as in any other part of health care and medical practice, and conform to the type and scope outlined throughout the Standards. Decisions made by criminal justice officials should not deprive a person of the right to the health care and services that he or she needs.

356. As a general rule, health services in the criminal justice system should be equal in standard to health services in the community (the principle of equity). There should be links between the criminal justice system and community-based services to ensure uninterrupted services, continuity and sustained quality of care.

357. Treatment for drug dependence in the criminal justice context: when an offender who is highly likely to have a drug use disorder comes into contact with the criminal justice system (for instance being arrested by the police for a drug-law offence, such as drug possession), they should undergo screening, followed by an assessment and brief interventions conducted by a trained health professional. The assessment can determine whether the offender meets the diagnostic criteria for a drug use disorder that includes drug dependence or a harmful pattern of drug use. In case of drug use without diagnostic features of drug use disorders or in case of harmful pattern of drug use, it is possible to provide a brief treatment intervention (see section 4.2.1) while assessing further needs, risk and protective factors. This is also to prevent reoffending and/or recidivism. If the diagnostic assessment identifies drug dependence, it necessitates evidence-based treatment for drug dependence. This should be offered as an alternative to conviction or punishment, or in parallel to sentencing and incarceration, depending on the legal situation. If the assessment identifies other somatic/mental health or social problems, the offender needs to be referred to services that can provide appropriate treatment and care. Alternatively, these services can be integrated into the management of drug use disorders.

358. When an offender with drug dependence comes into contact with the criminal justice system, it is highly unlikely that they have been receiving adequate treatment for their drug use disorder. The interaction with the criminal justice system can be an opportunity to offer the offender the treatment they require for their drug dependence.

359. Assuming that the individual consents to treatment, diagnostic assessment by a clinician should, lead to the development of a treatment plan. At this point it is necessary to establish whether the individual is eligible and ready to participate in available treatment options, including treatment as an alternative to conviction or punishment, where applicable. The diagnostic assessment should also cover other medical, mental or social problems as well as factors that could modify the risk for

reoffending and/or recidivism. This is crucial to the development of a treatment plan that responds to an individual's needs. If the person is willing to participate in treatment, it is necessary to discuss the availability and accessibility of appropriate treatment services. If the decision is to proceed with treatment, the relevant criminal justice system actors should decide whether it should be offered as a partial or complete alternative to conviction or punishment. They also need to decide whether the treatment should to be delivered during incarceration – for example, in prison – and specify the conditions that formed the basis of their decision. Justice system conditions may vary, from initial attendance of treatment sessions and continuous compliance with treatment to particular intermediate treatment outcomes, such as abstinence or reduced drug use. If a treatment approach does not achieve the desired outcome, it may be necessary to consider alternative treatment approaches better suited to the health and social care needs of the offender with a drug use disorder.

360. Services for individuals with drug use disorders who are in contact with the criminal justice system should focus not only on health care needs but also on cognitions, behaviours, attitudes and the individuals' contextual factors that are associated with recidivism and re-offending. Treatment programmes and interventions should take into consideration these specific needs of offenders with drug use disorders and address them in a comprehensive manner. This will not only help achieve the expected health outcomes, but also prevent re-offending and recidivism.

C.1 Treatment as an alternative to conviction or punishment

361. To offer effective public health and public safety responses, while addressing the challenge of the growing prison populations worldwide, alternatives to conviction or punishment need to be considered for people with drug use disorders.

362. For people with drug use disorders who commit offences regarding the possession of internationally controlled substances for personal consumption, and other minor offences, international drug control conventions have envisaged measures, such as treatment, education, aftercare, rehabilitation or social reintegration, including as complete alternatives to conviction or punishment (UN, 1961, 1971, 1988). Additionally, States have a range of standards and norms concerning the application of non-custodial measures, which they should draw upon (UN, 1990, 2011).

363. There is a broad range of alternative applicable measures along the criminal justice continuum from pretrial, throughout trial, and the post-trial phase, with some differences in common and continental law systems (UNODC and WHO, 2019). Individuals with drug use disorders who are in contact with the criminal justice system encounter multiple problems. As such, treatment programmes must have the capacity, through their networks, to adequately address patients' additional needs, such as housing, employment, legal, financial and family problems.

364. Treatment programmes in the criminal justice context often start by providing fairly structured treatment interventions, including stringent toxicology monitoring and the incentives system and, to a lesser degree, sanctions to ensure compliance with treatment. Over time, as patients make progress, the programmes reduce the intensity of services and supervision.

365. The Table 3 lists some key intervention points and types of diversion programmes that different countries have implemented along the criminal justice continuum of care (UNODC and WHO, 2019). The individual should always have the choice to accept or decline the treatment option and the conditions associated with it. The usual legal safeguards, including the right to appeal, should always go hand-in-hand with treatment under judicial supervision.

Table 3

Key interventions and types of diversion programmes different countries have implemented along the criminal justice continuum of care (UNODC and WHO, 2019)

ADMINISTRATIVE RESPONSE	CRIMINAL JUSTICE RESPONSE		
PRE-ARREST Police	PRETRIAL Police, prosecutor, defence, examining magistrate	TRIAL/SENTENCING Judge, probation officers	POST-SENTENCING Prison director, parole board, minister for justice
Administrative response with information/referral to treatment	Caution with a diversion to education and/or treatment	Postponement of the sentence with a treatment element	Early release/parole/pardon with a treatment element
	Conditional dismissal/ conditional suspension of the prosecution	Deferring the execution of the sentence with a treatment element	
	Conditional bail (alternative to pretrial detention)	Probation/judicial supervision	
		Special courts/docks (for example, the drug treatment court)	

C.2 Treatment in prison settings

366. Prison should be a measure of last resort. When people with drug use disorders receive a prison sentence–which is a measure of last resort in the criminal justice system–but are ineligible for treatment as an alternative to conviction or punishment, they should be offered treatment for drug use disorders inside the prison system.

367. In general, treatment interventions in a prison setting should be equivalent to those available to the general population (as described in previous chapters). Such interventions should take into account the unique situation of individuals with drug use disorders who face criminal justice sanctions, including imprisonment. Treatment interventions must always be voluntary and based on the patient's informed consent. Everyone who has access to services, including individuals under the supervision of the criminal justice system, should have the right to refuse treatment, even if this entails other custodial or non-custodial measures.

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

369. One of the more complex issues relates to the appropriate staffing of treatment programmes. In some prisons, in-house staff members are trained to provide treatment services, while in other prisons, external treatment providers are contracted to deliver services. These staffing decisions should aim to achieve the best outcomes at the lowest possible costs. In general, however, outcomes for patients depend on the quality of services provided rather than on the provider's affiliation.

370. Ideally, those participating in treatment should be separated, as appropriate, from other incarcerated individuals to maintain a therapeutic environment. If individuals who are in recovery return to the general prison environment, they run a high risk of using drugs and relapsing, which can undermine gains achieved while in treatment. When separated or stand-alone treatment environments are not possible or available, it is important to try and minimize exposure to external risk factors (for example by setting separate dining and recreation times). Treatment decisions must also take into account the amount of time left in an offender's sentence. Agencies should consider how long an individual will be incarcerated and either require them

to complete assigned treatment before their release or ensure the continuation of treatment thereafter.

371. Certain special considerations apply to the delivery of treatment interventions for drug use disorders in prisons:

(a) Medication-assisted withdrawal management: If a correctional agency lacks in-house withdrawal management, it is imperative that the individual be referred to outside medical services. Forcing individuals to go through withdrawal without medical attention is not only unethical; it can endanger the person's health and safety;

(b) Outpatient or office-based treatment in prisons can include periods of intensive treatment followed by periods of less intensive treatment. This method of "downgrade" in treatment intensity is particularly suited for individuals receiving intensive treatment services in prison and who, on returning to the community, still need treatment services, albeit less intense. Gradual decrease in the treatment's intensity should depend on whether an individual is meeting their treatment goals;

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

(d) A therapeutic community is a model of residential treatment that can be adapted to a prison population. Prison-based therapeutic-community programmes should be located in a separate unit of the prison with a structure and services similar to comparable programmes outside the prison setting;

(e) Opioid-overdose prevention is a key intervention especially at prison release. For people with opioid use disorders, initiating or continuing opioid agonist maintenance treatment in prison has proved effective in preventing opioid overdose upon release;

(f) To reduce the risk of opioid overdose after discharge from prison, people with a history of opioid use, as well as their families and friends, should be equipped with take-home naloxone, along with instructions and/or training on how to use it in the event of an opioid overdose.

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