



UNITED NATIONS
Office on Drugs and Crime

Treatnet

International network of drug dependence
treatment and rehabilitation resource centres

Drug Dependence Treatment: Community Based Treatment



**Treatnet: International Network of Drug Dependence
Treatment and Rehabilitation Resource Centres.
Good practice document**

Community Based Treatment Good Practice

www.unodc.org/treatnet

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Disclaimer

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This document has been produced by members of one of four Treatnet working groups and the topics of the documents available are:

- Community Based Treatment
- Interventions for Drug Users in Prisons
- The Role of Drug Dependence Treatment on the Prevention and Care of HIV and AIDS
- Sustained Recovery Management.

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Introduction and Overview

A Brief Background

This manual is a product of Treatnet¹, the International Network of Drug Dependence Treatment and Rehabilitation Resource Centres, initiated by the United Nations Office on Drugs and Crime (UNODC). The goal of the network is to improve the accessibility, affordability, and the quality of drug dependence treatment and rehabilitation. Twenty drug treatment and rehabilitation organisations from all regions of the world have joined Treatnet as Resource Centres, and 15 treatment providers are associate members.

Four good practice documents, developed by the Treatnet workgroups, are products of this initiative and are available to assist drug dependence treatment providers around the globe. Their focus is on:

- Community-Based Treatment;
- Interventions for Drug Users in Prison;
- The Role of Drug Dependence Treatment in HIV/AIDS Prevention and Care; and
- Sustained Recovery Management

The working group on Community Based Treatment identified approaches and intervention tools that can be useful for community-based treatment services of diverse range of resources and funding in a variety of settings.

Furthermore the Treatnet Capacity Building Package provides in-depth training manuals on the following topics:

- Screening, Assessment, and Treatment Planning;
- Elements of Psychosocial Treatment;
- Addiction Medications and Special Populations; and an
- Administrative Toolkit.

Definitions of Good, Evidence-based, and Promising Practices

Treatnet defines **good practice** as an umbrella term that encompasses evidence-based and promising practices. Good practices display the following features:

- Relevance to local needs;

¹ "Treatnet, the international network of drug dependence treatment and rehabilitation resource centres aims at improving the quality of drug dependence treatment through the cooperation, information exchange and empowerment of twenty selected resource centres representing all regions. The twenty centres are committed to the synthesis, demonstration and dissemination of good practices and application of state of the art approaches to effective drug dependence treatment and rehabilitation." Treatnet was launched by UNODC in 2005. (Please see: <http://www.unodc.org/treatment/> for more information.)

- Ethical soundness;
- Sustainability likelihood (low cost, cost efficient, integrated, supported), and
- Replicability, that is, practices that have been sufficiently documented.

Evidence-based practices are supported by scientific studies and were ideally replicated in multiple geographic or practice settings. These practices produce specific, consistent, outcomes and have been documented in scientific journals; sometimes they are available as manuals.

The strength of the evidence available can be ranked into specific gradations, for example as follows (British Hypertension Society, 2001):

Strength of Evidence Gradations:

- Ia:** Evidence from meta-analysis of randomized controlled trials;
- Ib:** Evidence from at least one randomized controlled trial;
- Ila:** Evidence from at least one controlled study without randomization;
- Ilb:** Evidence from at least one other type of quasi-experimental study;
- III** Evidence from descriptive studies, such as comparative studies, correlation studies, and case controlled studies; and
- IV:** Evidence from expert committee reports or opinions or clinical experience of respected authorities, or both.

Promising practices have been demonstrated to be effective, using objective measures, in one or more organisations. These practices may be at an early stage of development, but show promise of replication, and long-term sustainability with the possibility of becoming evidence-based practices.

Who This Good Practice Document Is Written For

This document on community-based treatment services (**CBTS**) is meant to be an initial guidance for those who want to develop or improve services for people with drug use problems within the community. This document is not meant to be a full guideline for the delivery of drug dependence treatment². It is developed from practical experience with community-based drug dependence treatment in many regions of the world and a review of the available literature.

The document strongly emphasizes the importance of having multidisciplinary teams and diverse people from the community to support substance abuse treatment such as:

² For more information, please consult also the documents on drug dependence treatment available in the Virtual Library of the UNODc Treatnet website www.unodc.org/treatnet: The Toolkit on Drug Dependence Treatment and the Training Package

- Community groups (e.g., leaders, professionals or other people involved in meeting the needs of a known group(s) in a specific area),
- Professionals in direct contact with clients (e.g., psychiatrists, doctors, social workers), and
- Allied professionals (e.g., teachers, counsellors, prison officers, police).

The document is meant to be a starting point for health care leaders to consider the information herein, and use the recommendations as needed. The document includes practical case studies at the end of each chapter to demonstrate how community-based services in different parts of the world have applied the approaches and methods outlined in this document.

Focus and Model Used

The focus is on **illicit** substances such as cannabis, crack cocaine, amphetamine-type stimulant (ATS), inhalants, and heroin. But the recommendations may also be applicable for those that have problems (or dependence) with alcohol and tobacco.

The **biopsychosocial model** is used here as a basis for service and treatment planning. This is a holistic approach that takes into account the complex variety of factors such as genetic, psychological, social, economical, political factors to explain drug use problems and drug dependence. The biopsychological model proposes that the best way to treat drug use problems or dependence is through a multidisciplinary team.

What Community-Based Drug Dependence Treatment Means

Community-Based Drug Dependence Treatment needs to respond to the needs and resources of communities, beginning with a careful assessment. CBTS networks should work to mobilize all available resources in the community to meet their clients' needs. CBTS are based on a holistic vision of the multifactorial range of drug related problems that may affect persons with drug dependence, their families and their communities. Such perspective encourages the use of a variety of paths to treatment, recovery and increased quality of life.

Many of the emerging community-based approaches to drug dependence have been adapted from the reform of psychiatric services, including day hospitals, day centres, work rehabilitation services and residential services. The shift went from "supply-oriented" organizations to "needs-led care" organizations that currently focus more on what the patient needs rather than what the organization wants to provide (Kunze, Becker & Priebe, 2004).

Community-based treatment needs to involve but then also go beyond the local community in order to address the complex variety of needs of drug dependent people; for instance service providers need to work with law enforcers and law agencies, potentially including at the national level.

The coordinated active involvement of community based agencies, government (state, regional and local) religious organizations, cultural groups, community leaders, businesses, drug use treatment centres of all modalities and other organizations is essential.

The community as a whole needs to be educated in perceiving drug use as multifactorial disease with a strong social/systemic component, not as an individual weakness. Community-based treatment is characterized by a high degree of participation of the members of the community both in project planning and implementation. It empowers local people to initiate action, take ownership of the process and outcome of their activities. CBTS rely on grassroots initiative and the capacity to continue progress without depending on national interventions.

Only if the problem is “owned” and understood in its complexity by the community in order to really involve community stakeholders can play an active role in promoting treatment services and other critical supports (e.g. job opportunities for people in recovery, education, resources), along a continuum of care both for treatment and prevention. The community furthermore plays an important role in the reduction of the negative health and social consequences of drug abuse in different areas (physical-mental health, social, economic, legal, etc.) and at different levels (individual, family and community).

Accessibility and Range of Services

Treatment services should be accessible, affordable and evidence-based to deliver quality care for all people in need of support. One of the greatest strengths of properly designed CBTS is that they can be provided where and when needed (e.g., in a client’s home). To grant a high level of accessibility, drug treatment services can be mainstreamed in the public health care system, but also Non-Governmental Organizations (NGOs) play an important role in the delivery of treatment services, sometimes even being the only service provider offering drug dependence treatment.

CBTS, from a clients perspective, are designed to:

- Help clients develop the skills to manage their lives within their communities,
- Respond to a wide range of client needs, and

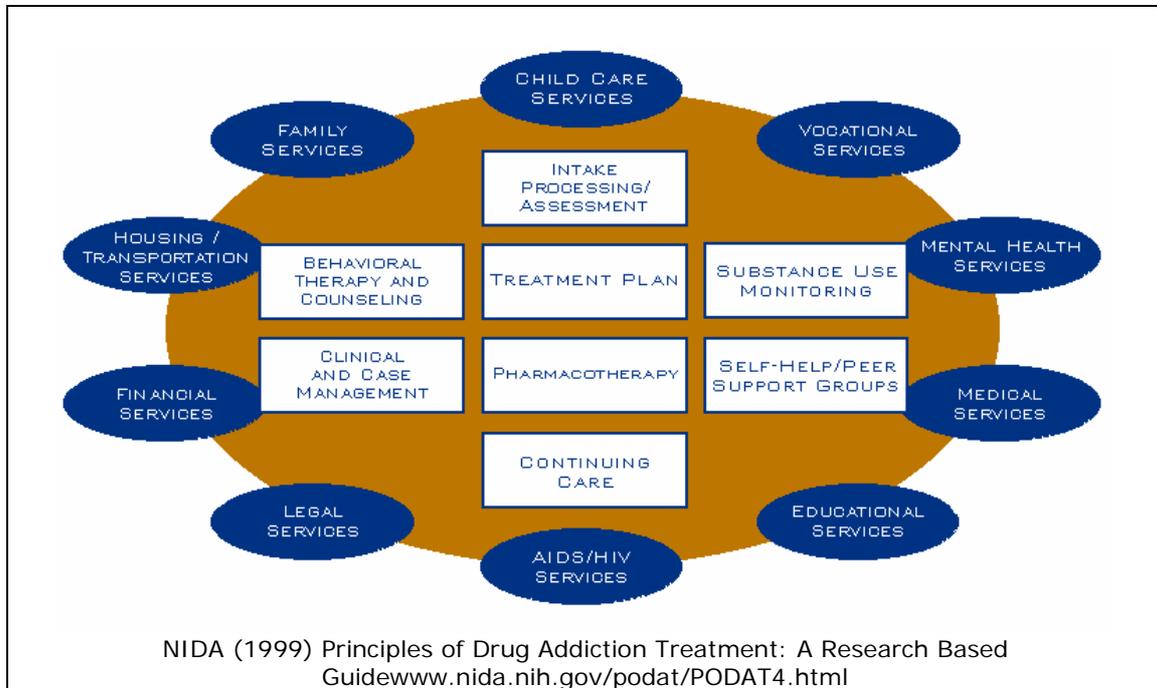
- Ensure the best possible outcomes for people with drug use problems or drug dependence³

People with drug dependence and other related problems need a wide range of services. CBTS may include the following, depending on the needs identified in the community:

- A wide range of coordinated services along a continuum of care (from outreach and detoxification to aftercare)
- Assessment and case management
- Psychosocial support such as Counselling, Motivational Interviewing, and Cognitive Behavioral Therapy
- Lifestyle and personal counselling (individual and/or group settings);
- Professionally assisted pharmacological treatment (e.g. withdrawal management, pharmacological treatment of opiate dependence, treatment of co-occurring disorders),
- Harm reduction interventions such as needle and syringe exchange programmes
- Public education and advocacy
- Housing support if needed
- Structured programmes provided through community-based day treatment or evening programmes
- Linkages to sustained recovery management services.
- Coordination of non-specialist services to meet clients' needs

³ See: National Academy of Science, Institute of Medicine (1990). Broadening the Base of Treatment for Alcohol Problems.

A model of comprehensive service provision was developed by the National Institute of Drug Abuse (NIDA) and is integrated here as an illustration of the above said:



UNODC (2002) published a review of evidence-based contemporary drug dependence treatment that highlights core activities of community-based treatment services, which are:

- Encouraging attitude and behavioural change among community members,
- Actively implicating local organizations and community members,
- Targeting populations in setting up and keeping an integrated network of community-based services that supports and empowers people with drug dependence.

Community based services can be implemented along a continuum of intensity, starting from services delivered only during some hours a day to more comprehensive services delivered on a 24 hours/7days basis. For service users it is beneficial if comprehensive and holistic services can be delivered when and where needed in the community.

Benefits of Community based treatment services (CBTS)

Through the establishment of strong collaborations with health, social and other treatment related services, providers can offer a more complete range of treatment services, to benefit their clients with drug use problems or drug dependence.

CBTS are cost-effective. Evidence shows that when clients use CBTS services, such as well-designed and delivered case management, there is a big drop in the number of hospital stays and emergency-room visits.

Some of the benefits of community-based treatment include the following:

- It is a less invasive approach than other treatments (e.g. residential, hospitalization, intensive treatments, etc.)
- It facilitates patients access to treatment
- It is less disrupting of family, working and social life
- It focuses on social integration from the beginning
- It is appealing for patients
- It is more flexible than other modalities of treatment
- It fosters patient's independence in patients' natural environment
- It is affordable for patients, families and the community
- It educates the community to reduce stigma
- It focuses on community empowerment

Overview of Chapters

Chapter I (Networking) outlines the principles and practices that can guide the setting up of successful community treatment network, including:

- Mobilizing/empowering the community
- Establishing goals for the network (including primary care and specialized services)
- Identifying and paying attention to the needs of special populations, such as women, children, youths, persons living with HIV and AIDS, the homeless, sex workers, and marginalized minorities
- Mobilizing (knowing and gathering together) a comprehensive range of resources, which is the key to success
- Providing a wide variety of services within the community

Chapter II (Information, Needs and Resource Analysis –INRA) looks at the importance of conducting comprehensive assessments of the community needs, available information, and resources. Chapter II discusses the following:

- The importance of assessing and documenting individual treatment needs and community needs to act accordingly and prioritize resources;
- The value of taking into account the attitudes of service providers to the needed services;
- The importance of having qualified health workers or community leaders;
- The value of measuring specific needs and available resources based on essential principles and a real commitment to follow up;
- The use of Information, Needs and Resource Analysis (INRA) in specific communities; and
- A short description of how to do community INRAs (including areas to be assessed), rationale, methods and helpful community resources.

Chapter III (Promoting change through Programme Development and Evaluation) explains the steps for the development (planning and implementation) of effective treatment programmes as follows:

- The biopsychosocial model as a basis for programme planning;
- Using a pragmatic approach to identify harms and implement risk reduction strategies;
- Accounting for the diversity of potential clients in their jurisdiction, and planning on the basis of identified needs; and
- Meeting needs and maximizing the impact and effectiveness in service delivery.

Chapter IV (Engaging clients in Community Based Treatment Settings) stresses the importance of engaging the client through reducing barriers to the services and resources in the community. This is the key for a successful development and delivery of all aspects of CBTS. Several strategies are suggested, as follows:

- Developing protocols and guidelines to ease access and use of services for clients;
- Early interventions;
- Recognizing that each client is unique and needs an individual treatment plan to meet his/her needs; and
- Ensuring that programme managers engage clients by understanding the client as a person with a variety of strengths and needs and not only focusing on the drug use problem.

Chapter V (Treatment principles, steps and psychosocial strategies in Community-based Settings) discusses the importance of nine basic treatment principles recommended by UNODC- WHO. The suggested principles can be implemented in progressive steps in accordance with resource availability and stages of development of the treatment system. The chapter also discusses intervention steps and psychosocial strategies for a comprehensive evaluation, intervention and treatment of substance abuse.

The provision of appropriate pharmacotherapy is essential for community-based treatment services. Thus, **Chapter VI** provides an overview of pharmacological interventions that can be delivered in a community setting, with family and social support. It recognizes that, to implement a successful programme, professionals should consider the following:

- The importance of having a good knowledge on substances effects, withdrawal symptoms and medications available;
- Knowledge of when and how medications may be required to ease successful withdrawal, with the likely severity of withdrawal symptoms being a key consideration; and
- Relapse prevention and the role of medication.

Chapter I : Networking and Community Empowerment

This chapter describes the main principles and practices needed to create effective service networks for alcohol- and drug-dependent clients. It is assumed that a community-based treatment service (CBTS) works best if it is located within a network of community resources and services. Such a service network would provide better care to clients offering affordable, accessible and evidence-based services in a holistic framework.

In order to maximize flexibility, accessibility, and safety for users, it is necessary for programme planners to develop an integrated continuum of services that provide easy access. It is also important to take into account the varying environmental, psychological, and biological reasons why people use both licit and illicit drugs as well as their patterns of drug use (see chapter IV) .

In establishing a community network, programme planners need to develop basic guidelines and agreements to create a common focus, vision, and direction to take care of clients' needs and set out the role of each service within the network. They also need to think about available resources, interests, and the purposes of each service in order to create a comprehensive and balanced network that can provide a continuum of care serving clients' needs.

When all services in a community network have a vision of shared responsibility, then clients benefit by receiving needed treatment no matter where they access or search help in the network. This can include to share all material and human resources across the network. When clients seek help, the professionals can guide the client based on the quality and level of the clients problems, vulnerability and resources.

Involving the Community

Those planning the services network need to involve community members, for example by sharing information and being open and responsive to community needs. In this way, the community begins to trust, value and promote the work of the network.

Possible partners in the community are:

- Neighborhood associations
- Organized groups of users, family members, and health workers
- Organized groups who identify themselves based on gender and ethnicity
- Educational and research institutions
- Professional organizations
- Government agencies and NGOs that can be involved in aftercare activities such as skills-based training and employment opportunities
- Human rights organizations
- Religious and community leaders
- Trade and services establishments
- Health services such as hospitals and clinics
- Youth organizations and youth leaders
- Social services
- Media

It is very important to find ways for the community to be involved directly in developing and evaluating the network's mission and work on an ongoing basis.

Working with a primary health care network (PHCN). The PHCN in the community provides access to different multidisciplinary team members such as physicians, nurses, social workers and psychologists. Its greatest strength is its location: Care and support can be provided locally, directly where clients live and work. Their location allows PHCN workers to develop strong relationships with their clients, while also understanding better their clients day-to-day lives and needs.

Community-based treatment services can work with PHCNs to provide drug dependence treatment services by

- Sharing information about drug problems in the community,
- Building capacity of PHCN professionals through training, education, sharing experience, and consultation,
- Sharing case management/coordination,
- Offering ongoing expertise and support to the network, and
- Smoothly working referral services.

Working with specialized services. To improve a treatment network and meet the health and social needs of clients, programme planners need to include many specialized services, such as:

- Medical and mental health emergency services to support community-based services by providing beds, and laboratory services that may not be available within community-based services or networks;
- STD, HIV and AIDS programmes that can provide integrated care to clients through its clinics and various supports;
- Community-based outreach partnerships;
- Physical rehabilitation programmes or home care for clients who cannot leave home because they are too sick;
- Health and safety programmes in the work place that community-based services' teams can help develop;
- Programmes that promote affordable and supportive housing and/or support income and employment;
- Work and social skills training, and income generating opportunities

All of the above service providers are necessary partners for **biopsychosocial** support in community-based treatment services.

Working effectively in a network means setting up common goals that community-based services and partners agree upon. Partnering with specialized service providers depends on:

- Knowing the mission, guidelines, and principles of the services to be involved in the network;
- Working together as interdisciplinary teams within the community;
- Sharing and bringing together the delivery of evidence-based care for clients;
- Setting up common workflows, standards and practices;
- Improving the partners' ability to reach common goals and provide for community needs by sharing resources (material, time and human resources) and skills;
- Sharing information;
- Establishing regular meetings and exchange of information with the various partners;
- Setting up workable ways in which to link different social organizations that are able to contribute to a better quality of life for clients, and to the promotion of a more inclusive society;
- Being willing to function following a plan to achieve the desired goals, and
- Searching constantly for ways to share responsibility and accountability for the actions and outcomes of the network.

Community networks operate more effectively if one or more of the following conditions are met:

1. Maintenance of community infrastructure (their community base);
2. Close co-operation with already existing health and welfare networks and with other community organizations;
3. Adequate and diverse funding arrangements;
4. A social climate of acceptance and/or tolerance around issues as sexuality, sexual preference or drug use (Morrison, 1989)

Identifying the needs of vulnerable populations. Building open communication channels with the community increases the chances of identifying vulnerable populations who have limited access to health care services.

In trying to know and understand marginalized communities, it is important to identify persons who can act as go-betweens for service providers and community members. It is also important to know the social rules of marginalized communities, their behaviours, and needs so as not to intrude.

Outreach workers can build relationships with owners of local establishments that might agree to hand out public health resources to customers. This could for example be shop owners giving drug users materials, prepared by the CBTS, to reduce risky health and social behaviour. Another example of possible partners are sex workers, who might be trained as peer educators. They can also reach out to and work with other sex workers outside of the regular opening hours of the CBTS (e.g., in the middle of the night). Through such a linkage the CBTS becomes more accessible.

One important component of outreach work is to contact persons from marginalized groups and to engage members of their communities to help develop work plans and guidelines. Another component is to get to know all members of the community, respecting their unique needs, and to build trust.

It has to be ensured that everyone needing treatment is treated fairly and has easy access to services anywhere in the network. At the same time, where possible, the service providers should empower their clients to know and defend their civil and human rights. Service providers such as social workers play an important role in advocacy to mobilize the system for better treatment services and better coordination of resources. Service providers help also in changing the perception of drug users by the community and mobilize the community to participate in anti-stigmatisation campaigns.

While building relationships between the health service and the community, service providers need to follow ethical principles to win and keep the community's trust. They should also know the extent to which they can respond to the community's needs, and to which extent they are able to support them in an ongoing and sustainable way. It is important not to make promises that cannot be kept. It is better to take suggestions and to discuss them instead of imposing own ideas.

Mobilizing resources in the community. Often, communities have resources that only they are aware of and some that were not even taken into account yet. In addition to more formally assessing community resources (chapter II), information on available resources can be obtained by starting to build a network, in a snow-ball effect. For example, on an informal basis, owners and workers at local leisure establishments (such as bars and clubs) may become partners in preventing the negative health and social outcomes of drug use. That could be one creative way of mobilizing the human resources in the community.

On a more formal level, the network can build partnerships with educational and research organizations in order to:

- Exchange information and work processes;
- Increase educational institutions' ability to train others on drug dependence treatment, for example through a residency of a researcher in the treatment service;
- Contribute to the dissemination of clear and reliable information to the community; and
- Develop research projects that respond to the needs of the service networks and communities.

The following two case studies provide the example of two community-based treatment services in different settings (Brazil and Canada.).

CASE STUDY: SÃO PAULO, BRAZIL

BACKGROUND INFORMATION

Project Name: *Santo André's Mental Health Network*

City/Country: *São Paulo, Brazil*

Contact Details Including Contact Person(s):

*Psychosocial Attention Centre for Alcohol and Other Drug Users,
Santo André's City Hall
Public Health Secretary
Public Mental Health General Coordination
Santo André, São Paulo, Brazil*

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- *Graziella Barbosa Barreiros, Technical Coordinator of Psychosocial
Attention Centre for Alcohol and Other Drug Users
Email: graziellasantoandre@gmail.com, Phone +55.11.49923668*

Website: *None available*

Project Status: *Ongoing since 1997*

Funding Source: *Municipal Government of Santo André*

Years of Operation: *10 years*

Target Groups:

- *Long-term patients in psychiatric hospitals;*
- *Alcohol- and other drug-dependent persons and their families;*
- *Vulnerable populations (e.g., sex trade workers, runaway children and adolescents who may be at risk of sexual exploitation, and homeless);*
- *Persons who need information and/or orientation on drug use (e.g., teachers, students, other professionals); and*
- *Persons from the government sector (e.g., frontline public service workers and policy makers)*

Issues That Have Been Dealt with in the Case Study:

It was necessary to set up a centrally coordinated network of services with common goals and principles to take care of the needs of alcohol- and other drug-dependent persons in the city. Another challenge was finding the best possible way to share and use the network's resources to provide highly effective treatment services in the community.

Project Background:

In 1997 the municipality started a mental health system reform. At that time, the mental health system was organized around four outpatient services, some small teams in the primary health care service, a psychiatric emergency service, and the support of a psychiatric hospital. The public services in the community were not able to respond to the clients' demands. Thus, almost all patients who arrived at the emergency service were sent for inpatient treatment at the psychiatric hospital.

Objectives:

- *To develop a community-based mental health network, including services for alcohol- and drug-dependent persons*
- *To promote social rehabilitation of clients*
- *To avoid social exclusion*
- *To develop actions that can contribute to minimizing harms and risks to clients' health. (E.g., offering informative and preventive materials designed to protect clients' health; offering conditions to keep clients out of dangerous settings)*
- *To reduce stigma and address prejudice*
- *To extend clients' quality of life*

Process/Activities:

To start the transformation, the Medical College and the city government signed an agreement. The medical college became responsible for the emergency service, giving medical support to the community-based services being set up. This resulted in drug users no longer being admitted to the psychiatric hospital.

All knowledge and resources were used to improve community services to meet clients' needs. Community, government, workers, families, and users were involved in that process. The National Health Coordination started to develop a national program reform with the same goals, which gave much support to the local process. At present, there is a partnership between the Public Health System and a Non-Governmental Organization of users, families, and workers that give fundamental support to the project.

Lessons Learned:

- *The active participation of users in all process of network construction is fundamental to develop good practices.*
- *There is no value in a service that cannot be accessed by its users.*
- *The work is developed by people from the community who have their own history, interests, possibilities, and needs. Therefore, the entire range of their*

experiences should be considered, valued, and factored into developing real and effective services for the community.

- *Family involvement in developing a community-based network improves the quality of services. At the same time, these families can become a powerful social resource to help solve the community's problems.*
- *There are many resources in a community that can be set in motion to support services.*
- *Clear and objective information is a key component for community-based services.*
- *Community-based services should have a welcoming environment.*
- *It is extremely important to build up legal support within the network.*
- *To develop community-based services is economically feasible and technically recommendable.*

Outcomes/Achievements:

The municipality has developed 13 public community-based services as follows:

- *Three psychosocial centres operating 24 hours a day, seven days a week, (24/7) (two for clients with mental health problems, and one for clients with problems related to alcohol and drugs, including outreach activities);*
- *One psychosocial centre for children operating 12 hours a day;*
- *One outreach team;*
- *One service to take care of vocational training and employment reinsertion;*
- *Three residential services (These are therapeutic residences in the community. Though not an inpatient service, they provide care for patients who lived a long time at the psychiatric hospital.);*
- *The psychiatric emergency system (in partnership with the Medical School); and*
- *Three outpatient services to take care of clients with less severe symptoms*

*Fundamental principles and basic lines of communications that are outlined in a network **protocol** guide the work of this network. According to this protocol, all services of the network are developed around seven fundamental principles:*

1. *Guaranteed access for clients;*
2. *Interdisciplinary teams;*
3. *Development of individual therapeutic projects;*
4. *Development of the work process in collective institutional forums;*
5. *Social control and citizenship;*
6. *Work with families; and*
7. *A properly functioning and supportive network.*

The number of client admissions per month at other municipality hospitals in the region, on an inpatient basis, is insignificant. Therefore, demand rates for services at the local psychiatric hospital has been reduced. At this point, the National Mental Health Coordination recognizes the Santo André's Public Mental Health Network as a national reference centre in this area.

Challenges:

- *To expand the network;*
- *To promote research and develop a scientific base for the work of community-based services;*
- *To contribute to the development of a national mental health network;*
- *To receive social recognition for this way of working; and*
- *To spread this way of working throughout primary health care services.*

Situational and Cultural Issues Related to This Project:

About the services developed particularly for alcohol and other drugs users in this project: This is a centre that works (24/7), serving citizens in a city of 650,000 inhabitants. There are approximately 60 workers, and the actions are developed in two different settings: internal and outreach work.

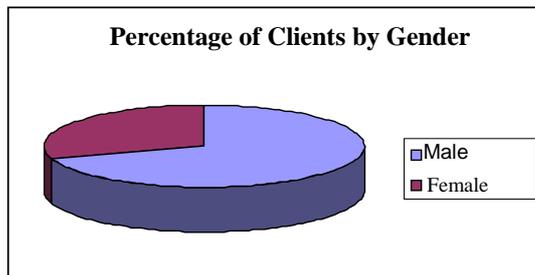
Internal work: *At the centre, the team is prepared to work in interdisciplinary functions from the first instance of contact with a client. After a first interview (previous agenda and/or medical indication(s) are not required), clients are referred to suitable treatment and care for their individual needs. This includes: medication; beds (day and night); individual counselling; therapeutic groups; workshops; information; and harm prevention material.*

Outreach work: *This is done in the streets; in places that house sex trade workers; at nightclubs; places where drugs are traded; and wherever else the need arises. In these places the team offers: printed health information material; condoms; counseling; general simple health care; clean needles and syringe; water; coconut water; and vaccines. At the same time, they refer clients to the centre or other services in the health system.*

All clients who come to the centre have a therapeutic reference from a professional who is responsible for the client's therapeutic project. Therapeutic referees are those who joined with the clients in developing the procedures and activities required in caring for their needs and desires.

The cultural use of alcohol by Brazilians significantly contributes to the early use of alcohol by youth. Many Brazilians start using alcohol in the teenage years. They use alcohol for a whole variety of reasons (e.g., to relax with friends during "happy hour," to enhance sexual performance). There is a widely held belief among youth that alcohol consumption increases virility (duration and size), intelligence, and physical strength. Addressing these cultural beliefs should be factored into the initial stages of program planning in order to examine these attitudes through various means and resources.

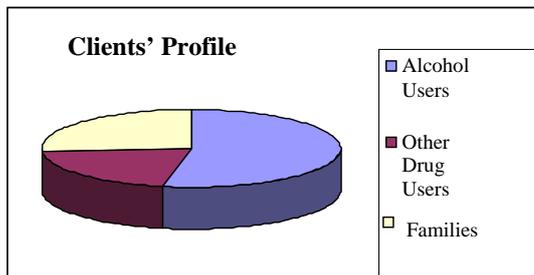
Some Evaluative Data Available Related to the Project:



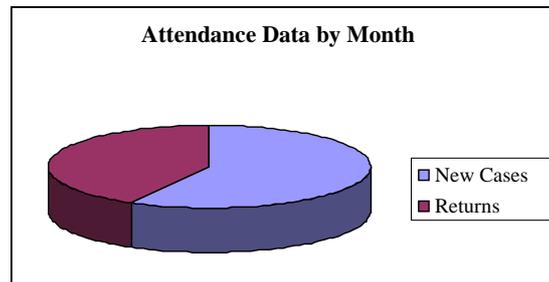
MALE: 70%
FEMALE: 30%



USERS: 40%
FAMILIES: 60%



ALCOHOL USERS: 53%
OTHER DRUGS USERS: 21% (Including Nicotine)
FAMILIES: 26%



NEW CASES: 58%
RETURNS: 42%

Actions developed: 200 procedures/day
Number of patients registered: 16,800 persons
Number of patients actually in attendance: Approximately 1,000 persons
Number of clients who receive treatment only once and never returned: 15%

Key Findings:

- *One of more important actions in the centre is the daily team meeting. It is extremely important for the project's success that the team is in agreement for planning and evaluating the work being developed.*
- *The number of inpatient clients admitted to the Psychiatric Hospital before the community-based network had been set up was 96 per month. Now that the network has been established, the number of clients being admitted there on a monthly basis is six.*

- *Setting up an “open doorway” model of community-based treatment services (CBTS) is not cheaper or easier than setting up a traditional model of care. Looking for “hidden resources in the communities” (as Benedetto Sarraceno, Director of Mental Health and Substances Abuse at the World Health Organization mentioned) has led to developing closer and more permanent approaches based on fewer requirements, flexibility, and diverse methods of care. Nowadays, there is an increase in the quality of work and results. More clients are being engaged, and for longer periods of time. Also, more families are being engaged, including families who could not bring their substance-dependent relative(s) for early intervention(s) initially.*
- *In order to keep clients in the program and to take care of them, a more varied therapeutic intervention was adopted. The open door approach does not guarantee successful client engagement, and vice versa: different approaches for different persons. The most important thing to keep in mind is that, where possible, all known resources must be offered, must be available. This is especially so for the most vulnerable populations among our clientele. It is also important to engage as many people as possible in this task.*
- *Some indications that CBTS are becoming socially accepted in the area:*
 - *The increase in the number of solicitations to share case management from the Primary Care Services (other community-based network) with the Centre;*
 - *The many awards received in recognition of the networks contributions; and*
 - *Recognition of the outreach team’s work.*
- *Also, more and more organizations are becoming part of the CBTS network, including NGOs*

CASE STUDY: TORONTO, CANADA

BACKGROUND INFORMATION

Project Name: *The Substance Abuse Program for African-Canadian and Caribbean Youth (SAPACCY): Passport to Manhood and Bridges to Womanhood Program, A Program for Promoting Values and Responsible Behaviour in Boys and Girls Ages 12–18*

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Project Status: *The project is currently active in one community health centre, two high schools, three Elementary Schools, and one Boys and Girls Club.*

Funding Source: *SAPACCY received startup funding from a donation to the Child Youth and Family Program at the Centre for Addiction and Mental Health, Toronto, Canada.*

Years of Operation: *Ongoing since 2006*

Target Groups: *At-risk African-Canadian and Caribbean youth and their parents in 13 at-risk communities*

Issues That Have Been Dealt with in the Case Study:

Adolescent boys negotiating the passages to young adulthood are more likely to commit violent crime, get into trouble in school, drug use, and join gangs. Even under the best conditions, this time can often be a confusing and perilous one as boys struggle with mixed messages about what it means to be a man. In many of these communities, the journey is made even more difficult as adolescents (boys and girls) struggle with competing forces such as low expectations and popular culture, without adequate supports from personal mentors and/or role models.

The education system does not seem to have resolved the problem of providing favourable outcomes for this vulnerable population. This results in high drop out rates, expulsions from school, and vocational streaming. Coupled with this are the difficulties some single parent, mostly female-led households face in dealing successfully with these issues. Poverty is also a part of this volatile mix. The goal is to reverse the trend that places African-Canadian and Caribbean youth at risk of remaining disproportionately represented in the criminal justice system.

Project Background:

“Passport to Manhood and the Bridges to Womanhood Program” is a gender-separate curriculum for adolescent boys and girls that address several key areas of development, while stressing and promoting positive values and behaviour. The program promotes and identifies a frame of reference that builds resilience for participating youth. At a critical and transitional time in their adolescence, boys and girls are encouraged to adopt the character virtues that will give them a strength-based head start in their journey through adolescence to adulthood.

These at-risk youth often lack the supports of a cohesive, positive, and culturally relevant value system that eases and supports their development into young man- and womanhood. Tragically, their “mentors” are often social values that promote individualism, violence, materialism, acquisition, greed, and, sometimes, violence.

The Substance Abuse Program for African-Canadian and Caribbean Youth recognizes that negative stressors exist within Toronto’s 13 at-risk communities. It is concerned with the high rate of gun violence and substance use within these communities. SAPACCY introduces the “Passport to Manhood and Bridges to Womanhood Program” as a catalyst for social change.

Objectives:

The program aims to promote positive values and behaviour through a frame of reference that builds resilience and character in participating youth. The goal is to provide guidance and supports to at-risk youths through activities that will help them develop confidence and high self-esteem.

The Process/Activities:

Each program consists of 14 sessions and a four-week civic service project that is facilitated in separate groups and according to gender. Participants journey through each session that focuses on a specific aspect of manhood/womanhood through highly interactive activities. All are issued their own “Passports” to stress the idea that they are on a personal journey of maturation and personal growth. At the end of each session, each participant receives a cultural artefact and a stamp to recognize their achievement of another milestone in their passage to maturity.

SAPACCY staff, peer leaders, community college/social work students, volunteers, and parents are welcome to become involved in the implementation of the program. The sessions include:

<i>Program Components</i>	
<i>1. Getting to know You</i>	<i>8. Fatherhood/Motherhood and the Family</i>
<i>2. Values in Personal Decision Making</i>	<i>9. Employment and Careers</i>
<i>3. Code of Ethics</i>	<i>10. Personal Leadership and Community Responsibility</i>
<i>4. Personal Wellness</i>	<i>11. Diversity</i>
<i>5. Substance Abuse</i>	<i>12. Cooperation and Conflict</i>
<i>6. Responses to Authority</i>	<i>13. Self esteem and Image</i>
<i>7. Relationships with Girls/Boys</i>	<i>14. Graduation</i>

Lessons Learned:

A deeper understanding of the extent to which poverty plays a significant role in the lives of participants has been acquired. Also, it was observed how necessary it is to be mindful of communicating the program content clearly when youth discuss what they learn from parents. Flexibility is also key in delivering the program. On frequent occasions, when participants experience conflict outside the program, the result is group discussion.

Outcomes:

Several developmental outcomes are envisioned at each phase of the three-step program. They are:

	Initial	Intermediate	Long Term
1.	<i>Successful leadership experiences</i>	<i>Leadership opportunities in the community, school or club</i>	<i>Demonstrate strong leadership skills</i>
2.	<i>Setting personal goals</i>	<i>Keep setting goals and work to achieve them</i>	<i>Are adept at setting and attaining goals</i>
3.	<i>Can articulate an education and career goal</i>	<i>Make decisions in support of education and careers goals</i>	<i>Have a knowledge base with which to pursue education and career goals</i>
4.	<i>Believe civic responsibility and leadership is important</i>	<i>Are active in civic events</i>	<i>Continue to be involved in community service projects</i>
5.	<i>Are aware of physical development and health</i>	<i>Practice good health habits and physical fitness</i>	<i>Have an ongoing health and fitness routine</i>
6.	<i>Have initiated a group service project</i>	<i>Understand the group process and tasks</i>	<i>Have a positive self-identity resulting from group experiences</i>
7.	<i>Have completed a group "Code of Conduct"</i>	<i>Demonstrate positive behaviour</i>	<i>Demonstrate a positive personal code of conduct</i>

It is hoped that the structure of this program will be preserved through partnerships with identified schools, Boys and Girls Clubs, and other social services providers of community-based services. Funding applications in collaboration with identified partners will be developed. It is expected that the mentor's role will be a paid position. Including the business sector in this project is also one of the aims of this project.

As they graduate from the program, it is hoped that the process of maintaining the civic activities that each participant develops will serve as a promotional tool for the program. Interested older graduates of the program will have an opportunity to assume a mentoring role to new program participants.

Challenges:

The age range of the program's participants is 12 to 18 years. Difficulties have been experienced in keeping younger adolescents interested, because the level of maturity varies greatly between the ages of 12 to 14. Since participants typically lack the needed supports in their home environment, the maturity process is often slower. The program needs to be adapted to more activity-base learning for younger participants in order to keep them engaged. Since gang affiliations play a major role in conforming to the morés of their peers, it is necessary to be mindful of gang interactions when program participants come from different neighbourhoods.

Evaluative Data Available Related to the Project:

The program is just approaching the completion of its first cycle. Post-tests will be conducted at the end of December 2007.

Some Key Findings:

For boys, the prospects are grave and daunting. They are more likely than girls to have discipline and other problems in school. They are more often diagnosed with Attention Deficit Hyperactivity Disorder; outnumber girls in special education classes; belong to gangs; engage in using/abusing alcohol and other drugs; experience early parenthood; commit violent crimes; and end up in jail.

Chapter II: Information, Needs and Resource Analysis (INRA)

This chapter on the Information, Needs and Resource Analysis (INRA), what is commonly known as “need assessment”, is an essential part of community based treatment planning. Treatment planning includes a wide range of services for the entire community, not only for the affected individual. It describes the procedures to establish the types of services that are most needed and appropriate for a particular context⁴. This can be done by learning about the needs of the community, while developing well designed plans to use available resources for the benefit of community members.

Treatment needs for drug dependence can be different within and across countries, because of differences in drug use patterns, vulnerable groups, the way services are set up and managed, and resource availability. Sometimes, there may be clear signs of drug use in a particular community and public funding and may be available to address the problem. In other communities, signs of drug dependence may be more hidden, or information about the problem may only be available from scattered sources.

A comprehensive assessment can tell health care providers a lot about the problem. Using both qualitative and quantitative data collection methods, service providers can assess the nature and dimension of the problem in the community. Assessments can also be used to develop treatment plans at the individual and/or programme level. When health care providers are aware of the importance of data collection, they can gather information needed for future service planning.

The decision to establish a community-based service for drug users often evolves as a combination of client needs and public pressure. Public pressure may be rooted in the perception that a neighbourhood has become unsafe due to social problems associated with substance use.

Once a comprehensive assessment uncovers the problem and related needs as well as resources, dimensions and requirements, the next step is to consequently develop a comprehensive programme to address the identified needs. Problem identification should be followed by action. If the assessment is not followed by an appropriate action, the community may feel hopeless and lose trust. Some basic guidelines for getting the best results in comprehensive assessments are as follows:

⁴ For detailed guidance on how to meet specific needs assessment, please see materials developed by UNDCP, WHO, and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) <http://www.emcdda.europa.eu/html.cfm/index1572EN.html> LINK TO TREATNET WEBSITE

- Ensure that those assessing the community needs are closely involved with the community and/or are from the community.
- Have a well planned comprehensive assessment that reflects the community's sense of urgency, while ensuring that the assessment is careful and accurate.
- Develop and implement a plan to access necessary resources.
- Repeat the assessment and evaluate the programme at given times to see how well it is working in reducing the identified problems. This is a way to monitor the changing community needs (e.g., changes in reported access, acceptability and/or drug use patterns within a particular group.)

Programme goals vary over time, or across programme sites. However, they often begin with a very concrete activity, such as education or outreach to inform drug users in the community about the health risks of sharing needles. Though programme targets may seem clear and straightforward, the ways to reach them are seldom scrutinized in the early planning phase for their appropriateness or feasibility.

Assessing Community Needs and Resources

A Strengths, Weakness, Opportunities and Threats (SWOT) analysis⁵ may be helpful as an initial step to find out what is most needed in terms of drug dependence treatment and related services in a community. Such an analysis includes to involve community members in a brainstorming exercise on the four areas⁶:

A conventional SWOT matrix (Leigh, 2006) already helps to obtain a good overview of the current situation and can be used as a tool for further planning.

⁵ More information on SWOT analysis can be found at http://www.undp.org/psd-toolkit/2c_swot.html, accessed 28.07.2008 or siteresources.worldbank.org/WBI/Resources/213798-1194538727144/8SWOT+CU.pdf, accessed 28.07.2008

⁶ Adapted from SWOT + Causal Utility, available at siteresources.worldbank.org/WBI/Resources/213798-1194538727144/8SWOT+CU.pdf, accessed 28.07.2008

Strengths	Weaknesses
• • • • •	• • • • •
Opportunities	Threats
• • • • •	• • • • •

Strength: An internal competence, valuable resource or attribute that a service can use to support the community
Weakness: An internal lack of competence, resource or attribute than a service requires to perform in the community
Opportunity: A possibility that a service can pursue or exploit to gain benefits for all stakeholders
Threat: An external factor that has the potential to reduce a service's performance

At the community level, the **Information, Needs and Resource Analysis (INRA)** is used to understand the nature and extent of a health or social problem in order to respond adequately. The process usually involves two separate stages: (a) to identify needs, and (b) to decide which ones are the most important and therefore, need to be prioritized. These stages may be useful for both client and community level needs assessments, and findings are used to make decisions about programmes, plans, and/or budgets. Table 1 shows the process of community comprehensive assessments, including goals, areas to be assessed, methods that can be used, and community resources⁷.

⁷ For detailed guidance, see *Evaluation of Psychoactive Substance Use Disorder Treatment, Workbook 3: Needs Assessment*, developed jointly by WHO, UNDCP, and EMCDDA <http://www.emcdda.europa.eu/html.cfm/index1572EN.html>
 See, also, *Drug Abuse Rapid Situation Assessments and Responses*, describing the method developed by UNDCP http://www.unodc.org/pdf/report_1999-03-31_1.pdf
 See also the method of rapid assessment and response developed by WHO <http://www.who.int/docstore/hiv/Core/Contents.html>.

Table 1. Community Level Information, Needs and Resource Analysis (INRA)

Areas to Be Assessed	Purposes of Assessment	• Suggested Methods	• Community Resources
Contextual assessment	To describe those structural, social, cultural, and political factors that may play a role in the overall drug use situation	<ul style="list-style-type: none"> • Population surveys • Surveys of target population • Observation • Key informants • Reviews of the literature • Interviews • Focus groups • Questionnaires • Reviews of treatment service data 	<ul style="list-style-type: none"> • Local hospitals • Treatment programs • Health clinics • Community mental health clinics • Schools • Local Police Department • Criminal justice agencies • Outreach workers • Harm reduction programs • University researchers • Medical examiners and coroners • Recreation facilities • Pharmaceutical associations • Community experts/leaders • Work site • Policy/decision makers • Drug hotlines • Youth organizations/leaders
Drug use assessment	To have a full description of the drug use situation and related problems	<ul style="list-style-type: none"> • Population surveys • Surveys of target population • Interviews • Focus groups • Questionnaires • Reviews of treatment service data • Biological assays • Documentation 	
Resource assessment	To identify what resources are already in the community, such as funds, organizations, and human resources	<ul style="list-style-type: none"> • Interviews • Focus groups • Questionnaires • Records review • Observation • Documentation 	
Intervention and policy assessment	To assess the nature, suitability, and adequacy of existing specific interventions and policies	<ul style="list-style-type: none"> • Reviews of the literature • Interviews • Focus groups • Questionnaires • Documentation 	

Needs Identification and Prioritization

There are various ways and data-collection methods to identify community needs, for example, using surveys and focus groups to collect information directly from community members. Methods such as key informant interviews (e.g. using the Delphi technique⁸) use experts in the field who are expected to know about the needs to be identified. Other approaches use

⁸ The Delphi technique seeks agreement among experts by asking them to reply by fax, email, or written notes over a number of cycles. It is done anonymously (i.e., no one knows who said what). A facilitator compiles summaries of the experts' opinions and reasons for them.

available epidemiological data on different indicators (e.g. mortality, morbidity, etc.) to assess the nature and extent of drug use problems in the community as direct or indirect measures of community needs. Each method has its own strengths and weaknesses. It is recommended to use a combination of methods for the assessment.

For an assessment at the community level it is good to:

- begin with an ideal range of services.
- use this as a model to assess how easy it is to access local or regional services.
- include estimates of the expected demand, and what resources are needed to deliver drug dependence treatment within a continuum of care.

It is often hard to advocate for evidence-based services to address needs as identified, when politics is the driving force in the decision-making process. If the task is to decide which geographic area has the highest need, it may be possible to develop multiple indicators for various areas being considered. If the task is to choose the highest priority among many service options, then a carefully planned and transparent decision-making approach could be used to reach agreement⁹.

Role of the Community in INRA

In order to fully address the community's concerns about drug use problems and drug dependence treatment efforts, it is recommended to involve and train community members and decision makers in the following stages:

- Planning the assessment,
- Developing questions to be explored, and
- Setting the study limits.

Once the community is involved in the process, it is more likely that the appropriate parties will take action according to the findings.

The following paragraph describes the rationale for implementing a comprehensive assessment within specific systems and contexts. It also provides some guidance on how to use these tools in several settings such as the health care and the criminal justice system, work-professional

⁹ For detailed guidance, see *Evaluation of Psychoactive Substance Use Disorder Treatment, Workbook 3: Needs Assessment*, developed jointly by WHO, UNDCP, and EMCDDA <http://www.emcdda.europa.eu/html.cfm/index1572EN.html>
See, also, *Drug Abuse Rapid Situation Assessments and Responses*, describing the method developed by UNDCP http://www.unodc.org/pdf/report_1999-03-31_1.pdf
See also the method of rapid assessment and response developed by WHO <http://www.who.int/docstore/hiv/Core/Contents.html>.

environments, social service agencies and community-based treatment services.

Health care system. Drug dependence is a health care issue that both directly and indirectly affects a number of areas of health care delivery. Within the health care system, the opportunity should be taken to study and monitor admissions to drug treatment. The drugs used and characteristics of users are of concern in developing a better picture of drug use in the community and in establishing an appropriate treatment response.

It needs to be taken into account that drug dependence is often associated with:

- Infectious diseases (e.g., Hepatitis B and C, and HIV/AIDS),
- Malnutrition
- Harmful reactions, such as overdoses
- Non-infectious diseases
- Mental health and alcohol problems.

Data collection and monitoring health care systems can provide significant information about drug users, and the link between drug use and infectious diseases. Also, agencies serving pregnant women and infants may provide useful data about women's health in the community. All measures to ensure confidentiality also have to be granted in a network service.

Assessing the results and problems linked to problematic drug use in a community may provide the following:

- A better understanding of those negatively affected by drug use
- An overview of the types of drugs that may create specific health care problems, and
- A basis for tracking the changing nature of drug use.

This information, especially when collected on an ongoing basis, can then be used to develop and/or adapt treatment efforts within the community.

Criminal justice system. A significant number of drug users are involved in the criminal justice system. They may underreport drug use and its related problems due to many reasons including fear to a breach in confidentiality that may lead to further problems (e.g. problems with drug dealers). This particularly applies to those waiting for sentencing.

When conducting assessments, it is important to guarantee clients that all self-reported information will be kept confidential.

Law enforcement officers may give information regarding a community's drug use, such as buying and selling patterns; which drugs are banned from entering the community; and arrests for drug violations. Information on drug buying and selling activities can also provide insight regarding the following:

- The types of drugs available on the streets,
- The potency and purity of drugs, and
- The kind of drugs that may be reflected in current or future treatment needs.

It is important to keep in mind that the characteristics and numbers of persons arrested may represent normal police activity or may reflect a special concern of the community, such as an effort to “clean up” a particular area and, therefore, may not represent the drug problem in the larger community.

Although gathered under far less strict conditions than other data described in this chapter, data from law enforcement officers can be useful if collected at community events, and if triangulated with data from other sources.

Social service agencies. Data from social service agencies can also provide information for INRAs. Large numbers of homeless people may show symptoms of drug dependence and co-occurring mental health problems. The social service population (e.g. runaway youth, the homeless) is often involved in drug use at different levels (depending also on the socio-political and economical situation of a particular geographic area). Staff and organizations serving such populations are often asked to address drug use problems with their clients. When involving community organizations for INRAs, it is important not to overburden service providers working with marginalized groups with assessment and data collection tasks that need to be carried out additionally.

Community leaders and experts. The connotation “expert” may refer to a wide range of people with a knowledge on drug use in the community, including drug users themselves.

Experts and key informants are those who may directly observe and monitor drug use from very different perspectives. Drug users can be key informants because they know best about the availability of drugs in the community and patterns of use. Experts can include the following:

- Drug users
- Community leaders
- Teachers and school counsellors,
- Youth leaders,
- Police and probation officers,
- Caseworkers in the social service system,
- Religious and/or other spiritual leaders
- Administrators of homeless shelters and housing authority personnel,
- Medical practitioners (e.g., doctors and nurses),
- Pharmacists
- Social workers
- Shop & small business owners

Their views are important because they can describe drug use from their perspective and provide detailed information that was not thought of before. They can become stakeholders in change processes in the community. For example, Pharmacists in some countries have direct regular contact with drug users and they may support them to some extent, when trained on brief intervention techniques or harm reduction education.

Two data collection strategies are commonly used with key informants as follows:

- (1) Individual interviews using open-ended questions about general topics to explore, and that allows key informants to discuss and even introduce other related issues; and
- (2) Focus groups in which community experts meet to discuss a topic, clarify issues or share ideas.

The ability of community experts to explain trends in the pattern and extent of drug use problems, as well as to identify needed community treatment and support services, has to be taken into account for the design and implementation of a comprehensive community assessment.

Data collection, in the general population, e.g. the workforce, could provide a broader picture of drug use in a given community. Nevertheless it is very cost intensive and strict ethical guidelines need to be followed for data collection in the general population¹⁰.

Assessing Community Resources

Community programmes that can support treatment, rehabilitation and reintegration of drug users need to be identified and included as a resource for the delivery of community-based treatment. For example, in low-resource settings, volunteers may be identified in the community, that are ready to support service delivery, even though their training needs have to be taken into account. Furthermore for example, office space or other rooms may be available within local institutions such as churches or community halls. Ways to identify available and accessible resources include questionnaires, records checking, observation, and informal discussions with conversations with community members.

Interviewees should be chosen from the community and be knowledgeable about a range of community issues, rather than persons concerned only with

¹⁰ For more information please see the UNODC publication: *Global Assessment Programme. Module 7. Ethical Challenges in Drug Epidemiology: Issues, Principles and Guidelines* available online at <http://www.unodc.org/unodc/en/GAP/index.html>

drug use related issues. Attitudes and the openness of community service providers who may be chosen to give treatment services can be assessed through in depth interviews, questionnaires, or focus groups.

The use of focus groups has several advantages:

- (1) It can set up a systematic process of sharing concerns and exploring possible solutions.
- (2) It can encourage the discussion of new plans in a public setting and might support ownership and commitment leading to a better follow-up and implementation of a particular approach of service delivery, such as community based treatment.

Assessments of community treatment needs and resources work best when community groups understand the importance of their involvement in bringing about change. Ideally, these groups should have the will and power to encourage the wider community to cooperate in the assessment process, and to provide leadership through the process of systems change and expansion.

An ideal outcome is for community groups and interested parties to come together to assess uncovered needs and treatment resources. Also, the community should be informed about the findings of the assessment. Finally, community leaders should make clear who is responsible for the implementation of recommendations, and assure the community that everyone will be held to the highest standards of accountability.

CASE STUDY: AFGHANISTAN

BACKGROUND INFORMATION

Project Name: UNODC's Drug Demand Reduction Support Project (AFG/G26): Community Drug Profiles Series, Community Drug Profile #5, An Assessment of Problem Drug Use in Kabul City (2003)

City/Country: Kabul, Afghanistan

Contact Details: Mr. Jehanzeb Khan, International Project Coordinator
Email: jehanzeb.khan@unodc.org

Website: <http://www.unodc.org/afg/index.html>

Project Status: Operationally complete

Funding Source: UNODC with donor support from Canada, Ireland, Italy and the United States of America.

Years of Operation: 2002–2003

Target group: Drug users in Kabul, Afghanistan

Issue That Has Been Dealt with in the Case Study:

Assessments of specific drug problems and at-risk groups within Afghan communities

Project Background:

The Community Drug Profiles (CDP) Series provided assessments of specific drug problems and at-risk groups within Afghan communities. The CDP provided part of the necessary information and data to plan and develop rational and realistic intervention strategies for drug prevention activities, and service delivery for the treatment and rehabilitation of drug users.

Community Drug Profiles for Afghanistan so far were produced for:

- *Problem Drug Use in Afghan Communities: An Initial Assessment (1999)*
- *Opium and Other Problem Drug Use in a Group of Afghan Refugee Women (1999)*
- *A Comparative Study of Afghan Street Heroin Addicts in Quetta and Peshawar (2000)*
- *Problem Drug Use in Rural Afghanistan: the Greater Azro Initiative (GAI) project (2001)*
- *An Assessment of Problem Drug Use in Kabul city (July 2003)*

Objective:

To assess the extent, nature, and pattern of problem drug use in Kabul in order to plan activities in the areas of drug dependence prevention, treatment, rehabilitation, aftercare, and social reintegration

The Process/Activities:

As far as possible, the profiles are based on a Rapid-Assessment (RSA) methodology¹¹ that uses a combination of several qualitative and quantitative data collection techniques. This method draws on a variety of sources that can lead to an understanding of the nature and extent of drug dependence. It also uncovers the structures and services that do or do not exist in order to address drug-related problems.

The profiles were based on an action research framework, where indicators suggest a problem exists, but not enough reliable data was available on which to base realistic or evidence-based interventions.

Both primary and secondary data were collected for the assessment. UNODC visited police stations and hospitals in different locations of Kabul and collected any statistics they kept on drug use. They interviewed doctors and police about their perceptions of the nature of the drug problem in their area of Kabul. More formally, 12 fieldworkers were hired and provided with a five-day training program on research methodology. They then conducted comprehensive interviews with 100 key informants and 200 drug users in Kabul city. Since the interviewers came from a community-based drug dependence treatment and rehabilitation centre in Kabul, they had a professional understanding of drug use and working with drug users. (See Appendix A for the interview checklist ("UNODC Country Office for Afghanistan – Community Drug Profile # 5") that was used for this project.)

For assessment purposes, Kabul was divided into 10 districts (in reality it has 16) and, in each district, 20 drug users and 20 key informants were targeted for interviewing.

The interviewers were provided with a list of preferred types of key informants (e.g., doctors and healthcare staff, police, teachers, pharmacists, and shopkeepers) who lived in their target area for at least one year. Random sampling was then used to select key informants from these occupational groups.

Trying to find drug users willing to be interviewed was more difficult. The previous contact of the interviewers through their work in a treatment centre made access easier. Once a contact had been made, snowball sampling (in which one drug user/abuser introduced the interviewer to another) was used to contact other drug dependents in the area. Sampling is ideal when those interviewed do not all use the same type of drugs.

¹¹ See, *Drug use Rapid Situation Assessments and Responses*, describing the method developed by UNDCP (1999) and the method of rapid assessment and response developed by WHO.

Lessons Learned:

Expectations of drug users regarding “help” are understandably always raised during such assessments. Developing interventions that logically follow from in-depth assessments of problem drug use should ideally be normative, and built into such an action research framework.

Achievements/Outcome:

- *The estimated figures clearly presented that Kabul has a serious drug problem. Tens of thousands of persons with drug dependence require assistance with social, financial and health-related problems, which results from their drug use and affects them, their families and their communities. UNODC Afghanistan's website at http://www.unodc.org/afg/drug_use.html gives the complete report, *An assessment of problem drug use in Kabul city (July 2003)*. It was distributed with a Dari translation of the “Key Findings and Issues” to government ministries, diplomatic missions, UN agencies and international and national NGOs.*
- *The outcome of the assessment determined demand reduction activities in Afghanistan, such as an outreach referral system and home-based detoxification and treatment service through Drug Dependency Treatment Centre, Kabul Mental Health Hospital.*

Challenges:

- *Collecting reliable data about illicit drug use in a city like Kabul is problematic, because of the stigmatisation and fear of being arrested. These attitudes resulted in drug use becoming increasingly hidden and secretive. Drug users and community members feel ashamed and are reluctant to reveal information. They prefer to keep secret the existence of such social problems in their communities.*
- *Community representatives experienced NGOs and international organizations as making assessments but not delivering on promises for development assistance.*
- *Pharmacists were suspicious of interviewers because they were afraid of being reported to the Ministry of Public Health for selling pharmaceutical drugs without a medical prescription.*
- *Female interviewers asking questions about drug use were sometimes subjected to harassment, although this was rather infrequent.*
- *Interviewing only 200 drug users in a city like Kabul is not statistically representative, and it should be noted that the drug users interviewed are not necessarily representative of all drug users in Kabul.*
- *It was often difficult to find a dry, warm and safe place to conduct interviews.*

Cultural or Situational Issues Related to This Project:

Decades of war since 1979 has left the Afghan population (inside and outside the country) extremely vulnerable to a wide range of mental health problems, including anxiety, depression, insomnia and Post Traumatic Stress Disorder. People have to cope with the loss of family members, home, work, security, country, and well-being.

This puts them at risk of turning to drugs to cope with the physical and psychological pain of such loss.

*There has been a long history of drug use in Afghanistan, particularly that of opium and cannabis. Poppy-seed-based products are traditionally used for cooking, and opium as medication. Over the past decade Afghanistan has become the world's leading producer of opium, accounting for an estimated three quarters of the world's **illicit** opium production. An increasing amount finds its way into the local market, where there is demand for its analgesic properties.*

Evaluative Data Available Related to the Project:

The final project progress report identified some major problems and steps taken to solve them. Some of the listed problems were:

- *Tight schedules prevented the full implementation of all aspects of the project.*
- *There were initial problems in establishing good contacts with the Ministry of Public Health.*
- *Lack of knowledge and understanding of key issues and problems relating to demand reduction needed a more systematic and comprehensive training approach than was at first anticipated.*

Some Key Findings:

In less than four months the project made significant headway in supporting and advising the government of Afghanistan to establish a sustainable coordination mechanism for demand reduction initiatives in the country.

CASE STUDY: SWEDEN

BACKGROUND INFORMATION

Project Name *Maria Ungdom participated in UNODC project GLO/H43, Treatnet – International Network of Drug Dependence Treatment and Rehabilitation Resource Centres*

City/Country: *Stockholm, Sweden*

Contact Details: *Paula Liljeberg M.D. clinical director at Maria Ungdom
Email: paula.liljeberg@sll.se*

Website:

http://www.unodc.org/treatment/en/Sweden_resource_centre_17.html

<http://www.mariaungdom.nu/>

Project Status: *ongoing*

Funding Source: *public funding*

Years of Operation: *since ?*

Target group: *Teenagers with drug abuse in the capitol, Stockholm area.*

Issue That Has Been Dealt with in the Case Study: *Implementation of community based treatment units spread locally in the capital area*

*The capitol, Stockholm with suburbs has 2 million inhabitants
160 000 boys and 160 000 girls between 12 and 19 years are living in the area, 2
200 teenagers and their families make 15 000 visits to Maria Ungdom every year. In
Sweden the social services has the responsibility for treatment of drug and alcohol
abuse. The health care system is complement and treats health issues and
psychiatric problems that occur together with abuse and dependence. Maria
Ungdom, Beroendecentrum, covers the metropolitan area in Stockholm for youth
that experiment with drugs, that take risks when intoxicated, that abuse drugs and
alcohol, or have become dependent Maria Ungdom has a holistic view and deals with
psychiatric and lifestyle problems that the patient might have.*

Background:

*Previously all treatment for drug was inpatient at hospitals and residential treatment
of different kinds. The majority of persons with substance misuse problems were not
engaged in treatment. And a substantial proportion of those in residential treatment
relapse or discontinue their treatment after returning to their home environment.*

Community based treatment is an approach more in line with the realities of the problems of substance abuse and refers specifically to an integrated model of treatment in the community. It includes services such as detoxification, pharmacological and therapeutic treatment. The treatment should be longterm and involve a number of services that are needed to meet client's needs. Outcomes should be evaluated.

How did Maria Ungdom start

A questionnaire was given to school students (15 - 17years) to understand the problem in the different local communities.

The surveys are made continuously to measure and describe what drugs are used and to what extent in every part of the capitol area and evaluate if preventive intervention and treatment will improve the situation.

Depending on the local communities' resources and the pattern of the drugs and related problems it was decided what type of interventions to start, who to involve and what treatment programmes to use in that specific community.

Lessons Learned:

The best result when it comes to adolescents was achieved by networking.

Teenagers are relying on their families and siblings so it is important to get them all involved in the treatment planning.

Other important partners in local networks could be police, juvenile prosecutors, parole officers, schools and teachers, sport clubs, NGOs, Units for maternal care, housing agencies, vocational training agencies or other services needed the problems the family presents.

Community based treatment

Efficient and effective evidence based treatment options are critical for the treatment success of clients/patients/users living well adjusted lives.

A key focus of community- based treatment is to reach out to people that are affected by the negative health and social consequences of substance abuse by offering services well known and accessible in the community. Community-based interventions must engage a broad range of community stakeholders to secure their sustainability, offer accountability to society, and attain short and long-term results. Public and professional awareness and political commitment are vital to improve access and quality of treatment services available to people with drug dependence problems.

It is apparent that no single approach can be adequate for all possible forms of community based treatment and can not simply be transferred to other sites or patients groups without adaptations that address cultural and other local circumstances.

An open door; friendly, engaged, competent staff make the patient curious and hopeful

Listen to the presentation of the problem from the patients point of view (and start from there)

Prove to the patient that our methodology works

Retention is crucial, attachment and stay with the patient throughout problems and crisis, work with relapses

Characteristics of a community based approach to substance abuse among teenagers at Maria Ungdom:

- *Active involvement of youth and family in treatment planning and development of services*
- *Open access services open 24 hours*
- *Low threshold (limited exclusion criteria)*
- *Promoting change*
- *Emphasis on continuing engagement*
- *The central role of networking, multidisciplinary work and care coordination*
- *The use of reliable and valid screening instruments for assessments*
- *Evidence based interventions and treatment*
- *Using additional pharmacological treatment*
- *Evaluation of treatment outcome and patient satisfaction*

Maria Ungdom community based treatment units and clinic

27 local community based treatment centres with social workers and nurse and doctor working closely together treating drug abusing teenagers. Maria Ungdom has a hospital with an emergency room and 6 beds as a back up for inpatient assessment. There are programmes for treatment of cannabis use, raped girls and boys, traumatized and suicidal children. The community based units are too small to cover severe psychiatric problems of the drug using teenagers.

Maria Ungdom offers all teenagers sexual advice and tests for pregnancy, sexually transmitted diseases (STD), hepatitis and HIV

A networking project with the local police for early detection of drug use among teenagers and immediate intervention

A cooperation project with the police for early detection and intervention was originally founded by the Swedish government, Department on Health and Welfare. The project was successful. The police was taught motivational interviewing skills to motivate the teenager to attend a meeting with a nurse and their parents on the spot.

Challenges:

Professional, and public attitudes towards multidisciplinary working and networking.

Limited possibilities of matching treatment services to different problems.

A common definition of best practice in diverse areas of treatment of teenagers is yet to be established.

Varying characteristics and features of communities

Characteristics of a community based approach to substance abuse among teenagers at Maria Ungdom:

- *Active involvement of youth and family in treatment planning and development of services*
- *Open access services open 24 hours*
- *Low threshold (limited exclusion criteria)*
- *Promoting change*
- *Emphasis on continuing engagement*
- *The central role of networking, multidisciplinary work and care coordination*
- *The use of reliable and valid screening instruments for assessments*
- *Evidence based interventions and treatment*
- *Using additional pharmacological treatment*
- *Evaluation of treatment outcome and patient satisfaction*

Chapter III: Promoting Change Through Programme Development and Evaluation

The purpose of this chapter is to help those involved in designing and developing drug dependence treatment programmes. Some smaller communities may wish to plan and set up a community treatment network involving a variety of services. At the very least, communities may wish to coordinate services they are already implementing with new ones. Community treatment services and networks can be set up effectively and run by either government- or non-governmental organisations (NGOs). Once a community decides to set up treatment services, collaborative and effective planning is essential for long-term success and sustainability.

Planning on the Basis of Identified Needs

As mentioned in chapter II, already in the planning phase, whether for a single programme or a network, a number of community groups should have a voice to grant support and develop a shared vision for substance dependence programmes. Those directly involved (such as specific government agencies and NGOs, community institutions and agencies, community leaders, clients/users and concerned citizens) need to devote time to ensure a transparent and collaborative planning process so that decision making and implementation can proceed smoothly once plans are agreed upon¹².

There are many sources of information concerning strategic planning techniques. These generally involve attention to the following (adapted from McNamara, 1999):

¹² For more information please see 1) Joseph Rowntree Foundation available at http://www.jrf.org.uk/knowledge/findings/socialpolicy/2013.asp_2 UNODC discussion paper: Principles of drug dependence treatment , Principle 7: Community involvement, participation and patient involvement available at <http://www.unodc.org/treatnet>

Objectives	Outcomes
Doing strategic analysis	Assessing needs
	Setting priorities
	Determining needed resources
Setting strategic directions	Setting objectives
	Developing strategies
	Formulating a strategic philosophy
	Developing a mission statement
	Developing a vision statement
	Formulating a statement of values
Action plan	Determining activities
	Assigning responsibilities
	Planning time lines
	Organizing
	Communicating
	Monitoring and evaluating
Budget	Allotting available funds

Planning dimensions. Strategic planning for the development of a treatment programme or network requires that attention be given to the following planning dimensions:

- **Organization and management.** Clarity of organizational vision, mission, values, and objectives, as well as consideration of structure, administration, personnel policies, and financial management
- **Employment and personnel practices.** Employment philosophy, orientation of staff, job descriptions, qualifications of staff, staff development and training, supervision of staff, performance appraisal, and employee problem resolution procedures (See Ogborne and Gavin, 1990.)
- **Programme components.** Nature and quality of programme philosophy, objectives, methods/types of interventions, admission criteria, assessment instruments and procedures, client monitoring, follow-up, and continuity of care
- **Coordination.** Collective and sustained good will to develop a state of harmonious functioning and interaction in goal-related activity among constituent elements
- **Community involvement.** Ensuring that stakeholders and community leaders have ample opportunity to have input and react to planning at every step
- **Training and education.** Building into the planning process a systematic, ongoing plan for upgrading the knowledge, attitudes and skills of programme staff (as described in "Employment and personnel practices" in bullet two above), and providing the required information for key personnel in government, professional communities, and the public
- **Staff supervision.** Maintaining high standards of care through ongoing attention to staff performance and appropriate staff supervision
- **Funding.** Clarity about the human and budgetary resources required and the sources of revenue in the short and long terms
- **Utilization of available resources (other than funding).** Community/institutional settings, such as sport fields/facilities, parks, theatres, libraries, meeting rooms, etc.
- **Monitoring and evaluating.** Setting up clear strategies for monitoring and evaluating planning processes and program operations from the outset. (See Chapter IV.)

Strategic Objective Areas: Examples

Developing objectives is part of the strategic planning and analysis. Strategic objectives should be fitted to the specific community, treatment network, or programme. Implementation objectives state intent. Outputs are countable indicators of service delivery. Short-term outcome objectives usually start with "to increase," "to decrease," "to maximize," or "to minimize." Outcome indicators give examples of achievements showing that outcome objectives have been met. Long-term objectives are equal to the programme's main goals (Graham, et al, 1994). Establishing objectives and outcomes also provides a solid basis for evaluation, and can be set in relation to the major parts of the programme. *Objectives should be precise, attainable, measurable, and time bound.*

Sample objective areas, such as those presented next, can be set out as implementation objectives, outputs, short-term objectives, outcome indicators, and long-term-goals:

Implementation objectives (Examples):

- Initiate processes for early identification and treatment of drug users.
- Identify substance use problems among offenders.
- Provide a full program of aftercare to prevent relapse and to ease a successful re-entry into social activities (e.g., school, family life, community, the workplace) in order to gain and sustain an improved state of physical, mental, and social well-being
- Start treatment programme/rehabilitation services for offenders in jail or on parole.
- Create a drug-free environment within prisons
- Provide other methods to withdrawal management with hospital support.
- Stop physical, emotional, spiritual, or social deterioration and restore individuals to an optimal state of health.
- Introduce a sterile needle and syringe exchange program.

Sample outputs:

- Increasing the number of clients coming into the network/agency for treatment
- Having in place a new detoxification unit in the community by a given date
- Increasing the number of residential facilities for the treatment and rehabilitation of substance abuse clients
- Opening a residential facility for the treatment and rehabilitation of adolescent substance abuse clients
- Opening a certain number of halfway houses and/or other similar facilities to help clients get back into the flow of society by a certain date
- Putting in place new employee assistance programs (EAPs) to provide assistance to substance abuse clients in the workplace
- Having drug use prevention programs, policies, and counselling services in a given number of schools
- Putting in place complete courses on drug-related information so that key personnel in the public and private sectors can upgrade their knowledge
- Having trained helping professionals who can focus on counselling persons with drug related problems
- Setting up a fully functioning, citywide database regarding the nature and prevalence of drug use in the community/country

Long-term outcomes (mission or goal):

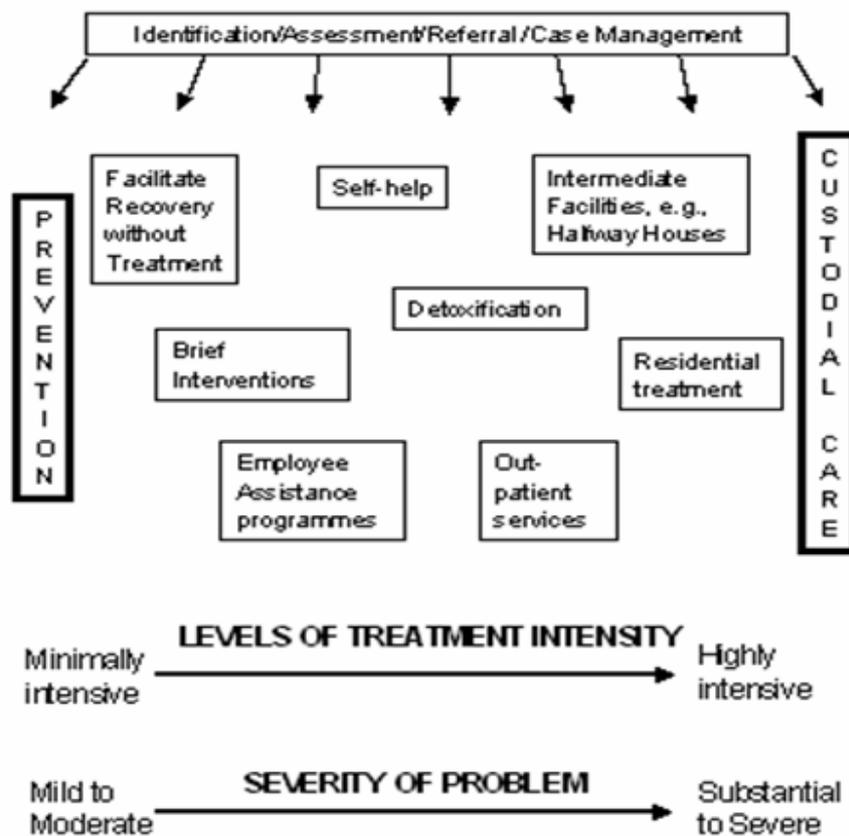
- Reducing the incidence of drug use and HIV/AIDS in correctional facilities
- Reducing the incidence and prevalence of cocaine abuse in a given community

Multifunctional treatment programmes. The American Society of Addiction Medicine (ASAM) stresses that levels of care represent treatment ranging from mild, to moderate, to serious. Each level may be provided by different types of programmes, including those that offer more than one level of care (Mee-Lee, 2001). Specialized treatments are suitable for persons with substantial to severe problems. Brief interventions may be most effective for persons with mild to moderate problems. A community network

(see Chapter 1) can arrange its services to provide the basic components as shown in Figure 2 (Hall, 1997).

Figure 2

A Community Continuum of Care for Addiction Problems



Source: Walker, D. 1997. A community continuum of services for addiction problems. Overview of addiction interventions and counselling course, Addiction Research Foundation Education and Training Services, ARF, Toronto.

As drug dependence is a multifactorial disease, multifunctional programmes are needed that may provide two or more types of care in one centre and/or may collaborate with other agencies in the community network. Treatment would range from problem identification, detoxification, assessment and treatment planning to treatment and rehabilitation (e.g., intermediate, halfway houses and aftercare). Multifunctional programmes are valued for three main reasons: a) they manage programmes well; b) they give ongoing care; and c) they provide suitable treatment options.

Planning on the Basis of a Biopsychosocial Model

Drug dependence treatment involves a wide range of interventions to work with drug-dependent individuals and their families. The biopsychosocial model is a public health approach that sees drug dependence as interrelated with individually different physical and psychological factors, as well as social and/or spiritual issues. As such, it requires the combined efforts of many vocations, professions, disciplines, and interested parties to address the clients needs properly (Meeks and Herie, 1998).

In a multidisciplinary approach a range of medical, social, and behavioural approaches as well as self-help and religious belief based-supports, are all important parts of the treatment process. As different professional disciplines have different skills to offer; a team approach has advantages for the service user. The biopsychosocial model thus proposes that the best way to proceed on drug use or drug dependence treatment is to involve a variety of professionals.

The following principles on the subject are adapted from the National Institute on Drug Abuse (NIDA) in Martin (2000):

- No single treatment is right for all individuals. Treatment services and interventions should be matched to the problems and needs of each client.
- Treatment needs to be easily available. Immediate access to treatment programmes when the client decides to seek help may be key in connecting with the client.
- Comprehensive treatment serves many needs, not just the individual's drug use. To succeed, treatment should focus on the individual's drug use and any related medical, mental health, social, work related, and legal problems.
- A client's treatment and services plan should be checked and changed to make sure that it meets the person's changing needs. While one client treatment programme might need a mix of counselling, psychotherapeutic, medical, social, legal and other services, another might not. The treatment approach should suit the individual's age, gender, ethnicity, and culture.
- The client should be in treatment long enough for it to work. The right length of treatment should be suited to the client, though many clients will leave treatment too soon.
- Individual and/or group counselling and other behavioural therapies are important parts of effective treatment for drug dependence. In therapy, clients look at:
 - Determining the issues that lead them to drug use,
 - Building skills to resist it,
 - Replacing drug-using/abusing with useful and satisfying non-drug-using/abusing actions, and

- Improving problem-solving abilities.
- Substitution treatment/pharmacotherapy, combined with counselling and other behavioural therapies, is an important part of treatment for many clients. Methadone, buprenorphine and buprenorphine/naloxone are proven to be effective in helping to stabilize and reduce consumption in persons dependent on heroin or other opiates¹³. Naltrexone is also effective for combined opiate use and alcohol dependence.
- Co-occurring disorders are frequent. Persons with mental health problems who are using/abusing drugs should be assessed and treated for both problems.
- Medical detoxification may be the first stage of drug dependence treatment and, by itself, does little to change long-term drug use. It safely manages the severe physical symptoms of withdrawal linked to stopping drug use
- Clients in voluntary treatment show a real desire for change and can make the treatment process easier. However, supportive family, job setting, or the criminal justice system can be important partners in engaging clients into treatment and help them stay in treatment interventions programmes for the period required.
- Screening for drug use during treatment reinforces the process, since relapse into drug use during treatment is frequent. Monitoring a client's drug and alcohol use during treatment by someone other than the client can help her or him resist urges to go back to using drugs. In this way, early signs of use can be detected and the client's treatment plan adjusted. Feedback to clients who test positive through urinalysis for illegal drug use can be an important part of monitoring. Screening is not recommended as a control measure, but as a way to engage in discussion with the client.
- Treatment programmes should include voluntarily testing for HIV, Hepatitis B and C, tuberculosis and other infectious diseases. Programmes should include counselling to:
 - Help clients change behaviours that may expose them or others to infection, and
 - Assist those already infected to manage their illness.
- Recovery from drug dependence can be a long-term process and often needs many episodes of treatment. As with other chronic illnesses, drug relapses can happen during or after successful treatment. Long-term and multiple episodes of treatment may be needed to achieve long-term abstinence and a return to a healthy life. Participation in self-help support programmes during and after treatment often is helpful in staying drug-free.

¹³ WHO and UNODC have developed guidelines for psychosocially assisted pharmacological treatment of drug dependence. These guidelines will be made available on the Treatnet website www.unodc.org/treatnet

NIDA's research into treatments for cocaine dependence, based on this model, has identified a variety of workable treatments ranging from individual to group drug counselling. Combining treatment approaches can be very effective. A NIDA-funded clinical trial looking into the usefulness of four types of treatment found that cocaine-dependent patients receiving both individual and group drug counselling were more likely to reduce their drug use than those who received group drug counselling alone or in combination with psychotherapies that are used to treat drug dependences (Zickler, 1999).

Developing a treatment programme or a network of programmes involves bringing together persons and/or groups from differing backgrounds and helping philosophies, values, and skill sets. Their combined efforts can lead to effective interventions. There is a potential richness and challenge in these differences that, if skilfully managed, can make them an asset. From the outset, it is important to acknowledge differences and to deal with them as an ongoing agenda item. The key challenge, then, is not to think alike but to act together.

Community-Based Treatment Services (CBTS) should prioritize their interventions because regularly community providers have limited resources. In cases where a community does not have enough funds, a network of staff and volunteers coordinated in community programmes becomes even more important. Planners will still need to decide which service(s) are most needed in the community and focus on providing those to their clients.

Accounting for Client Diversity and Their Needs

Programme developers should take into account the diversity of potential clients in their area. Accepting client diversity supports the principle that no single treatment is equally effective for all. Diversity refers to the difference in clientele. Clients will differ by the following characteristics:

- Gender
- Age
- Ethnicity
- Social class, income levels
- Existence or levels of concurrent disorders: mental, emotional or physical
- Drug choice and the severity of the substance use and related problems
- Religion, education, family, and other social supports
- The nature of medical and, psychosocial problems
- Motivation to seek or use help in a sustained manner
- Sexual orientation

Implementing the biopsychosocial model for diversity planning leads to a multidisciplinary approach, matching clients to treatments results in

providing different treatment choices that recognize and value client differences. This approach affects staff composition, the availability of services, education, and the type of treatments offered. Further, all staff might benefit from training in inter-cultural communication.

Reducing the adverse health and social consequences of drug abuse

Harm reduction is a practical approach that employs a range of different strategies with the goal of preventing and minimising the risk of the client contracting infectious diseases, overdosing, or suffering other consequences related to the use of substances. Strategies may include changing the way people consume drugs or ensuring that the environment in which they use minimises the risks of negative consequences to their health (infections, overdose) or quality of life (legal problems, social and familial issues, etc.). Strategies can vary depending on the drug, the type of harm related to its consumption, and the individual who consumes the drugs (Addy & Ritter, 2000, 2004)¹⁴.

The community plays an important role in finding and engaging clients into treatment to prevent and reduce drug related harms both for the drug user and others, for example among family members, sex partners, friends, employers, etc. They play a key role in preventing the clients' drug related harms and also to avoid negative consequences of high risk behaviours (e.g. unprotected sex) on themselves.

Maximizing Impact and Effectiveness in Service Delivery

Training and education. Staff training and education (using, for instance, the training package developed by Treatnet¹⁵) are invaluable means of maximizing staff capabilities. A competency model may be the most appropriate for community-based treatment programmes as solution focussed skills building is a major need of providers.

Planning, development, and implementation of a drug dependence programme/network need a systematic process of training and education. Training of psychosocial and medical practitioners may focus on such areas as the following:

- Training in various treatment modalities
- Assessment for treatment matching
- Behavioural self-control training

¹⁴ Please see UNODC Treatnet training materials on the reduction of negative health and social consequences of drug abuse: <http://www.unodc.org/ddt-training/treatment/d.html>, Volume C, Topic 4

¹⁵ Please see the Treatnet Training Package for further reference: <http://www.unodc.org/ddt-training/treatment/>

- Stress management
- Cross-cultural counselling
- Social skills training, including work skills
- Motivational counselling
- Concurrent disorders
- Psychopathology
- Stages of change
- Structured relapse prevention
- Program evaluation and qualitative research methodologies
- Rehabilitation and reintegration into society
- Prevention (community, school, family)

The need for evidence. In order to maximize impact and efficiency, programme planners also need to build up their own evidence base for planning and decision making. Such evidence can only be secured through research that falls into two categories: a) research to build a database on the type, frequency, and amount of drug use problems, and b) evidence to determine the effectiveness of programmes and/or programme approaches. Judging programme usefulness is not the same as measuring the effectiveness of particular treatments. The latter requires expertise beyond what is usually found in clinical services. Different experts on drug dependence treatment recommend to team up with research specialists (See, e.g., Hester and Miller, 2003; Tims and Ludford, 1983, Graham, et al., 1994.)

Evaluation as a means to improve services. Data collection and evaluation are important steps to know how well a programme is working, in which areas a services is achieving good results and where results might be improved still. Evaluation results should be shared and used in the organization for effective programming, expansion of successful procedures and changes with regard to unsuccessful interventions can be implemented in a timely manner.

Initial resistance towards change often occurs and is normal. Several measures can help to implement successful changes. First, all staff within the network/organization (not just those connected with the treatment service) need to be able to connect the information from the evaluations to the original service goals. Reflection on the data help staff understand the reasons why change may be needed.

Counting on staff to interpret evaluation results is important also because it helps them to develop positive attitudes towards evaluation and future organizational and programme changes made subsequently. Also, involving staff in the process of suggesting changes and the development of schemes to improve and/or expand the programme based on evaluations makes change more likely. Sometimes, evaluations may suggest that staff need

more training on a particular area. In such cases, it is wise to make the effort to fulfil that need, since skills and knowledge are the core of effective service delivery. Properly trained staff can carry out new procedures effectively. From a management perspective, it is necessary to systematically reinforce attempts towards positive change that support the goals and mission of the organization.

When new procedures and/or services go beyond what one organization can achieve, working together with other services, authorities, universities and NGOs helps to meet community needs.

Collaboration with outside groups might draw resources away from clinical treatment services, because of the increased need for planning meetings and fine-tuning procedures. It is best to work with a few groups at a time. Repeated evaluations will ensure that each collaboration is adding benefits to the treatment service. Furthermore an evaluation goal could be to decide whether specific programmes are more effective than others. Normally, this is not possible to tell from regular evaluations. In these cases, a more elaborate evaluation strategy needs to be developed and implemented.

Evaluation methods should be determined as a part of programme planning and not “tacked on” at the end. Graham et al. (1994) offer a Logic Model as a basic format to understand the reason behind a programme (see Appendix B, Figure 3, for an example of a Logic Model for a hypothetical detoxification centre.) Logic models are also helpful to examine how and why certain steps are carried out in a programme and to identify areas that need improvement. For example, if a logic model is to be used, the aims of the project should be stated in terms of the following:

- Main components
- Implementation objectives
- Outputs
- Outcomes
- Mission or goal

The importance of data collection, monitoring and evaluation of treatment programmes cannot be stressed enough. Although some changes to this format are possible, policy makers, programme planners, funding sources, and clients need to know how well treatment programmes are working.

A synthesis of evaluation methods can be found in the UNODC Treatnet training materials¹⁶.

In addition to this, the World Health Organization, UNODC and the EMCDDA developed in 2000 the “Evaluation of Psychoactive Substance Use Disorders Treatment; Workbook Series” a

¹⁶ http://www.unodc.org/ddt-training/treatment/VOLUME%20D/Topic%203/1.VoID_Prog_Eval.pdf

comprehensive series of workbooks that provide detail information on evaluation methods¹⁷.

¹⁷ Workbooks can be found at the following website:
http://www.unodc.org/treatment/en/UNODC_documents.html (accessed 25.07.2008)
http://www.who.int/substance_abuse/publications/psychoactives/en/index.html (accessed 25.07.2008)

CASE STUDY: MYANMAR

BACKGROUND INFORMATION

Project Name: TDMYAE76EMM: Community-Based Drug Demand Reduction in Three Key Townships in the Northern Shan State

City/Country: Northern Shan State, 30 villages in Lashio, Kutkai and Muse township area, Myanmar

Contact Details Including Contact Person:

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Website: <http://www.unodc.org/myanmar/index.html>

Project Status: Ongoing since 2000

Funding Source: Australia (AusAID) and United States of America

Years of operation: September 2000 to December 2007

Target Group: Villagers in three township areas in Northern Myanmar, Lashio, Kutkai, and Muse

Issue That Has Been Dealt with in the Case Study:

Setting up community-based, drug dependence treatment centres in Northern Shan State, Myanmar

Project Background:

Traditionally, opium smoking has been the main form of drug consumption in Myanmar. It has been used also for its medicinal properties as a painkiller, and to alleviate the symptoms associated with diarrhoea or cough, especially in remote areas or conflict zones where the population has little access to health care services. Alarming trends have emerged in recent years: an increasing move from opium smoking to heroin injecting, and an escalating consumption of Amphetamine-Type Stimulants (ATS). Data shows that 90.2% of registered users are addicted to opiates, with 40% registered for opium abuse and 45% for heroin abuse. Opium addiction rates are higher in the villages where poppy cultivation takes place, while more urban populations, such as seasonal gem minders, use heroin. The trend from opium smoking to injecting heroin poses the added threat of increasing HIV infections among users.

The HIV situation in Myanmar is one of the worst in Asia. In 2007, UNAIDS estimated that there are between 200,000 and 570,000 people living with HIV, out of a

population of 50.5 million. Even though the main source of infection is heterosexual intercourse, drug injecting is becoming one of the fastest growing ways of HIV transmission in Myanmar, and accounted for approximately 43.2% of new infections in 2005.

Objective:

To reduce the incidence in drug use in the region, through building the capacity of communities and local institutions to carry out community-based demand reduction programmes

Process/Activities:

UNODC, in collaboration with the departments of Health and Social Welfare and the local communities, established community-based treatment centres in three townships— Lashio, Kutkai, and Muse. These programs are supervised by a senior consultant psychiatrist of the drug treatment centre in Lashio, and are assisted by qualified medical personnel and volunteer social workers of the respective communities.

The activity began in June 2001 at existing village primary health care clinics, monasteries, schools (during holidays), and churches (used as temporary detoxification centres). The initial detoxification period is 20 days, which is then followed up by aftercare services within respective communities. The centre-based detoxification programme involves medical treatment using opium tincture and other medicine, group psychotherapy, individual counselling, vocational skills training and recreational and occupational therapy. The patient returns to the family after that, and local volunteers, who have been trained by project members, carry out follow-up support.

This psychosocial support, coupled with vocational skills training and income generating activities (e.g., bee-keeping, livestock breeding and crop substitution), helps to rehabilitate drug users, reduce their risk of relapse and support them in becoming active and contributing members of the community.

Follow-up includes primary health care services, awareness education on health and illicit drugs and related harm (e.g., HIV/AIDS) for formerly drug-dependent persons and their families. Referrals to the government rehabilitation centres and drop-in centres of UNODC are also made for those who are interested.

Each village has a project implementation team of five to six village elders and various community action groups, such as women's, youth, and income generation groups, that lead all community activities and provide assistance whenever necessary.

Lessons Learned:

The project contends that reducing the incidence of drug use works better when the community is actively involved in related activities. These include awareness education and community counselling on illicit drug use. Such activities help to reduce relapse by providing the necessary support to the drug user through all

stages of the detoxification, treatment, and rehabilitation process. At the same time, sufficient support needs to be provided to the families of drug-dependent persons.

Outcome/Achievements:

Community-based services established through the project are easily accessible and user friendly. They are effective in motivating drug users to undergo detoxification, and in supporting their social reintegration. The mobilisation of communities, through involving them in services, provides a basis for sustainable results, and helps to create a positive attitude in the community towards persons with drug dependence issues as well as those who are in recovery.

Those who relapse are accepted by the centres for another treatment. Because of the involvement of families and communities, relapse rates for participants in community-based detoxification are low. This approach may be applicable in other areas with similar environments such as in the Wa area under UNODC's C25 Project where poppy cultivation is being eliminated or is about to be eliminated.

Challenges:

- *To convince law enforcement officials that small-scale drug dealers, who were dependent on drugs themselves, should be offered treatment like any other villager instead of being arrested*
- *To overcome administrative and political difficulties in implementing community-based treatment, because the law recognises and identifies only drug treatment centres or hospitals as treatment providers*
- *To persuade, at the community level, local leaders, such as elders and village heads, to support the project, because they were afraid that since they fall between the lines of law enforcement and drug dealers, the changes would affect their daily routines*

Cultural or Situational Issues Related to This Project:

*The project has provided primary health care, including dental and eye care, for more than 3,000 patients. Training sessions, such as gender, drugs, and HIV/AIDS education, were made available to drug-dependent persons and their families, as well as to the general community. Information on child rights, human trafficking, and the like were also provided. Every weekend the local nurse would invite a group of women and young girls to form a reading session. The nurse would read books such as the Myanmar version of David Werner's *Where There Is No Doctor* to the group with the necessary explanations.*

Vocational training was offered for interested villagers in the areas of social work, tailoring, beekeeping, organic farming, teaching skills, food preservation, and so on. After the training, access to microcredit loans was provided to support women in setting up their own businesses. Income generating activities were also meant as a protection against leaving the village and becoming victims of human trafficking.

Village commodity shops and rice banks have been established. Literacy training and local languages and culture lessons are also provided mainly to the youth. Drug users' families are provided with rice and basic commodities when the men are undergoing treatment. In addition, the project provides a clean water supply from

the nearest natural source, sanitary latrines, and support to mini hydroelectric power plants.

The focus on women's empowerment is a core component of the project, and has been mainly achieved through women's increased participation in decision making regarding project activities, and their access to training and education.

Evaluative Data Available Related to the Project:

STATEMENT SHOWING NUMBER OF ADDICTS PROVIDED WITH TREATMENT BY THE PROJECT										
TOWN-SHIP	2001 (SEP)	2002	2003	2004	2005	2006	2007	TOTAL	RE LAPSED	ACTUAL TOTAL
LASHIO	6	14	7	13	27	0		67	2	65
KUTKAI	22	0	67	140	130	70	40	469	19	410
MUSE	48	38	122	99	133	56		496	86	410
TOTAL	76	52	196	252	290	126		1032	107	925

One hundred and seventy-seven out of 925 persons are injecting drug users (IDUs).

Key Findings:

- Awareness of the existing problems/issues within the target communities and the local authorities (from anti-narcotics task forces to social workers)
- Accepting that this problem/issue exists within the communities
- Agreeing to have relevant local authorities and communities participate in solving the problem/issue together
- Providing tools, such as capacity building at all levels, to solve the problem
- Finding and creating ways, such as community-based treatment facilities, that are acceptable and accessible to the target clients (i.e., drug users and families)
- Advocating for drug users with the local authorities (e.g., issues related to the Narcotics Law) and finding ways to overcome them even on a pilot basis. (E.g., Section 15 of the Law states that all drug-dependent persons are to be registered at the nearest hospital and take treatment. Failure to register can be punished by imprisonment from three to five years. Treatment at the drug treatment centre or authorised hospital is six weeks, followed by three months at the rehabilitation centre. Drug-dependent persons in the areas where the project is operating cannot afford to spend that time in detoxification and rehabilitation programmes. Moreover, it costs more than they can afford to stay at the treatment centre. However, the community-based centres are free of charge and clients' families can provide them with meals there.)
- Finally, the project's members need to consider and look after the needs of families who support their drug-dependent relatives during their detoxification. Thus, clients undergoing treatment would not have to worry about their families while staying at the centre. Furthermore, supporting their health and basic needs are also part of the holistic approach to recovery for drug users, their families, and communities.

Chapter IV: Engaging Clients in Community-based Treatment Settings

This chapter focuses on strategies for outreach and client engagement into treatment. Client access and retention to treatment is key to meet the treatment goals. Community-based treatment services should accept the challenge of developing a network of services by partnering with organizations to bring about helpful results in the lives of drug-dependent clients—both individually and socially.

CBTS' responsibility is to have their teams addressing the difficulties their clients face in meeting their immediate needs. They are also committed to developing plans to look at the social determinants of health and disease, such as finding housing, providing court support, and rights advocacy. The teams should approach their work with an awareness of the full range of their clients' needs in such areas as employment, family/intimate relationships, and future hopes and dreams. Such a holistic approach challenges practitioners to adopt broad ethical and procedural commitments.

An important part of "engaging the client" is for service providers to look at how their organizations encourage drug-dependent persons to participate actively in planning for service provisions in their own communities. In this way, clients are helped to take responsibility for their own lives.

The service network's reasons for engaging its clients and deciding on the range of therapeutic interventions should be developed to suit the level of social vulnerability and severity of the problem(s) among the client group.

Factors to be considered to define problem severity:

- Degree of autonomy displayed by client.
- Impairments resulting from numerous or long-term psychiatric admissions.
- Social and affective relationships.
- Damage in the structure of existential support (housing, job, etc.).
- Bio-psycho impairment resulting from drug use.

It is very important to reach out to those who are not (yet) involved in the social and health network and to reduce drug related harms among this group.

Outreach in community-based settings

Outreach involves identifying and establishing a relationship with substance using individuals in their natural environments (homes, streets, parks, religious institutions, etc.) in order to engage them into any type of intervention to reduce substance use related harms and promote abstinence. Outreach workers should do the following tasks (NIDA, 2000):

1. Identify individuals
2. Initiate contact and establish rapport,
3. Obtaining some commitment to initiate behavioural change (reducing or stopping drug use, attending treatment sessions, etc.), and
4. Providing information about risk behaviours and strategies to eliminate or reduce risk.

Community-based outreach workers

Community-based outreach workers should represent the ethnic, gender, and cultural diversity of the drug users targeted for the intervention and, when appropriate, should include individuals who can speak local languages and are able to function comfortably in different subcultures.

Outreach workers that had a personal experience with drug use may be helpful, but this is not required. Outreach workers that are affiliated with community-based service providers (CBTS) or governmental agencies, religious groups, needle and syringe exchange programmes, methadone maintenance programmes, etc. enhance their visibility and involvement in the broader community context. These individuals are often uniquely in bringing essential aspects to the programme as follows¹⁸:

- Enhance programme legitimacy;
- Translate technical information into readily understood concepts;
- Understand the norms and values of group members to help identify viable behaviour change strategies;
- Recognize the contextual barriers (e.g., paraphernalia laws) that impede progress toward risk reduction;
- Establish trust with target group members;
- Improve follow-up capabilities for reinforcing behaviour change;
- Facilitate access to high-risk sites;
- Foster wider community acceptance; and
- Know local community settings that can be effective sites for outreach activities

¹⁸ Information adapted from The NIDA Community-based Outreach Model (2000) available at <http://www.drugabuse.gov/CBOM/Index.html>

Engaging Clients through the Open Door: Reducing Barriers to Service

An important aspect of engaging clients is to create an “open door” policy and to facilitate easy access to services. Flexibility, accessibility, and safety should be the guiding principles¹⁹. Several steps are suggested to achieve these goals, including the following:

- Avoiding making it necessary to schedule services in advance; instead being flexible about schedules and opening hours;
- Avoiding making necessary formal referrals to the service;
- Reducing waiting lists;
- Avoiding pressuring the clients to completely stop using drugs; instead working with them on their needs and motivations
- Ensuring confidentiality;
- Being non-judgmental and open to clients’ experiences;
- Promoting personal responsibility;
- Being sensitive to clients’ needs;
- Cover basic needs; (e.g. food programmes, shelters, hostels, protected houses, first aid, emotional support, and drop-ins);
- Promoting low-risk practices (safe injecting drug use, safe sex practices, etc.);
- Help the clients make decisions on the type of treatment that is most appropriate for them

The “open door” approach and work developed around the clients’ needs, also implies an according service organization (e.g., having staff available to receive clients entering or returning to the services at any time). Well-trained and friendly reception staff can provide a welcoming and non-judgemental environment by guiding the client to the right treatment service.

The open door policy means actively influencing the way clients experience and understand the organization’s goal and mission. CBTS providers should not to judge their clients, but to provide care in line with the following principles:

- Offer evidence-based treatment;
- Encourage clients and staff to cooperate;
- Lessen clients’ vulnerability;
- Reduce risky behaviours to prevent negative health and social consequences;
- Support the client’s choice;

¹⁹ Information on service improvement can also be found in the Treatnet Training Package: <http://www.unodc.org/ddt-training/treatment/d.html>, Volume 4, Topic 1: Improving Patient Access and Retention, based on a model developed by the *Network for the Improvement of Addiction Treatment (NIATx)*.

- Empower users by teaching them how to articulate their needs and interests in a way that will be taken into account by decision makers;
- Make it easier for clients to use the service;
- Integrate clients into society so that they enjoy full quality of life and independence; and
- Strengthen social networks.

As mentioned above, community-based treatment services (CBTS) also need to be strongly tied to the community in order to know its resources, understand social relationships, and reach clients who do not access mainstream services. This is especially important for such vulnerable groups as sex workers, homeless, and street-living/working persons.

Protocols and Guidelines

Protocols and guidelines are meant to ensure the best quality of care, and to support the actions of staff and clients. These play a fundamental role in decision making within community-based treatment services. Protocols and guidelines that have to do with certain professions or refer to different types of drug dependence should complement the treatment network's vision and mission. It is recommended that protocols and guidelines be informed by answers to the following sample questions:

- How can we welcome clients to our services and make them easy to use?
- How can we promote the right kind of support across the different professions in the network?
- How will we promote the active participation of our users to both establish and evaluate the quality and effectiveness of the services we provide?
- How can we empower our users to influence decision making that affects the services they use?
- How will our outpatient programme work?

Work in the Community

Outreach teams should include people from the communities with whom treatment services intend to work. Such persons may share, to some extent, similar experiences, life situations, practices, and choices as those using the services. Their experience may also include personal experience of use of drug use.

The involvement of (ex-) drug users as workers in outreach teams has a number of benefits. It can show them how to use their own experiences to empower themselves and others. It improves access to drug-user clients by helping treatment teams bring services right to clients' "doorsteps." It can make interventions more helpful by improving access to clients. It can also

help to build networks, and encourage users to take an active part in their own community and society. Peers can be a living example that it is possible to be a productive part of society.

Pragmatic public health approaches and related materials are basic tools for developing outreach work in communities. The outreach teams can do the following:

- Hand out materials such as needles, syringes, condoms, labial protectors, and disposable gloves;
- Support personal care in users by providing personal hygiene resources;
- Promote health and disease prevention activities through information; vaccinations, consultations, and support;
- Make sure clients know and understand their rights and duties as citizens;
- Provide emotional support to deal with crisis;
- Encourage motivation for harm reduction and treatment;
- Promote the establishment of peer support groups;
- Support political organization and action;
- Be the go-between in relationships between drug users and public institutions;
- Involve the rest of society in the discussion on drug use and dependence.

The following can also improve client access to services:

- 24 hours/7days available phone hotlines to provide direction and support;
- Emergency aid in general hospitals;
- Safe spaces for clients within their communities (e.g., local needle exchanges, brief care facilities, drop-in-centres);
- Working with the media to publicize services, while addressing negative views of drug dependence and related stigma; and
- Training professionals from other areas of health care (e.g., social workers, youth and community workers, and police) to respond effectively to the needs of drug- and/or alcohol-dependent clients by being open, caring, and non-judgmental.

Making early interventions. Identifying persons with a possible, developing, or established drug dependence problem may be done in several ways: through outreach, informal contacts, structured screening interviews, or questionnaires. Early intervention is associated with better treatment results. Other goals of identification are:

- Identifying individuals at risk or who already have problems to include the following:
 - Variations in the substance(s) used;

- The different patterns of using;
- Circumstances and stimulus that induce substance consumption;
- Immediate and post-effect consequences of using;
- The history of a client's social relations;
- Specific issues affecting the client at any one time;
- The mental, physical and spiritual status of users
- Economic and social problems
- Intervening as early as possible;
- Preventing development of further problems; and
- Referring them to assessment and treatment, when indicated.

Early interventions may include an outreach and prevention component that provides drug awareness information to schools, community centres, and prisons.

Engaging users and developing individual treatment or care plans. It is recommended that CBTS develop individual treatment plans, since each client is unique. When developing a treatment plan, the staff member should fully respect the client's social, cultural, spiritual views and support networks.

Care plans should always assess and identify a person's strengths and problem areas. These can be used to match individuals to the services they need, including referral to services offered by other agencies in the community. A care plan should include the client as a partner. This means that the client participates fully in the development of treatment goals (e.g., reducing the level of use/abstinence), timelines, and approaches to treatment. A care plan may include different interventions from educational sessions to counselling to promote self-autonomy.

The Addiction Severity Index (ASI), a diagnostic tool, which was adopted for international use by Treatnet can be used for assessment and treatment planning²⁰.

Case Managers

Assigning a case manager to each client is the best approach when using the individual treatment plan model. Case management plays a key role in keeping clients in treatment services and making sure their needs are met. The case manager is responsible for the following:

- Ensuring that the client's goals are in the centre of the treatment plan;
- Mobilizing internal and external resources such as housing, education, employment, and networks to support the client's care;

²⁰ Further information can be found in the Treatnet training package (Volume A, Module 2), available online at <http://www.unodc.org/ddt-training/treatment/a.html>

- Ensuring easy access for the client to the various actors of the CBTS support system;
- Ensuring that the plan is meeting the client's needs at all times.

The case manager's first step is to work with the client to develop the treatment plan, keeping in mind the identified needs, desires, choices, and interests of the client. Flexibility, creativity, and a non-judgmental attitude should be at the heart of this process.

Methods of Care

CBTS teams should develop specific actions and a holistic approach to engage the client beyond her/his obvious help seeking. This requires the client's input on the following key components of care:

- The amount of resources allocated to individual and group support;
- Specialist consultations (e.g., medical, psychological, and nursing);
- Information and support regarding health and human rights;
- Individual case management;
- Inpatient care;
- Outpatient care, which may require infirmary care, and day shelter;
- Aftercare and secure food access;
- Distribution of materials that support health, reduce risks, and prevent disease;
- Assured access to medication and food;
- Hygiene and personal care;
- Therapeutic workshops and groups;
- Family support;
- Links to other health and social service networks;
- Cultural or leisure activities;
- Support in seeking employment and income security;
- Support in getting shelter and housing;
- Legal support;
- Recognized practices in evaluating treatment plans and services (individual and group);
- Regular team meetings across various health care disciplines;
- Registration tools and information sharing (e.g., books, handbooks, reports, procedures, and so on);
- Intake and assessment; and
- Transportation and child care.

It needs to be taken into account that low-resource/impoverished countries or communities will not be able to provide many of these services, even under close established networks. Therefore engaging the client/s should focus on a strong alliance with the client and using the services available to serve their needs. Services can always be scaled up at a later point of time within an existing framework.

When a CBTS's residential programme (i.e., provision of shelter) is part of the treatment service network, it can be used to meet the various needs of clients. No demand for shelter should be ignored, as this is a basic part of a person's well-being. Often residential treatment programmes can also take a role in the process of psychosocial rehabilitation, if they are not only offering medical services but a larger spectrum of services and are well linked to the community.

Aftercare refers to the resources or services that provide continuing support and counselling after a serious period of treatment. Because drug dependence can take the course of a chronic, relapsing disease, aftercare is a critical stage of treatment. A good aftercare plan could help maintain a stabilized, functional and healthy lifestyle. The purpose of aftercare is to support the client in the following:

- Reducing or stopping any behaviours that may cause her/him to return to drug use;
- Handling relapses in a non-stigmatising way;
- Developing and improving social supports in the community, and case management;
- Supporting the client to engage in vocational training, school, employment or other sources of income, leisure activities, and family and peer networks in a positive way; and
- Helping clients develop ways to solve risk situations.

Supporting family relationships and working directly with the families of service users require actions that welcome, include, and inform them. This work should also help family members to overcome prejudice, understand drug use, minimize the vulnerability of clients and their families, and support their social and political organization.

Team Roles and Collaborative Work

The work of CBTS should be carried out in teams. All persons involved should play a coordinated and collaborative role in the work and be made to feel equally responsible for its outcomes and successes.

Within the CBTS team, several designated staff should be able to act as intake workers or case managers in order to maximize coverage. Therefore, the respective staff should be appropriately trained to provide a full range of relevant services such as:

- Conduct assessment interviews;
- Have a good overview of available treatment services;
- Know how to identify healthy and risky behaviours;
- Know how to manage co-morbid disorders; and

Power and responsibility should be handled so that organizational practices are uniform and shared across the range of disciplines. In a collaborative environment, sharing power equals sharing accountability. The challenge in reaching this goal is to ensure that the specific nature of each professional's job remains the same. One of the basic actions in this process is to set up and maintain regular all-staff meetings for coordination purposes.

Multidisciplinary teams include:

- Managers;
- Professionals with specific university degrees or suitable experience and training (medical doctors, psychologists, social workers, nurses etc.);
- Other specialized professionals (e.g., art therapists, vocational rehabilitation);
- Support staff (e.g., reception, administration, and cleaning staff); and
- Technicians.

Staff meetings are an ideal way to discuss clinical cases, evaluate and define work processes, distribute responsibilities, and talk about technical and management issues. It is essential that the meetings create space for the expression of diversity among staff, such as different points of view, knowledge, values, and interests. In this way, CBTS can ensure the richness of the process and favourable results for the benefit of the clients.

Collaborative work-methods and procedures need to be developed openly, and not behind closed doors. Client representatives and staff should try to agree on what is best in caring for the clients—from defining the work processes to the interventions and their evaluation. Doing so increases the impact of the service and its quality. Individual treatment plans, developed in this way, make up the key components of CBTS. Other collective forums include the following:

- Therapeutic groups and workshops;
- Regular, general, and specialized actions;
- Therapeutic groups for users' families;
- Regular team meetings that include the range of professionals involved;
- Team logbook that records decisions and meetings; and
- Management meetings that include users and their families.

Working in an extended team ensures that clients and their families participate directly in deciding what is most important, the processes and the prioritisation of services. This approach goes a long way in making sure that everyone—users and staff—is equally included.

Treatment Setting

The setting in which services are provided should be welcoming for everyone. Persons using the services may feel fear or discomfort, or conclude that they cannot trust that their needs will be met if service centres are unwelcoming. On the other hand, clients will feel welcomed, and that their needs can be met by staff if the centre is set up to welcome them.

Unwelcoming Environment	Welcoming Environment
Many locks or closed doors	Run by persons who welcome their clients' and understand their situations
Bars or gratings on windows	Open and informal; staff treat clients as persons and not as their illnesses
Armed security guards or police	Set up so that clients can easily tell the difference between users and staff
Long lists of rules or punishments; posters and antidrug messages declaring "War on drugs"	Bright, clean, organized, and posters that encourage hope

This list may of course differ in different cultures and environments or for different client groups. It should be mentioned that in countries with conflict and post-conflict situations armed guards and bars might be necessary for the security of both the staff and the clients. Therefore in situations such as this, other welcoming environment components can be helpful, such as a positive staff attitude. Regardless of the conditions that a centre may offer, success depends largely on the attitude of staff.

A good indicator that the CBTS centre is a welcoming place is that many clients from different backgrounds use it on a repeated basis.

Information

CBTS should have clear and objective service information on hand to share with staff, clients and their families. This practice allows everyone involved in the process to be fully informed and confident about the way of work. Information that is intended to prevent drug use and support drug dependence treatment should be clear and simple to understand; if not, clients will feel left out and pushed away. When presented in this way,

information can be a tool to break down prejudice and stigma throughout community education and support.

Information should include preventive actions and general guidance on the risks of drug use. In this way, the community can be taught how to reduce harms and risks; prevent individual and collective health injuries; and prevent (early onset of) use of psychoactive drugs.

Legal Support

Legal support is needed to develop the CBTS and/or treatment network and to support the users.

Adequate legal support, on another level, can also increase the management capacity of the service. Legal support can help to remind practitioners of the importance of supporting clients' rights.

Providing support for persons with HIV

Outreach and engagement are essential components in the treatment planning for individuals with HIV, AIDS and substance abuse in community-based settings. Screening for those that are at risk of contracting HIV could be done by asking if they have engaged in drug injecting, shared needles or other paraphernalia, unprotected sexual conducts or if the client simply presents with any of the symptoms that might indicate recent infection with HIV or early symptomatic infection (CSAT, 2004)²¹.

Testing for HIV/AIDS is the first engaging step for many infected substance users into treatment. Testing for HIV should be encouraged on a voluntary basis when clients report one or more of the following (CSAT, 2003):

- having engaged in risky behaviours;
- if the client has ever had a sexual transmitted disease;
- if the client has a history of sharing drug injection equipment; or
- if the client is presenting with any of a number of symptoms that might indicate recent infection with HIV or early symptomatic infection

Treating HIV/AIDS and substance use is complex and needs the support of a multidisciplinary team. Medical care is essential for these individuals and should include an integrated medical team that also knows about substance

²¹ Screening tools may be obtained at the CSAT treatment improvement Protocol Series 37 (2003). Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons with HIV. Treatment Improvement Protocol ((TIP) Series No. 37. DHHS publication No. (SMA) 03-3850. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2003.

abuse treatment. Medical practitioners in primary care settings need to understand their patients needs' and the risk and probability of relapses.

Adherence to antiretroviral treatments is essential for HIV positive patients and requires that the medical team, community-based staff, family members, friends and others involved coordinate efforts in ensuring that patients take their medication and attend the necessary medical services. Adherence to treatment can be achieved using psychoeducational strategies such as motivational strategies, cognitive-behavioural therapies, contingency management, family involvement and education.

Services and resources that might be needed by this population include:

- Medical and pharmacological care and HIV drug therapy
- Dental care
- Mental health treatment
- Psychosocial treatment and counseling
 - Individual, family and group therapy
 - Outpatient and inpatient treatment
 - Support groups
 - Primary and Secondary HIV prevention and harm reduction strategies
- Peer support, self-help groups and one-on-one emotional support
- Legal support
- Social services and welfare for economic support
- Housing and shelters
- Home-Based Services
- Day centres
- Vocational rehabilitation

Strategies to reduce the negative health and social consequences of substance abuse are of critical importance for these clients. Chapter V discusses related pharmacological approaches in more detail.

Overall, CBTS for drug-dependent clients can ensure their effectiveness by:

- Guaranteeing the access of drug users to networks of support and care;
- Adopting an interdisciplinary team model;
- Establishing a collective approach; and
- Developing individual treatment plans.

When CBTS are able to fully engage all persons involved in different areas of programming and service development, including service users, it is likely that the most vulnerable clients will be reached and served effectively. CBTS should work to ensure that each person is given a range of choices that best reflect their goals and life situation. To provide effective care in community-

based settings is to strive to promote self-direction, autonomy, and to improve and extend the quality of life of drug- and alcohol-dependent clients.

CASE STUDY: TAMIL NADU, INDIA

BACKGROUND INFORMATION

Project Name: *Providing detoxification and follow-up for alcoholism for and with rural communities*

City/Country: *South India, rural areas*

Contact Details Including Contact Person: *Dr. Shanthi Ranganathan, Honorary Secretary, TTK Hospital, IV Main Road, Indira Nagar, Chennai 600 020, Tamil Nadu, Chennai, India
Phone: +44 - 24912948 / 24918461 / 24416458/24426193, Fax: +44 - 24456078*

Website: *<http://www.addictionindia.org>*

Project Status: *Ongoing since 1989*

Funding Source: *Ministry of Social Justice and Empowerment, Government of India and contributions in kind from rural communities*

Years of Operation: *18 years*

Target Group:

Villagers, people in rural areas in India

Issues That Has Been Dealt With in the Case Study:

Providing drug dependence treatment in rural areas in India through community detoxification/counselling settings and follow-up in the community through local organizations

Project Background:

TT Ranganathan Clinical Research Foundation—also known as TTK Hospital—has been working in the field of addiction for the past 27 years. In 1989, a schoolteacher in a rural village in Tamil Nadu, India, drew the attention of the TTK hospital team to the prevalence of alcoholism in rural areas, resulting in students dropping out of school. The team recognized the difficulty of villagers to access treatment available only in cities and big towns. So they designed a community programme especially for the people in rural areas, “making treatment available at the doorstep.” When the first programme became a success, conducting community programmes has become one of the main activities of the centre. Each year, six on-site programs are conducted in rural communities, mostly for alcohol-dependent patients. On an experimental basis, two camps have been conducted for injecting drug users under

the sponsorship of UNODC. Two training programmes were also organized for functionaries of NGOs in an attempt to provide exposure to issues related to the "camp approach" for injecting drug users (IDUs).

Objectives:

To make a cost-effective community treatment programme, especially for the villagers, available at their doorstep

The Process/Activities:

Some months prior to the camp, it is announced widely in the respective village through pamphlets, in cinemas and churches, in schools and micro-credit groups. Clients are identified with the support of teachers, doctors, health workers, relatives, informal community leaders, or participants from earlier camps. The host organisation that is part of the community meets the client and her or his family at least three times prior to the actual camp for assessment. It provides information about the camp and a medical check-up through a local doctor. Ten days prior to the program, medications are given to deal with withdrawal problems and other related issues. Clients and their family members receive tips to help them abstain from alcohol before coming to the camp. Such clients are admitted first.

The host organisation makes all logistic arrangements for the camp, which is mostly held in a school or community hall that is provided free of charge by the community. Two counsellors provide treatment: one person in recovery who is trained as a counsellor, and, the other, a nurse from the treatment facility. The programme for clients lasts 15 days in an inpatient facility, and family members attend a half-day program on an outpatient basis for 10 days. Components of the inpatient program are detoxification, counselling, group therapy and leisure time activities. Family members meet in their own support group. For each client, two persons from the community are identified as support persons to help her or him in the recovery process following the community retreat.

Monthly follow-up programmes in the community are organized for one year. During those meetings, disulfiram is provided and counselling sessions are conducted. Members of the local host organization, who have been trained by TTK hospital, make home visits on a regular basis, especially around the dates of important festivals, to help prevent relapses.

Lessons Learned:

Critical components in organising camp programmes:

- *Working in partnership with the community/host organisation, prior to, during, and after the camp*
- *Identifying alcoholics living in one specific area through multiple entry points*
- *Motivating the client and providing home detoxification*
- *Developing a comprehensive treatment program and providing it in the community itself*
- *Providing support to family members through a separate program*
- *Creating support in the community and maintaining momentum*

Outcome/Achievements:

Health conditions have improved tremendously. Clients work regularly, assume household responsibilities and contribute to the well being of their families. They have electricity in their homes; repay debts; send their children to school; and get their daughters married. There is absolutely no violence, and they enjoy the respect of their community.

Challenges:

The host organization and the community may not see the relationship between alcohol abuse and violence, suicide and premature death. Therefore, they may not see alcoholism treatment as one of their priorities. Creating awareness about the impact of abuse of alcohol and the benefits of treatment would help in motivating the community to take up an active role and support the rehabilitation process is key. Guidance is needed for setting up these rural programmes, and so persons with leadership qualities should be empowered. Medical support is also critical; hence identifying back-up medical support is important and ensured.

Cultural or Situational Issues Related to This Project:

Most of the villagers are illiterate, so stories are narrated to make them understand certain concepts. Since the extended family is intact in villages, relatives are identified as support persons to provide extra help and support during recovery. Recovering clients from previous camps contribute by organising a few meals for new clients to show their gratitude. Clients, sober for more than one year, are given medals. During this occasion, many villagers participate to celebrate the sobriety of their fellow villagers.

Key Findings and Evaluative Data Available Related to the Project:

Experience from 96 camps in 18 years:

- *With minimal infrastructure, quality care can be provided at low cost.*
- *Since help is available at their doorstep, people are accepting help.*
- *Therapy and treatment procedures are made relevant even to the illiterate villagers, hence appealing.*
- *As the entire community gets involved in the process, the incidence of alcohol abuse reduces over a period of time.*

Chapter V: Treatment Principles, Steps and Psychosocial strategies in Community-based Settings

This chapter focuses on the application of evidence-based principles through different intervention steps on substance abuse in community-based settings. Meeting the needs of clients can be done by conducting repeated outreach, screening, case management, in-depth assessments, development of more comprehensive treatment plans based on the identified needs and providing treatments or interventions accordingly. The information provided in this chapter is based on the UNODC-WHO (2008) discussion paper on the "Principles of Drug Dependence Treatment".

Drug dependence is considered, under the biopsychosocial model, a multi-factorial disorder. Therefore comprehensive treatments should include pharmacological and psychosocial-educational components.

Principles of drug dependent treatment

The nine principles of drug dependence treatment outlined by UNODC-WHO (2008) provide a guideline that, depending on each country's or agency's human and financial resources, can be gradually implemented to provide treatments of quality to those in need. The nine principles are as follows:

Principle 1: Availability and Accessibility of Drug Dependence Treatment

- *Refers to the identification and minimization of barriers to treatment and services. Areas of consideration include the following: Geographical accessibility (e.g. outreach, transportation, mobile units, etc.)*
- *Timeliness and flexibility of opening hours*
- *Legal Framework (e.g. if the agency requires registration of clients to official records, may be a barrier to attend the programme)*
- *Affordability (e.g. low or no cost for service user, cost depending on income, insurance coverage, etc.)*
- *Cultural relevance and user friendliness*
- *Responsiveness*
- *Criminal justice system*
- *Gender-sensitiveness of services*

Principle 2: Screening, Assessment, Diagnosis and Treatment-Planning

As outlined also in this good practice document, comprehensive assessments, diagnostic and treatment planning are the basis for individualized treatments that address the specific needs of each client and that will also help to engage him/her into treatment.

Principle 3: Evidence-Informed Drug Dependence Treatment

Evidence-based good practice and scientific knowledge on drug dependence should guide interventions. The high quality standards required for approval of pharmacological or psychological interventions in all the other medical disciplines should be applied to the field of drug dependence.

This principle recommends a wide availability of a variety of individualized, comprehensive treatments including pharmacological (e.g. supervised withdrawal, maintenance medications) and psychosocial treatments (e.g. Cognitive Behavioural Therapy, Relapse Prevention, Motivational Interviewing), self-help groups, socio-cultural relevance, sufficient duration, the use of multidisciplinary teams, brief interventions, outreach and low-threshold interventions and the provision of basic services.

Principle 4: Drug Dependence Treatment, Human Rights, and Patient Dignity

It is crucial to ensure non-discriminative services for drug dependent individuals. Treatments interventions should comply with human rights obligations and provide the highest attainable standards of health and well-being.

Principle 5: Targeting Special Subgroups and Conditions

Several groups within the larger population of those affected by drug dependence require special attention. These special groups include adolescents, women (including pregnant women), individuals with comorbid disorders (either mental or physical), sex-workers, ethnic minorities and marginalized/homeless people.

Principle 6: Addiction Treatment and The Criminal Justice System

Drug use should be seen as a health care condition and drug users should be treated in the health care system rather than the criminal justice system. Treatment should be offered as an alternative to incarceration when possible. If not possible, prisons and jails should provide drug dependence treatment, ensure human rights principles and provide a continuity of services from before incarceration (if applicable), during the time in prison and upon release in the community.

Principle 7: Community Involvement, Participation and Patient Orientation

As this good practice document describes in much detail, community based responses to drug use/dependence can promote change. Changes may include obtaining community cooperation for service delivery, active involvement of local stakeholders, development of a network of health care services, etc.

Principle 8: Clinical Governance of Drug Dependence Treatment Services

As outlined earlier also in this good practice document, the centre policies, treatment protocols, programmes, procedures, definition of professional roles and responsibilities, supervision, financial resources, communication structures and monitoring systems (evaluation), updating services and coordination mechanisms should be clearly defined and re-evaluated to serve as a guide to the therapeutic team members, administration and target population.

Principle 9: Treatment Systems: Policy Development, Strategic Planning and Coordination of Services

On the level of treatment systems, a systematic approach to drug use disorders and individuals in need of treatment, as well as a logical, step-by-step sequence that links policy to needs assessment, treatment planning, implementation, and to monitoring and evaluation is most beneficial.

Intervention Steps and Psychosocial strategies

Psychosocial treatments that are based on psychological principles of learning have demonstrated being effective in numerous studies. There are multiple aspects of psychosocial treatment and this chapter focuses on those that might be particularly useful in community based treatment settings, outpatient or day care settings. Psychosocial strategies herein presented are also selected based on the support that community networks can provide to a programme or centre. Most of these psychosocial treatment techniques can be applied regardless of the modality of treatment (individual, couple therapy, family therapy, group therapy, etc.), the place where the treatment will be provided (prison, agency, street, mobile units, temporary locations on motel or hotel rooms, social services locations, field station, etc.) and the length of treatment (brief interventions, multiple sessions treatments or intensive treatments).

There are several recommended steps²² to follow. Some of them can be completed in one session. Considering the limitations of clients targeted in community-based treatment, conducting screening and brief interventions can be really helpful. However, continuing treatment is always recommended. The recommended steps are as follows:

Step 1: Repeated Outreach Contact and Engagement

Outreach is an essential component of community-based interventions to target out-of-treatment drug users, particularly those at high-risk for HIV infection (NIDA, 2000). Drugs use and other illegal activities related make difficult for those in need to reach traditional care and social services.

As stressed in chapter IV, outreach should be done by individuals that are familiar and feel comfortable with drug-use subcultures and have easy access to them. Outreach workers and community-based workers should be individuals that are respected among those to be served and that can act as role models, educators and advocates.

Repeated outreach contact is highly desirable to engage clients into treatment and even to provide brief interventions and discussions to prevent

²² For further information review CSAT Treatment Improvement Protocol (TIP) Series 33. Available at <http://ncadi.samhsa.gov/govpubs/bkd289/>

substance use harms. For example, screening for drugs and HIV risks plus providing adequate brief interventions on HIV and drugs may be too much work for a single intervention

Engagement is particularly important at treatment initiation but it is also essential to achieve maximum retention to treatment and a good therapeutic alliance among counsellors/educators/clinicians and clients (including family and others involved in treatment) in order to achieve intervention goals.

Programmes can maximize attendance by motivating the clients, supporting them and addressing their needs. Also better treatment retention can be achieved when minimizing the access to treatment (transportation, having flexible schedules, providing child care, etc.) and when clinicians or other professionals quickly attend the client and the centre manage staff properly to avoid waiting lists.

Counsellors should display their clinical skills and be empathetic, engaging and non-judgmental.

Some examples of psycho-educational strategies for community-based outreach may include the following:

<ul style="list-style-type: none"> • Providing information and easy-to-read education materials (photos, etc.) 	<ul style="list-style-type: none"> • Selective disclosing
<ul style="list-style-type: none"> • Weighing pros and cons 	<ul style="list-style-type: none"> • Giving real-life examples
<ul style="list-style-type: none"> • Praising and reinforcement 	<ul style="list-style-type: none"> • User role-playing
<ul style="list-style-type: none"> • Summarizing 	<ul style="list-style-type: none"> • Active listening
<ul style="list-style-type: none"> • Confidence 	<ul style="list-style-type: none"> • Reflecting

Probably one of the most important strategies to keep clients engaged is if treatment is able to meet his/her real needs. Before we can achieve this complex task, we need to know what actually those needs are and design the proper strategies to fulfil them. Only through a careful evaluation and a proper treatment plan services providers will be able to meet a client's needs.

Step 2: Assessments and orientations employing motivational strategies.

Motivational interviewing (MI) is an evidence-based, directive, client-centred style of interaction aimed at helping people explore and resolve their ambivalence about their substance use and begin to make positive changes.

As stated by Miller and Rollnick (1991), motivational interviewing is a “way of being with a client”. It is a counselling style, not just a set of techniques for doing counselling.

Motivational interviewing goals include:

- Resolve ambivalence
- Avoid eliciting or strengthening resistance
- Elicit “Change Talk” from the client
- Enhance motivation and commitment for change
- Help the client go through the Stages of Change

Motivational interviewing is founded on 4 basic principles:

- Express empathy
 - The crucial attitude is one of acceptance
 - Skilful reflective listening is fundamental to the client feeling understood and cared about
 - Client ambivalence is normal; the clinician should demonstrate an understanding of the client’s perspective
 - Labelling is unnecessary
- Develop discrepancy
 - Clarify important goals for the client
 - Explore the consequences or potential consequences of the client’s current behaviours
 - Create and amplify in the client’s mind a discrepancy between their current behaviour and their life goals
- Roll with resistance
 - Avoid arguing against resistance
 - If it arises, stop and find another way to proceed
 - Avoid confrontation
 - Shift perceptions
 - Invite, but do not impose, new perspectives
 - Value the client as a resource for finding solutions to problems
- Support self-efficacy
 - Belief in the ability to change (self-efficacy) is an important motivator
 - The client is responsible for choosing and carrying out personal change
 - There is hope in the range of alternative approaches available

Motivational Interviewing is a useful component in the entire assessment, orientation and intervention process to ensure a proper alliance between clinician and clients.

Assessment and orientations

It is recommended to keep the initial assessment brief and also provide clear/realistic orientations on the treatment and services that can be provided by the organization/institution.

Providing clear orientations to the services will maximize engagement. Individuals need to receive realistic information on the programmes and services that can be provided. In the same way, clients should develop a good understanding of the treatment process, programme rules, expectations of their participation and what is expected the programme will do for them and the timeframe. In addition to these orientations, a programme should offer clients different options of treatment and negotiate with them the more adequate approach or strategies (CSAT, 1999).

Once a therapeutic alliance has been developed, or during this process, a more deep assessment should be conducted. It is also important to involve family members (including close friends if needed) in the assessment process as well as other sources of information (urinalysis, medical reports, legal documents, etc.).

Client assessments may be done through a central assessment/referral service within a treatment network, or by an individual treatment programme. The goal of the assessment is to match clients with suitable services, wherever those services might be available within a specific programme in the community. Assessment does the following:

- Determines what and how serious the problems are; also what drugs are being used and whether or not the client is a drug user
- Screen for psychiatric comorbidity. During the first two weeks of treatment initiation it is important to assess the possible existence of other psychiatric conditions and, if present, initiate appropriate treatment (see chapter VI for further information on comorbidity).
- Screens for other problems that may require specialized assessment; and
- Identifies problems in general life, such as functioning at school, work, and in family interactions.

It is important to make a comprehensive assessment of different areas of the client's life (health, family, work, social, legal, etc.) and not just an assessment of the history of the current drug use. This data can be used to provide a source of demographic information across the system, as well as important information for research.

There are different assessment tools that can assist the process of screening and assessing the severity of drug dependence problems in different settings. One recommended screening tool is the ASSIST (WHO, 2002). The assessment tool adapted by Treatnet is the "Addiction Severity Index" (ASI). Since its introduction in 1979, the ASI is widely used in substance abuse treatment research (Grissom and Bragg, 1991). Tools used to measure the

seriousness of problems can also be used for treatment planning. In addition to the Treatnet ASI other screening tools may be helpful."²³

Based on the assessment, a personal plan must be developed to match and refer the client to the most suitable treatment programme. Service and clinical data collection should be coordinated with all areas of the network.

Step 3: Developing a treatment plan

This step is essential to organize interventions or treatment strategies. Treatment plans provide guidance both for the clinician, the client and his/her family and other people involved in the treatment process (e.g. employers, the criminal justice system, other providers, etc.). Treatnet training materials also include a section on treatment based on the assessment conducted with the ASI²⁴.

Results of individual treatment depend, among other variables, on the type and severity of the client's problems. It is important to suit all parts of the treatment to the client's needs and willingness to be part of the recovery process. Another critical aspect on the treatment planning is to take into consideration the duration of treatment.

Comprehensive treatment plans in community-based settings should count on a network of organizations and institutions. One centre will rarely provide all needed services for most substance using clients. In the same way, one programme (even if it is evidence based) will not work as good for all clients because individuals have different needs and they also respond differently to treatment and providers. Centres will need to find community resources to serve their clients' needs and therefore being well connected in the community. Treatment plans should therefore count with organisational outside resources as well as with its own resources.

In order to match clients properly with treatment modalities, there should be at least some options in a given agency or community. For example a client will be more comfortable if he/she is allowed to choose the treatment modality (e.g. individual treatment, group therapy, family, couples therapy, etc.). This approach works best when agencies can draw on the services of other agencies in a community network to support individualized client treatment planning. (See Chapter IV, under "Engaging users and developing individual treatment or care plans" for more details). It also depends on the type and level of drug used, for instance, opioids and alcohol dependence

²³ More information can be found in Volume A of the Treatnet training package: <http://www.unodc.org/ddt-training/treatment/a.html>

²⁴ For more information on treatment planning, please review the Virtual Library of the UNODc Treatnet website www.unodc.org/treatnet: The Toolkit on Drug Dependence Treatment and the Training Package

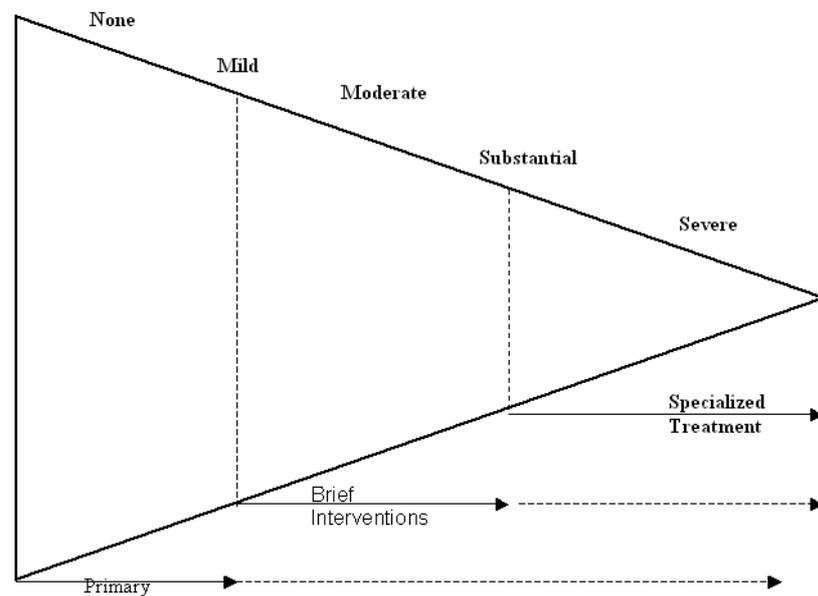
need detoxification services (in addition to psychosocial and pharmacological treatment options) while harmful use of alcohol for instance could be treated with psychosocial counselling (individual, group, etc.).

Following are some principles, adapted from Meeks and Herie (1999) that may be applied in treatment matching. Practitioners should:

- Be aware that drug-dependent persons present a variety of medical, psychological, social and, perhaps, economic, legal, and other problems;
- Have a variety of evidence-based treatment options available in an agency or in the community;
- Make careful assessments to determine the priority problems and their severity;
- Know that a one-fit-all approach will not work for all clients;
- Provide a treatment setting with a range of choices and, when needed, additional services should be available elsewhere in the community;
- Be able to coordinate helping activities and match clients with needed services;
- Provide aftercare in addition to the treatment and services they provide; and
- Be aware that self-help groups may be helpful in combination with other services.

Figure 1 shows substance abuse problems in a community may range from mild to severe, with related interventions ranging from primary prevention to specialized treatment (see National Academy of Science, Institute of Medicine, *Broadening the Base of Treatment for Alcohol Problems*, 1990). Interventions, shown on the lower side of the triangle, are selected to correspond with the severity of the problem. Primary prevention may be the intervention of choice for individuals who have not yet developed problems. So, prevention efforts can be directed towards the general public or bigger subgroups of the general public whereas certain treatment approaches are only delivered to a relatively small group in need of that intervention.

Figure 1: Alcohol and Other Drug Problems



Adapted from the National Academy of Science (1990). *Broadening the Base of Treatment for Alcohol Problems*

This step should also include screening for comorbidity or psychiatric disorders, gambling and risky behaviours to include compulsive sexual behaviours and unprotected sex. This is recommended during the first two weeks of treatment (CSAT, 1999).

Step 4: Provide Support: The sooner, the better

Brief Interventions

Brief interventions are low in cost and effective across all levels of hazardous and harmful substance use. Brief interventions are ideally suited for use as a method of health promotion and disease prevention with primary care patients. The main goal of a brief intervention is to reduce the risk of harm that could result from continued use of substances. Brief interventions can range from 5 minutes of brief advice to 15-30 minutes of brief counseling²⁵.

²⁵ Further information can be found at WHO ASSIST Brief Intervention manual available at the WHO Web site: www.who.int/substance_abuse/activities/assist/en/

Brief interventions may follow screening or the identification of needs by community-based treatment staff. In many instances clients that may be reached by community-based treatment are those out-of-treatment populations difficult to locate and engage. Brief interventions may consist of one simple intervention that might be conducted on the streets, homeless shelters, abandoned buildings, mobile units, methadone treatment programmes, needle & syringe exchange programmes.

Brief interventions can trigger change. One or two sessions can yield much greater change than no counselling. A little counselling can lead to significant change. Brief interventions can yield outcomes that are similar to those of longer treatments.

WHO (2003) recommended components of brief interventions include FRAMES that stands for: Feedback, Responsibility, Advice, Menu of options, Empathy and Self-Efficacy as follows:

Feedback: can include information about the individual's drug use and problems from the results of a screening instrument such as the ASSIST, information about personal risks associated with current drug use patterns, and general information about substance-related risks and harms.

Responsibility: A key principle of intervention with substance users is to acknowledge that they are responsible for their own behavior and that they can make choices about their substance use.

Advice: Providing clear advice that cutting down or stopping substance use will reduce their risk of future problems may increase their awareness of their personal risk and provide them reasons to consider changing their behaviour.

Menu of options: Providing the patient with a range of alternative strategies to cut down or stop their substance use allows the patient to choose the strategies that are most suitable for their situation. Providing choices reinforces the sense of personal control and responsibility for making change.

Empathy: Use of a warm, empathic style is a significant factor in the patient's response to the intervention and leads to reduced substance use at follow-up.

Self-efficacy: The final component of effective brief interventions is to encourage patients' confidence that they are able to make changes in their substance use behaviour. People who believe that they are likely to make changes are much more likely to do so than those who feel powerless or helpless to change their behaviour.

Case management

Case management is a client-centred approach envisaged for the care of people with complex problems. It is oriented to find solutions and designed

both for initial and sustained support in a continuum of care. Case management techniques should be based on a previous comprehensive assessment of client's problems and needs (not only the severity of substance use) and the treatment plan that takes into consideration client's resources and strengths.

Case management is particularly based on community resources. For instance, if clients need HIV testing that can not be provided by the treatment centre or organization, proper referrals should be done. Making referrals should be dynamic in the sense that case managers should facilitate the contact, not just give a phone number or address where a client can find more information. If possible the referral should be made actively with the client (e.g. accompany the client to the first session or having a conference call with the provider and the client) and end up with a session appointment. Case managers should also follow up with the client and the additional service provider. It is recommended to obtain the client's written permission both to initiate and maintain contact with other institutions, community organizations or individuals (including family members).

Step 5: Providing Strategies for Harm Reduction

The goal of harm reduction strategies and approaches is to reduce the negative consequences of drug abuse, not primarily abstinence from licit or illicit drugs (Hilton et al., 2000). Harm reduction is a practical approach that employs a range of different strategies with the goal of minimizing the risk of the client contracting infectious diseases, overdosing, or suffering other consequences related to the use of substances. Strategies may include changing the way people consume drugs or insuring that the environment in which they use minimizes the risks of negative consequences to their health (infections, overdose) or quality of life (legal problems, social and familial issues, etc.). Strategies can vary depending on the drug, the type of harm related to its consumption, and the individual who consumes the drugs (Addy & Ritter, 2000, 2004).

General harm reduction strategies include education strategies, brief interventions and counselling, interventions to reduce injury and violence and availability of measures to prevent the acute consequences of stimulant abuse in the outlets of frequent abuse of these substances could contribute to the prevention of related emergencies

Harm reduction strategies for injection drug users to prevent the spread of HIV and other adverse consequences are as follows:

- Low-threshold pharmacological interventions (opioid-antagonist and antagonist medication), directly related to immediate health protection;
- Needle/syringe exchange programmes;

- Emphasising non-injection routes of administration over injection routes;
- Voluntary HIV counselling and testing;
- Overdose prevention through medication;
- Prevention and services for the management of sexually transmitted infections;
- Wound care and vein maintenance.

In addition to the previously listed harm reduction strategies, the UNODC also recommends the following:

- Adequate social assistance should be provided for marginalized drug-dependent people;
- Vaccination programmes against hepatitis should be available to all drug abusers and in all appropriate facilities;
- Medication and emergency kits for management of overdoses should be available in appropriate places;
- Interventions in emergency rooms have to be guaranteed;
- Well-equipped street-workers and peer outreach workers have to be adequately trained to contact drug abusers and dependent individuals in need of assistance.

Step 6: Initiating Substance Use Treatment

Clients may have a period of emotional (depression, irritability, etc.) cognitive (e.g. attention, memory problems, paranoia, etc.) instability and other issues related to withdrawal (fatigue, craving, etc.). Therefore, the first weeks of treatment should include very simple and straightforward goals and activities. Among these priorities are stopping and reducing drug use, reducing harms related to drug use, taking prescribed medications, conducting urinalysis and maximize attendance. Treatment should include pharmacotherapy and psychosocial strategies to help the client manage withdrawal symptoms.

During this step it is important to establish a clear structure, provide coaching and supporting the client during the recovery process. The goal is to achieve control over drug intake and eventually achieve abstinence and/or a better quality of life and health status. This is a period that last between 2 to 6 weeks of treatment.

During the first 2 or 3 weeks a clear attendance schedule should be established for multiple weekly visits. This would include information on the number of times per week, etc. the client provides urine samples.

Provide access to medical care

Access to care by medical doctors and psychiatrist (if necessary) and other health professionals is essential for a comprehensive treatment, once clinicians screened and assessed the client and identified the need of medical care and pharmacotherapy.

Medical care is necessary for the management of intoxication, potentially lethal overdoses, withdrawal and drug-related health problems to include infectious diseases. Centres and institutions should always count on the expertise of health professional (medical doctors, pharmacist, psychiatrists, psychologist, etc.) and collaborate with local hospitals, health and centres.

Further information on how pharmacotherapy works in community-based settings can be found in chapter VI.

Increasing Knowledge, Structure and Support through Cognitive Behavioural Strategies

Cognitive Behavioural Therapy (CBT) is a counselling-teaching approach well-suited to the resource capabilities of most clinical programs. The approach has been extensively evaluated in rigorous clinical trials and has solid empirical support. Cognitive behavioural therapy is structured, goal-oriented, and focused on the immediate problems faced by substance users entering treatment.

Under the cognitive-behavioural paradigm, thoughts, feelings, and behaviours are separate areas of human behaviour and cognitive processing that become associated through learning. For instance, drug use is a behaviour that might be linked to thoughts, feelings, and even other behaviours by personal experience and observation. When these associations become stronger over time, they may act as triggers without any substances necessarily being present at the time.

The role of the clinician in CBT is to teach the client and coach her/him towards learning new skills for behavioural change and self-control.

Clinicians using CBT should provide education on critical concepts of drug dependence and teach clients specific behaviours to learn how to not use drugs. It emphasises the development of new skills. CBT involves the mastery of skills through practice.

In the early stages of CBT treatment, strategies stress behavioural change to include:

- Planning time to engage in non-drug related behaviour
- Avoiding or leaving a drug-use situation.

CBT attempts to help clients to follow a planned schedule of low-risk activities. It also helps clients, family and other individuals willing to support the recovery process to recognise drug use (high-risk) situations to avoid them and to cope more effectively with a range of problems and problematic behaviours associated with drug use.

CBT techniques to give up drug use must be accompanied by instructions and encouragement to begin some new alternative activities. Many clients have poor or non-existent repertoires of drug-free activities. Efforts to “shape and reinforce” attempts to try new behaviours or return to previous non-drug-related behaviour is part of CBT.

As CBT treatment continues into later phases of recovery, more emphasis is given to the “cognitive” part of CBT. This includes teaching the client and others involved (couple, family members, friend, etc.) the following:

- Knowledge about drug dependence
- Conditioning, triggers, and craving
- Cognitive skills (“thought stopping” and “urge surfing”)
- Relapse prevention strategies

Community Reinforcement and Contingency Management

These two approaches are based on operant conditioning theory. This theory assumes that future behaviour is based on the experience of positive or negative consequences of past behaviours. In the view of this theory, drug use is maintained by the positive reinforcement effects of the drugs or by the negative reinforcement effects (e.g. avoiding negative consequences of not using when experiencing withdrawal symptoms).

Due to the negative reinforcement effect, abstinence positive effects may not be sufficient to reinforce non-using behaviour. Therefore other positive consequences should be introduced to reward changes in lifestyle and continued abstinence.

Community reinforcement consists of contingency management (rewarding abstinence and desirable behaviours) through the client’s social life (family and friends) and through events that have a rewarding effect on the client (hobbies, job, social events, etc.) to provide the positive reinforcement that motivates drug dependent individuals to stop or reduce drug use and other harmful behaviours.

Clients are systematically rewarded (or, less often, ignored or punished) for their behaviour; generally, adherence to or failure to adhere to programme rules and regulations or their treatment plan. For example, clients receive points at the centre for each urine screen that is negative. Clients then accumulate points for each clean urine screen and they can change the points for a variety of items purchased by programme staff, family or others involved (diaries, books, pens, cinema tickets, etc.).

In order to be effective, community reinforcement and contingency management programmes need to focus on realistically attainable behaviours in a reasonable amount of time. Also the selected behaviours to be reinforced need to be part of the treatment plan or have a direct effect on the desired outcome.

Involving family and friends

Family constitutes the most important resource that clients may have for their recovery process. Therefore, involvement of family, couple and friends is essential in all phases of substance abuse interventions. It is especially important when embracing community-based approaches since the family is a crucial link between the community and the individual with drug dependence problems.

Most family members and friends are willing to be supportive during all phases of the treatment and rehabilitation process. They can provide relevant information on the client's substance use pattern and related harms and problems, especially among those unable to provide much information at intake due to extreme impairment of mental functions related to their substance use.

Family and friends are a key part of the treatment process. They are extremely helpful in retaining clients in treatment (e.g. attending sessions, taking prescribed medications), encouraging clients to follow community-based workers advice (practicing new skills, avoiding high-risk behaviours, etc.) and provide immediate care for them.

Family members and friends may join efforts to find resources for their loved one. They are usually connected to local organizations such as social services, religious institutions/people, clinics, family practitioners, etc. that could play an important role in providing a comprehensive treatment.

Family and friends may need help themselves to cope with the substance use of their loved one or even to adjust to his/her sobriety. There exist different family treatment models that can be applied ²⁶. Some of them are as follows:

- Structural/strategic family therapy
- Multidisciplinary family therapy
- Multiple family therapy
- Multisystem therapy
- Behavioural and cognitive-behavioural family therapy
- Network therapy
- Solution-focused brief therapy

²⁶ For further information review CSAT Treatment Improvement Protocol (TIP) 39 Substance Abuse Treatment and Family Therapy (2004).

Address polydrug use

Clients should be encouraged to address all substance use. Many clients present polydrug use problems. Their secondary substance use may not have been associated to adverse consequences or any dependency symptoms yet. Others clients may consider start using drugs to substitute the primary drug of use while in treatment. For instance, start using alcohol when in treatment for opioids. Clients should be educated about the risk of becoming dependent on another drug before this happens (if that is the case).

Address comorbidity

Drug use has been associated to a wide range of mental health problems such as depression and bipolar disorders. Other mental health disorders may include Anxiety Disorders, Schizophrenia and other Psychotic Disorders, Post-traumatic Stress Disorder (PTSD), Personality Disorders, Attention deficit/Hyperactivity Disorders (AD/HD), Eating Disorders and Pathological Gambling (CSAT, 2005). It is necessary to address mental health problems. Chapter VI discusses further the assessment and treatment of (mental) health problems or comorbid disorders.

Step 6: Maintaining Treatment

Based on research studies, it is recommended that treatments have a minimum length of 3 months in order to be effective (NIDA Principles of Drug Abuse Treatment, 2001). A recommended treatment time frame is between 3 to 6 months (CSAT, 1999). During the course of treatment the previously described strategies are applicable. The following aspects of psychosocial treatment are also recommended for the maintenance phase.

Maintaining regular contact with clients

Many clients need to be constantly reminded of their sessions and particularly on the activities (homework), external appointments and referrals, etc. In community-based settings there should be a plan for locating clients and remind them about the activities. Phone calls or brief letters (if possible) reminding the clients of their next appointment or inform them about a missing appointment or changes in the schedule or upcoming available resources are an option

Outreach staff or clinicians can work with locator forms for new clients with the participant's name, address, phone number and also the contact information for family and close friends. When working with homeless people, information on different places where the client may be staying (parks, etc.) is helpful to maintain contact.

If clients do not respond to phone calls or letters community-based outreach staff could visit them at their last known address or places where clients use to be.

Relapse prevention techniques

Broadly conceived, Relapse prevention (RP) is a cognitive-behavioural treatment (CBT) with a focus on the maintenance stage of addictive behaviour change that has two main goals:

- To prevent the occurrence of initial lapses after a commitment to change has been made and
- To prevent any lapse that does occur from escalating into a full-blown relapse

Relapse prevention aims to increase the client's awareness of high-risk situations and increases coping skills, self-efficacy, and control of internal and external variables that may make them more vulnerable to relapse. Relapse Prevention combines cognitive and behavioural techniques such as thought-stopping, coping skills, alternative activities, etc.

Relapse prevention techniques include the following²⁷:

- Psychoeducation about the relapse process and how to interrupt it
- Identification of high-risk situations and warning signs
- Development of coping and stress management skills
- Enhancing self-efficacy in dealing with potential relapse situations
- Counteracting euphoric recall and the desire to test control over use
- Developing a balanced lifestyle including healthy leisure and recreation activities
- Responding safely to slips to avoid escalation into full-blown relapse
- Establishing behavioural accountability for slips and relapses via urine testing or other objective measures.

Provide a variety of treatment modalities

In addition to individual treatment, family interventions and family therapy, other treatment modalities may include group therapy and support groups.

²⁷ For more information review CSAT (1999): Treatment for Stimulant Use Disorders. Treatment Improvement Protocol (TIP) Series 33. Available at <http://ncadi.samhsa.gov/govpubs/bkd289/>

A client may be involved in different modalities of treatment such as individual (psychosocial and medical) or family interventions and family therapy (as needed) to group therapy and support group. Family may also be involved in educational sessions with other family members, etc. A wide variety of treatments helps to retain clients in treatment and provide a continuum of care.

Step 7: Continuing Care

As stated by the UNODC-WHO discussion paper on the Principles of Drug Dependence Treatment (2008) a continuum of care plan should be part of a centre's treatment policy.

Since drug dependence is a chronic disease, programmes and centres should have a plan for those that complete treatment successfully. Also, given the multiple physical, psychological and social needs of people with drug dependence, coordinated care and support from additional community services is essential to ensure a stable recovery among those affected by drug dependence.

Continuing treatment may include services such as counselling follow-up (individual sessions, phone contact, family sessions, etc.), medical check-ups, support groups, self-help groups, vocational training and employment. External programmes at local organizations and NGOs also add to a continuum of care and financial stability to those in recovery. Creating the necessary supports to maintain a sustainable livelihood gives persons in the process of rehabilitation and social reintegration more financial security and the opportunity to shift towards social environments and relationships conducive to stabilization and positive changes.

Local organizations such as NGOs may play a significant role in the provision of services and resources for drug dependent people. It is critical to coordinate these services well with the public health system. NGOs can support the treatment process and may provide invaluable help to achieve the care plan goals and stabilization of clients. Some of the programmes or resources include self-help groups and vocational/professional skills development programmes.

The UNODC Treatnet Good Practice document entitled "Drug Dependence Treatment: Sustained Recovery Management" presents an integrated continuum of care framework and recommendations, developed through a review of literature and good practice, for effective long-term rehabilitation and social reintegration of drug dependent persons.

Chapter VI: Pharmacotherapy in Community-Based Setting

Refer to UNODC-WHO Guidelines on Pharmacological Treatment

This chapter proposes a method for staff members of drug dependence treatment and related services to manage drug use and related withdrawal symptoms. It focuses on the delivery of pharmacological treatment²⁸ in a community-based setting, and uses a case study to demonstrate how this can be implemented. The chapter also discusses the importance of assessing and treating co-occurring disorders. Finally there is a discussion on the role of primary health care professionals in identifying and providing brief interventions and referrals to specialized community services to at-risk individuals.

Using the right medication or pharmacotherapy is key in setting up an overall care plan for persons who are substance dependent. Medications are necessary in community-based settings for a number of reasons, including the following:

- Safely managing withdrawal symptoms (outside a hospital setting);
- Managing overdose and intoxication;
- Preventing relapse for variable periods of time until other processes of change take effect;
- Treating concurrent mental disorders;
- Managing the physical complications of prolonged substance dependence;
- Reducing the adverse health and social consequences of drug use and dependence
- Provision of pharmacological maintenance therapy (agonist, antagonist)

The aim of this chapter is to familiarize the field worker with the principles of medication management so that she or he can have a better understanding of pharmacological treatment approaches and client needs.

Managing Withdrawal

Withdrawal is a physical, mental and emotional state that occurs when drug use is stopped or reduced, and varies in severity. Withdrawal symptoms are the main indicators of emotional, mental and physical dependence on the

²⁸ UNODC's Treatnet training package, Volume C (pharmacological Treatment), describe in detail this important contribution of medication in substance abuse treatment. Please see <http://www.unodc.org/ddt-training/treatment/a.html>

effects of the drug. These symptoms are many and varied, but can often be associated with a particular substance. It is possible to know this because the results of stopping similar drugs give similar reactions. The client's behaviour and physical symptoms, which are almost always opposite to the effects of the drug used, are key indicators.

Research shows that withdrawal symptoms, anxiety about experiencing them, and the lack of care at the time of withdrawal are important reasons that individuals continue to use drugs. The adequate management of all aspects of withdrawal in a community setting is a complex and essential step for longer-term success in preventing relapse.

In a community setting, the main aims of managing withdrawal are to help the client:

- Attain and maintain abstinence or reduced consumption by lessening withdrawal symptoms, and safely managing complications;
- Reach the best possible level of physical health; and
- Stay in treatment and complete treatment

Withdrawal management is often referred to as "detoxification," or simply "detox." However, this term suggests a single medical approach, which is unlikely to be effective in helping individuals to "stay clean." A more integrated approach to manage withdrawal is to use medical, psychological, and social means together, from the first day of encounter.

Withdrawal management can take place in a community-based setting for example the client's home or an outpatient facility, among those cases that are not severe. The decision to start and/or continue to manage withdrawal in a person's own home should be based on evaluation of the following:

- **The likely severity of withdrawal symptoms.** This is judged based on the history of previous withdrawal experiences, especially whether they were associated with seizures, coma periods, hallucinatory and delusional phenomena, severe anxiety, irritability/aggressiveness, or suicidal thinking. Severe withdrawal symptoms should be managed in an inpatient setting.
- **The likelihood of physical complications during withdrawal.** These should be considered in the presence of major organ failure such as heart, liver, and kidney failure. In these instances, an inpatient setting is preferred to reduce risk.
- **The degree of motivation for abstinence and the availability of social and family support.** Home withdrawal is less likely to work if the client is extremely unsure about abstinence, or is likely to use withdrawal medication while continuing substance abuse, or does not have family/social contacts that provide companionship, support, and advice.

During the period needed to control withdrawal symptoms and help the client reach a state of balance, the client should be supported in the community, by counselling, medication, and support with problems associated with day-to-day life. In the absence of a doctor and/or psychiatrist, nurses and health workers can give needed support. A comprehensive management plan should use elements of the above-mentioned methods of treatment suited to the needs of the individual client.

The general principles of withdrawal management in the community are:

- Engaging with and having a therapeutic alliance with the client;
- Deciding with the client on a plan of care;
- Providing regular, almost daily, follow-up; and
- Involving significant others from the family or community in the process.

Using medications in a community-based treatment setting can ease successful withdrawal. Members of the community-based treatment team should know enough about abused substances and medications used to treat related withdrawal symptoms and how to promote continued abstinence or reduced consumption. They should also learn the common side effects of these medications and the effects they can have on other medicines.

Members of the community-based treatment team should set up rules and guidelines that ensure medications are used only for the intended purposes. They should ensure that clients are fully informed about medicines used in the treatment of withdrawal in the community, particularly their benefits and side effects. This knowledge is critical, because the choice of which medicine to be prescribed depends mainly on the substances and the types of symptoms the client experiences.

What follows is a brief listing of generally acceptable good practices for **managing withdrawal symptoms**. Also, UNODC's Treatnet training package, Volume C, describes in detail medication for withdrawal symptoms and substance abuse treatment²⁹.

Alcohol withdrawal. Mild to moderate alcohol withdrawal symptoms generally occur within 1 day (not less than 12 hours) of stopping or reducing heavy, usually long-term alcohol use. These include anxiety, restlessness, irritability, hand tremors, nausea, and sometimes vomiting, sleeplessness and frightening dreams, high blood pressure, rapid pulse and breathing.

The same symptoms occur in severe alcohol withdrawal, which can develop over days, and end up with delirium tremens. In addition to the manifestations of severe withdrawal, Delirium tremens shows up as

²⁹ Please see <http://www.unodc.org/ddt-training/treatment/a.html>).

confusion, short attention span, unclear and broken speech, emotional lability and, most characteristically, frightening hallucinations.

Opiate withdrawal Opiate withdrawal symptoms start within hours after the last dose. They include two main groups of symptoms: a) joint and muscle aches and pains in different parts of the body; and b) increased production of fluid from all body orifices (watery eyes, nasal discharge, coughing, vomiting, diarrhoea, frequent urination, and sweating). These vary in intensity depending on the dose of opioid used and the duration of use. In addition, the person experiences marked craving for the drug and becomes sleepless and sometimes agitated.

Numerous effective pharmacological interventions are available for the treatment of opioid dependence. Methadone and buprenorphine are effective agents for the detoxification treatment of opiate dependence and for the pharmacological treatment of opiate withdrawal.

Methadone is the most commonly used and most effective opiate agonist for detoxification treatment, leading to reduced withdrawal symptoms and increased completion rates (see: Haasen & Van den Brink, 2006; Sung, & Conry, 2006; Van den Brink & Haasen, 2006). It is a longer-acting opioid derivative. When available, oral methadone hydrochloride, preferably in solution form, is highly effective in soothing the symptoms of opioid withdrawal in a community-based treatment setting. Studies have suggested that slow tapers are associated with better outcomes, therefore methadone should be tapered off gradually over a period of weeks. Studies indicate that dropout from treatment decreases when methadone use is combined with counselling during withdrawal and information given to clients before initiating treatment, and when treatment is given by the doctor and not the client.

Studies of **buprenorphine** for opioid withdrawal have often found that clients are more inclined to use it and it is effective. It has properties similar to methadone. It is more effective at controlling withdrawal symptoms at the higher dose. However, due to funding problems in community-based services in developing countries, its cost are the main disadvantage, depending on the setting.

Clonidine reduces nausea, vomiting, diarrhea, cramps, and sweating, but, unlike methadone, does little to reduce other symptoms such as muscle aches, sleeplessness, and drug craving. Clonidine is less addictive, and its use, unlike methadone, is followed by mild rebound withdrawal symptoms. In addition, clients completing a course of clonidine-assisted withdrawal in the community can immediately be given an opioid antagonist (e.g., naltrexone). Low blood pressure is a potential side effect, and clonidine use needs to be linked to frequent measurement of blood pressure. Lofexidine has very similar effects to clonidine. Its advantage is a better side effect profile, including a lesser incidence of low blood pressure.

Stimulants (cocaine and amphetamine) withdrawal. There is a lack of evidence supporting pharmacological treatment for amphetamine and cocaine abuse and dependence. Psychosocial interventions such as cognitive

behaviour therapy and contingency management are the mainstay of treatment.

Cannabis (Marijuana) withdrawal. Although more attention is now being given to treatments for marijuana withdrawal symptoms, there have been no successful controlled trials of medication to date. Therefore no specific medication can be recommended at this time. Most people would use benzodiazepines or phenothiazines to manage anxiety and insomnia related to cannabis, but again, there are not researched control trials in this regards.

Benzodiazepine withdrawal. In early to mild stages of dependence, community-based treatment programmes may offer minimal interventions, such as advisory letters, information provision, general practitioner advice, or short courses of relaxation. Where dependence is established, a graded discontinuation of benzodiazepine is recommended. The appropriate treatment goals for most clients are safe withdrawal leading to stopping use. In cases where a short-acting benzodiazepine is being harmfully used, a switch to a long-acting benzodiazepine may be helpful. The longer-acting drug can then be stopped more easily.

Management of Overdose and Intoxication

Workers in community-based treatment centres will certainly meet clients who have consumed drugs to a point that endangers their lives. Naloxone rapidly and specifically counteracts the effects of opioid intoxication. Likewise, Flumazenil counteracts the effects of Benzodiazepine intoxication, however its use in benzodiazepine dependent may cause seizures. Both drugs can be life saving (see Lagu et al., 2006, for outcomes on the successful use of Naloxone to manage overdose in community settings with the support of peers). Otherwise, the mainstay of managing overdose is to allow the drug effects to wear off under careful observation, because of the possibility of increasing intoxication. Clients need to be observed for levels of awareness, the occurrence of seizures, and the ability to stand and walk.

Relapse Prevention and Promotion of Change through Pharmacotherapy

Research indicates that some withdrawal symptoms, such as sleeplessness, cravings, and low mood extend for weeks and may occur months after abstinence. Furthermore, controlled studies have shown the usefulness of some medications in reducing relapse rates, especially when their use is coupled with psychosocial management. Staff in community-based treatment settings are often faced with the dilemma that these medications are either unavailable or not nationally approved for use on a long-term basis.

Within a community-based setting, methadone and buprenorphine have an established track record in long-term relapse prevention of opioid abuse. When available, it can substantially reduce the harmful behaviour associated with substance abuse. Successful methadone maintenance in the community is enhanced by:

- Calculating the necessary daily dose to ensure control of withdrawal symptoms;
- Administering methadone daily under supervision;
- Using methadone liquid instead of tablets, which can be crushed and injected; and
- Engaging the client with a psychosocial intervention program.

In addition to maintenance therapies, the use of naltrexone might be another option for relapse prevention. Naltrexone is an opioid receptor antagonist that prevents the euphoria related to the use of opioids. Although, there is a smaller body of evidence to support the use of Naltrexone to prevent relapse into opioid use.

Assessment and Treatment of Co-Occurring Mental Disorders

Drug use has been associated with a wide range of mental health problems. The simultaneous presence of substance dependence and other mental disorders³⁰ in a large proportion of clients is well documented. Research indicates that between one-quarter and one-half of all individuals with a substance dependence problem have an additional mental health problem, most commonly Mood Disorders (depression, bipolar disorders). Other mental health disorders may include Anxiety Disorders, Schizophrenia and other Mental Disorders, Post-traumatic Stress Disorder (PTSD), Personality Disorders, Attention deficit/Hyperactivity Disorders (AD/HD), Eating Disorders and Pathological Gambling (CSAT, 2005).

Mental disorders can lead to the use of alcohol or drugs as a means of self-medication. For instance, some epidemiological studies show that mood disorders, such as depression, increase the risk of substance use (Quello, Brady & Sonne, 2005). Alternatively, individuals with a substance dependence problem may suffer depression and anxiety because of low self-esteem, breakdowns, disappointments, and social and family rejection that come with such dependence. Other individuals may have a combination of the previous two conditions.

Substance using individuals who exhibit symptoms of mental health problems may be actually displaying acute intoxication or withdrawal symptoms. A careful assessment of these patients must be conducted in order to

³⁰ Further information on treating special populations with comorbid conditions can be found at the UNODC Treatnet materials "Addiction Medication and Special Populations" (<http://www.unodc.org/ddt-training/treatment/c.html>)

determine if the mental health problem is indeed previous to the substance use or, on the other hand, it is caused by drugs. Careful attention to the characteristics of past episodes of drug use and abstinence with regards to the patient mental health symptoms is necessary. It is also helpful to assess the family history of mental health problems. Before any diagnosis can be concluded there should be a reasonable period of abstinence. Close observation of patient's periods of abstinence of one month or more can also be very helpful, in addition to the use of assessment tools.

The Structured Clinical Interview for Diagnosis (SCID) is a widely used instrument that guides the clinician to the differential diagnosis process between substance use acute mental symptoms and the presence of co-occurring mental health disorders previous to the use of drugs. Also, there exists a wide variety of tools for the assessment of mental health problems such as the Mini-International Neuropsychiatric Interview (MINI), the Mental Health Screening Form III (MHSF-III), the brief Symptom Inventory-18 (BSI-18) and specific tools such as the Beck Depression Inventory (BDI), or the Hamilton Anxiety Scale.³¹

Assessment guiding principles for mood disorders that may also be generalized to other mental disorders, include the following: 1) Expect that symptoms remit if the patient is showing behaviours that are typical of intoxication or withdrawal; 2) Affective problems will emerge four weeks after last exposure to drugs but are more severe and long-lasting than those related to intoxication or withdrawal; and 3) Individuals with mood disorders may experience different symptoms and with different intensity at any time during the treatment process (Quello, Brady & Sonne, 2005)

Twelve steps are recommended³² in the assessment process of co-occurring disorders, as follows:

1. Engage the client
2. Identify and contact family, friends, other providers (medical doctors, psychologist, etc.) to gather additional information
3. Screen for and detect co-occurring disorders
4. Determine severity of the mental health problem and substance use
5. Determine level of care
6. Determine diagnosis
7. Determine disability and functional impairment
8. Identify strengths and supports
9. Identify cultural and linguistic needs and supports
10. Identify problem domains

³¹ Further information on co-occurring disorders and useful assessment tools can be found at the Substance Abuse and Mental Health Services Administration TIP 42 at <http://ncadistore.samhsa.gov/catalog/ProductDetails.aspx?ProductID=16979>

³² Substance Abuse and Mental Health Services Administration TIP 42 at <http://ncadistore.samhsa.gov/catalog/ProductDetails.aspx?ProductID=16979>

- | |
|---------------------------------------------------------------|
| 11. Determine stage of change
12. Develop a treatment plan |
|---------------------------------------------------------------|

Regardless of the differential assessment outcome, there are three treatment options that could follow. A first option would be to deal with the drug problem first and later on with the mental health problem. A second option would deal with the mental health problem first and later on with the substance use. A third option, and probably the most practical approach is to treat both conditions simultaneously once the mental health problem has been diagnosed.

It is essential to involve psychiatrists and other mental health professionals to team up with the community, particularly when patients show acute comorbid conditions. For example, depression may lead to suicidal ideation/acts, bipolar disorders or schizophrenia may cause that the individual displays behaviours that are dangerous for themselves or others. Controlled medication, close follow-up and sometimes a controlled environment may be necessary.

In addition to pharmacological treatment, psychosocial approaches are also recommended, particularly the use of behavioural approaches (see chapter V for further information in this regards). Also, motivational interviews have proven successful for clients with comorbid conditions. It has been particularly useful to focus the client's attention on substance use, medication compliance, and attending treatment. Such approaches can also contribute immensely to a positive therapeutic relationship (see, Bellack and DiClemente, 1999; Martino et al., 2000; and Swanson et al., 1999).

There should be a comprehensive and continuous integrated system of care for patients with comorbid disorders. It is essential to link community and treatment systems and create strong and direct collaborations between mental health care and substance abuse professionals.

Managing the Physical Complications of Substance Use

The physical complications of substance use are many, and depend to a large extent on the substance used and how it is taken (route of administration). It is important that a health care professional, who is part of the multidisciplinary team of community-based services, makes an assessment of the physical complications and decides how these can best be treated. Alcohol use, for example, leads to a large number of physical complications, including liver failure and peripheral nerve disease, requiring immediate emergency room treatment. Other, less severe physical complications, such as local abscesses at the site of injecting drugs, can be managed at home / in the community. However, most complications require specialist and, often even inpatient care. Attention to the presence of these complications, and

supporting the client in managing them, can in itself be useful in promoting change and maintaining abstinence.

The Role of Primary Health Care Professionals

Primary health care professionals have the unique opportunity to develop long-term relationships with the community members that are seeking treatment for a wide variety of health problems. Clinicians are well-trained professionals respected in the communities and therefore have a critical role in early identification. They also have remarkable influences in engaging at-risk individuals into the treatment process.

Early identification can be done through conducting regular screening (even if patients previous screenings were negative) and making interventions and referrals to community services or substance use treatment specialists (see CSAT, 2008). The goal of screening is to identify those patients that have a potential risk to develop drug-related health problems to include drug dependence or to identify patients that have already developed these problems.

There exist many reliable screening tools that might be useful in this regards. Some of these tools were developed to identify the risk of using specific drugs such as alcohol screening instruments (AUDIT, CAGE, TWEAK, etc). Other tools were developed to detect different levels of risk related to the use of a list of comprehensive drugs such as the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) developed by the World Health Organization (Henry-Edwards, Humeniuk, Ali, Poznyak, & Monteiro, 2003) and available in different languages. A comprehensive list of tools is also available in the UNODC Treatnet training package³³.

Screening should be accompanied by brief interventions that are motivational in nature and that also provide referrals to community based services that may conduct in-depth assessments and specialized treatment to substance using individuals. Brief interventions are proven to be effective. Many substance abuse patients would respond to clinician's recommendations and modify their behaviour at some point (e.g. attend specialized treatment, reduce the frequency of use, etc.) in order to avoid physical and mental health problems. Further information on brief interventions can be reviewed at the UNODC Treatnet training materials or the related World Health Organization manual (Henry et al., 2003).

Primary health care physicians should also follow up with their patients in future medical visits. Follow up may include re-screening and conduct new brief interventions and make sure that at-risk patients seek specialized help.

³³ Further information can be found in the Treatment training package (Volume A, Module 2) available online at <http://www.unodc.org/ddt-training/treatment/a.html>

CASE STUDY: BARCELONA, SPAIN

BACKGROUND INFORMATION

Project Name: Programme for the Collaboration between the Community Assistance Service for Drug Dependent Persons SPOTT and the College of Pharmacists of Barcelona.

City/Country: Barcelona, Spain (metropolitan area)

Contact Details Including Contact Person: Francesc Hernández, Diputació de Barcelona. Àrea de Benestar Social. Passeig Vall d'Hebron 171, Barcelona, Spain, 08035

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Website: The EMCDDA's database EDDRA has some information on the project available that was used as a resource to prepare this case study. For more details, see <http://eddra.emcdda.europa.eu/>

Project Status: Ongoing and evaluated

Funding Source: Diputació de Barcelona (Àrea de Benestar Social) Social Welfare Area.

Years of Operation: Eight years, ongoing since 1 January 1999

Target Group: About 100 drug-dependent adults and persons with drug-related health problems per year, their families and social networks

Issues That Have Been Dealt with in the Case Study:

- Enhancing the role of the pharmacist as a health agent who is directly responsible for dispensing medicine and following up on patients' behaviour patterns);

- Enhancing parallel and complementary work between pharmacies and the community assistance service for drug-addicted individuals; and
- Increasing the effectiveness of detoxification treatments carried out at the community service centre for drug-dependent persons, in order to decrease risks and harm related to drug use.

Project Background:

The Diputació de Barcelona has two main goals in dealing with drug dependent people: 1) the treatment centre SPOTT and 2) to provide support (financial, informative, etc.) to the local governments of the province of Barcelona so they can design and implement programs to prevent drug dependence. A Drug Prevention Network has been created with the participation of 162 municipalities along the province of Barcelona. The network is composed of political and technical workgroups and it aims to developing and promoting public policies in drug dependence prevention.

It was noticed that some particular assistance centre patients, with special psychological or social characteristics, had problems completing an outpatient detoxification treatment. This was despite having a family member or educator from the centre as a treatment follow-up referee. So, it was decided to remedy this situation by inviting pharmacists in the community to work collaboratively with other professionals at the SPOTT centre.

This program was provided for clients who wanted to start or continue drug dependence treatment in the community. The collaborative treatment programs between pharmacies and SPOTT (centre for drug use prevention and treatment) are the following: detoxification, methadone maintenance programs, agonist maintenance programs and other organic patterns. The two different target groups in this program were:

- a) Persons who did not have a family member or friend to act as a referee for his/her treatment. (In this case, the pharmacist acted as referee for the follow-up and treatment of the patient.)
- b) Persons under a pharmacist's supervision who were either responsible for their own treatment or had a family member/friend to support them as a referee in the process. (In such cases, the pharmacist passed on the case to (SPOTT), while maintaining the usual consulting and medicine dispensing relationship with the person.)

Objectives:

The general objective of the program was to increase the value of detoxification treatments carried out at a community assistance centre for drug-dependent persons, in order to decrease risks and harm related to drug use.

Specific objectives:

1. To facilitate the assistance and follow-up of those individuals showing difficulties in accessing or maintaining contact with a centre for specialised treatment.
2. To optimise preventive actions through contact between users and health professionals (e.g., pharmacists)

3. To increase the number of patients who stayed in the program, and to develop a complete follow-up for all program users by pharmacists.

The Process/Activities:

Pharmacists were able to reach a group of drug-dependent persons who were disconnected from the specialized assistance network (the proximity approach). Drug-dependent persons could maintain daily, personalized contact with the pharmacist, which allowed him/her personalized follow-up of outpatient detoxification treatment. This allowed (SPOTT) to obtain personalised and thorough information on each patient's progress, as well as a wider and more thorough completion of the pharmacological follow-up of organic medical patterns (HIV+/AIDS and tuberculosis).

The project, using a comprehensive package of care philosophy, provided the following to its clients: HIV prevention kits, advice and support, environmental interventions, information, methadone maintenance, needle disinfection, opiate prescription, outpatient detoxification, prescribing medical drugs, social services, maintenance with drugs other than methadone, and syringe exchange

Lessons Learned:

According to the professionals, the treatment follow-up from the pharmacists promoted several facilitating factors such as:

- Greater patient access to the pharmacist because of the short distance between the patient and pharmacist locations (the proximity approach);
- Familiarity between program's users and pharmacists due to daily visits (contact was made before starting treatment);
- Improved treatment outcomes due to compliance with medical/pharmacological prescription
- Pharmacists' professionalism;
- Expanded multidisciplinary team due to the pharmacist becoming an additional member of the SPOTT centre;
- Greater collaboration with the family doctor; and
- Faster implementation of the treatment prescribed by the doctor.

Some of the following quotes from users indicate what made follow-up treatment from the pharmacist easier and more likely to succeed:

"The pharmacist is nearer home."

"They administer my daily dose at the pharmacist's"

"The pharmacist has encouraged me a lot and helped me with follow-up."

"I can see the pharmacist every day; the timetable suits me better."

"I think it is more confidential and private to pick up my medicines from a pharmacy instead of a drug centre."

"I do not have to see other heroin users, and I do not want anybody to see me in that environment."

All the above-mentioned statements supported the working hypothesis that treatments carried out at community assistance centres for drug-dependent persons decreased risks and harm related to drug use.

Outcome/Achievements:

The following outcomes refer to the period 1999–2005 for which an evaluation of the program was carried out.

Both users and professionals rated this program as "highly satisfactory." One of the main objectives of the program was confirmed: to enable treatment follow-up with the support of the pharmacist. The average satisfaction level of the program's users was 6.5, on a scale where the top score was 7. Retention rate during the first six months of treatment was around 74.2%³⁴. Personalised follow-up patterns by pharmacists enjoyed a 62.5% success rate. This rate was higher than for family member referees (35%) or educators (22%). Also, follow-up and support from pharmacists focused on inducing practices with Naltrexone (66% of individuals successfully completed the detoxification treatment).

These statistics supported the working hypothesis and users' opinions. Users and professionals considered extending the base of this alternative method of assistance from this experience to other areas and/or community centres. They were satisfied with the collaboration of pharmacists and professionals at the centre.

Challenges:

This project was based on an agreement between SPOTT and the College of Pharmacists of Barcelona. However, the decision to take part in the project depended entirely on the willingness of each pharmacist. It should be taken into account that it was extremely risky for pharmacists to deal with drug-dependent users. Also pharmacists' participation in this program could have had a negative impact on their clients. All of these factors could have been a disincentive for pharmacists to take part in the project. Also, prior to this project, there had been no precedent of collaborative work between pharmacists and professionals from the community service centre for drug-dependent persons. Therefore, a sustained effort had to be made to promote interdisciplinary work.

Cultural or Situational Issues Related to This Project:

The early 1980s saw Spain in the grip of the AIDS pandemic, since it had the highest rate in the world of HIV persons infected "via **parenteral**" (sharing syringes). The challenge to public administrators to decrease risks and harm related to drug use was enormous.

There were two cultural changes in Spain that facilitated the program's implementation. The first was that pharmacies used to be seen as just "medicine shops"; they are currently seen as health centres that work close to the people. The other social change refers to the drug-dependent person's image: They are no longer

³⁴ Retention rate = 100 x (1 – Abandon/Total of stable users)

seen as delinquents and transmitters of diseases. However, it took 10 years to change this negative image.

Evaluative Data Available Related to the Project:

Two internal evaluations were carried out: one for the period 1999–2000, and the other for the period 1999–2005. A questionnaire was designed for key informants (users, pharmacists, and the physicians at the centre for specialised treatment. The results were collected from clinical records as well as from in-depth interviews with the persons involved, and then analysed through the statistics program, SPSS. Data sources for evaluation were the community assistance centre for drug-dependent individuals (Diputació de Barcelona) and the College of Pharmacists of Barcelona. Documents supporting the evaluation included the program description, periodic progress reports, and the final report.

Evaluation methods:

Two techniques and two different instruments were used to achieve the objectives of the evaluation:

- In order to assess the effectiveness of the program, a study was done on the level of compliance with prescribed treatment for drug dependence in terms of the user and the referee group assisting her/him (e.g., the educator, family member, or pharmacist). A **protocol** was specifically designed for the study to collect and identify the most relevant variables. To complete these protocols, it was necessary to use 180 medical case histories, with 60 of them from each sample being selected according to who the referee was. The extracted information was verified and confirmed with the referee for each person in the study.
- Interviews were designed to determine the satisfaction levels of key informants (actual users, pharmacists, medical specialists, and drug-dependent persons from the centre) who took part in the study. The interview questions were semi-open-ended, and designed to elicit qualitative information not included in the above-mentioned protocols.

Description of the Sample Study:

The group studied belonged to three different groups, depending on the referee and/or the referee responsible for monitoring their treatment.

- The first group included persons ($N = 60$) who, as referees responsible for monitoring treatment, had an educator from the SPOTT centre. (N represents the number of persons in each sample group.)
- The second group included referee family members ($N = 60$) who were responsible for the monitoring.
- The third group included persons ($N = 60$) who had a pharmacist as a referee.

Thus, a random representative sample ($N = 60$) from each group was chosen, for a total sample of 180 people.

Characteristics of the sample that were of interest were:

- Of those included in the study, 81% were male and 19% female.
- The average age of those studied was 29 years.
- With reference to employment, the following was found: 57% unemployed, 40% employed (with or without a contract), 2% were pensioners, and 1% identified themselves as "other."
- The breakdown of which drugs were the main reasons for seeking consultation was: heroin 40%, cocaine and heroin 25%, and cocaine 35%.
- Sampling to determine how many persons were infected with HIV was 42% HIV+, and 58% HIV-.
- Sampling revealed that, among persons who had attempted a **detoxification** (detox) and who had a long history of addiction, about 54% had made previous attempts to stop using; 46% had never attempted a detox; 32% had tried detox; 12% had tried detox on two occasions; 7% had tried detox three or four times; and 3% five or more times.
- At the SPOTT centre, 86% tested positive for drug use through urine analysis, and 14% at pharmacies.

Key Findings:

During the period 1999- 2005, the program reached 496 direct beneficiaries and 992 indirect beneficiaries. (The estimate of indirect beneficiaries was carried out based on two persons in the close social environment per program user.) A total of eight pharmacists participated in the program. Users corroborated one of the main objectives of the program—to enable follow-up of prescribed treatment with the aid of pharmacists. This aspect reached level 7 (the top level) on a scale created to assess the level of easy access to treatment that the program offers. Participating professionals (e.g., medical specialists and pharmacists) assessed the quality of the program as "very high" and gave it a score of 7.7 out of 10.

This program has been highly valued by all participants (average evaluation is 6.7, where 7 represents the top score). The average satisfaction level of direct beneficiaries was around 6.5 out of 7. During interviews, individuals were asked to remember three messages. All of them remembered the messages and/or preventive advice given by the pharmacist. Of the individuals involved in the program, 194 were at the same time involved in the syringe exchange program carried out at pharmacies.

Between 1999 and 2005, the retention rate during the first six months of treatment in the program was 74.2%. This was higher than the expected 60% retention rate. Of the participants in the detoxification program, 62.5% completed the program successfully because of the support offered from pharmacists. The figure for users with a family member as their referee reached a 35% success rate. In those cases where the referee was an educator, the success rate reached only 22%. Of the users involved in this program, 66% who successfully completed the detoxification followed a Naltrexone inducing pattern. There have been 215 detoxifications with follow-up by a pharmacist, and 1,124 interactions between users and pharmacists have been registered. Continuous and complete follow-up from the pharmacist was carried out for 102 **psychotropic** patterns, 41 agonist maintenance patterns, and 126 organic pathologies follow-up (HIV+).

ANNEXES

ANNEX A: KABUL DRUG USER PROFILE: INTERVIEW CHECKLIST

ANNEX B: REFERENCES AND FURTHER READING

ANNEX A: KABUL DRUG USER PROFILE: INTERVIEW CHECKLIST

Date: _____
Time: _____

Location: _____
Interviewer: _____

Probes are in italics

1. Age: _____
2. Sex: Male _____ Female _____
3. Marital Status: (Single/married/widowed/divorced) _____
4. Number of Children: _____ (Ages?) _____
5. Ethnic status: _____
6. Level of education: _____
7. Employment status: (Current/previous) _____
8. Monthly income: (Source: own/family?) _____
9. How long have you lived in this area of Kabul? (See area list) _____
10. Where did you live before coming here? _____
11. Where are you originally from? (Born/childhood?) _____
12. *Have you ever used opium? Yes _____ No _____ (Go to Q25)*
13. When did you first start using opium? (Method/where?) _____
14. Why did you start using opium? _____
15. How often do you use opium now? (Time of day/daily/weekly) _____
(Never: When/why/how did you stop?) _____
(If never, go to Q25)
16. Why do you use opium now? _____
17. How much do you normally use in a day? (Method?) _____
18. How much do you pay for your opium/where do you get the money from/
source of opium? _____
19. Are there times when you use more, or less, than you do now? Yes, explain _____ No _____
20. Do you have any problems relating to your opium use? (Health/financial/social
relationships/family and community level) _____
21. Are you doing anything about these problems? Yes (What?) _____ No (Why not?) _____
22. Have you ever tried to stop using opium? Yes _____ No _____
23. If yes: When? Why? Were you successful? For how long? Why did you start again?
24. If no: Any reason why not? _____
25. Do other members of your family use opium? (Who?) _____
Yes (Who?) _____ No _____ DK _____
26. Do other people in this area use opium? (Habitual/recreational/medical)
Yes _____ No _____ DK _____
(If No or DK, go to Q32)
- Can you now provide us with some information about these people?*
27. Are they male or female? _____
28. How old are they? (Youth <25 /adults/ children) _____
29. Are they residents or returning refugees? _____
30. Do they belong to any specific group? (Ethnic group/ex-combatants) _____
31. How many people would you estimate use opium in this area? _____
32. *Have you ever used hashish? Yes _____ No _____ (Go to Q45)*
33. When did you first start using hashish? (Method/where?) _____
34. Why did you start using hashish? _____
35. How often do you use hashish now? (Time of day/daily/weekly) _____
(Never: When/why/how did you stop?) _____
(If never, go to Q45)
36. Why do you use hashish? _____
37. How much do you normally use in a day? (Method?) _____
38. How much do you pay for your hashish/where do you get the money from/source of hashish?

39. Are there times when you use more, or less, than you do now? Yes, explain: _____ No _____
40. Do you have any problems relating to your hashish use? (Health/financial/social
relationships family and community level?) _____
41. Are you doing anything about these problems? Yes _____ (What?) _____ No _____ (Why not?) _____
42. Have you ever tried to stop using hashish? Yes _____ No _____
43. If yes: When? Why? Were you successful? For how long? Why did you start again?
44. If no: Any reason why not? _____
45. Do other members of your family use hashish?
Yes (Who?) _____ No _____ DK _____
46. Do other people in this area use hashish? (Habitual/recreational/medical)

Yes _____ No _____ DK _____

(If No or DK, go to Q52)

Can you now provide us with some information about these people?

47. Are they male or female? _____
48. How old are they? (Youth <25 /adults/ children) _____
49. Are they residents or returning refugees? _____
50. Do they belong to any specific group? (Ethnic group/ex-combatants) _____
51. How many people would you estimate use hashish in this area? _____
52. *Have you ever used heroin?* Yes _____ No _____ (Go to Q65)
53. When did you first start using heroin? (Method/where?) _____
54. Why did you start using heroin? _____
55. How often do you use heroin now? (Time of day/daily/weekly?) _____
(Never: when/why/how did you stop?) _____
(If never, go to Q65)
56. Why do you use heroin now? _____
57. How much do you normally use in a day? (Method?) _____
58. How much do you pay for your heroin/where do you get the money from/
source of heroin? _____
59. Are there times when you use more, or less, than you do now? Yes ___ (explain?) ___ No ___
60. Do you have any problems relating to your heroin use? (Health/financial/social
relationships – family and community level?) _____
61. Are you doing anything about these problems? Yes ___ (What?) No ___ (Why not?)
62. Have you ever tried to stop using heroin? Yes ___ No ___
63. If yes: When? Why? Were you successful? For how long? Why did you start again?
64. If no: Any reason why not? _____
65. Do other members of your family use heroin?
Yes (Who?) _____ No _____ DK _____
66. Do other people in this area use heroin? (Habitual/recreational/medical)
Yes _____ No _____ DK _____

(If No or DK, go to Q71)

Can you now provide us with some information about these people?

67. Are they male or female? _____
68. How old are they? (Youth <25 /adults/ children) _____
69. Are they residents or returning refugees? _____
70. Do they belong to any specific group? (Ethnic group/ex-combatants) _____
71. How many people would you estimate use heroin in this area? _____
72. *Have you ever used pharmaceutical drugs such as tranquilisers like Valium or
painkillers?* Yes _____ No _____ (Go to Q85)
73. When did you first start using tranquilisers/painkillers? (Specify which drug/
method/where?) _____
74. Why did you start using tranquilisers/painkillers? _____
75. How often do you use tranquilisers/painkillers now? (Time of day/daily/weekly?) _____
(Never: When/why/how did you stop?) _____
(If never, go to Q85)
76. Why do you use tranquilisers/painkillers now? _____
77. How much do you normally use in a day? (Method?) _____
78. How much do you pay for your tranquilisers/painkillers/where do you get the money
from/source of tranquilisers/painkillers? (Specify pharmacist/other retailer?/
whether on prescription or not?) _____
79. Are there times when you use more, or less, than you do now? Yes ___ (Explain?) ___ No ___
80. Do you have any problems relating to your tranquiliser/painkiller use?
(Health/financial/social relationships – family and community level?) _____
81. Are you doing anything about these problems? Yes ___ (what?) No ___ (why not?)
82. Have you ever tried to stop using tranquilisers/painkillers? Yes ___ No ___
83. If yes: When? Why? Were you successful? For how long? Why did you start again?
84. If no: Any reason why not? _____
85. Do other members of your family use tranquilisers/painkillers?
Yes (who?) _____ No _____ DK _____
86. Do other people in this area use tranquilisers/painkillers? (Habitual/recreational/medical)
Yes _____ No _____ DK _____

(If No or DK, go to Q92)

Can you now provide us with some information about these people?

87. Are they male or female? _____
88. How old are they? (Youth <25 /adults/ children) _____
89. Are they residents or returning refugees? _____
90. Do they belong to any specific group? (Ethnic group/ex-combatants) _____

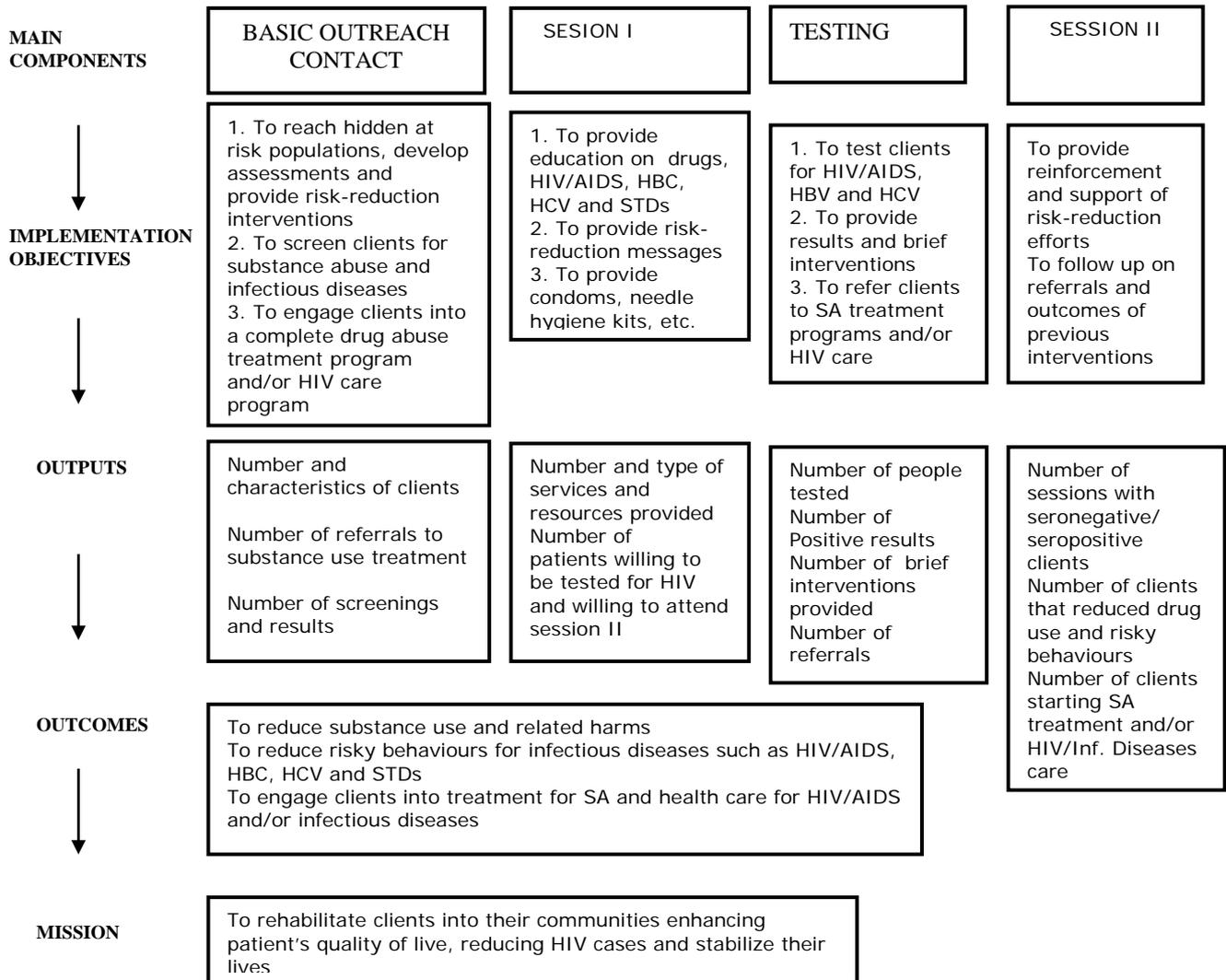
91. How many people would you estimate use tranquilisers/painkillers in this area?
92. *Have you ever used alcohol?* Yes____ No____ (Go to Q105)
93. When did you first start using alcohol? (Method/where?) _____
94. Why did you start using alcohol? _____
95. How often do you use alcohol now? (Time of day/daily/weekly?) _____
(Never: When/why/how did you stop?) _____
(If never, go to Q105)
96. Why do you use alcohol now? _____
97. How much do you normally use in a day? (Method?) _____
98. How much do you pay for your alcohol/where do you get the money from/source of alcohol?
99. Are there times when you use more, or less, than you do now? Yes____ (Explain?) No____
100. Do you have any problems relating to your alcohol use?
(Health/financial/social relationships – family and community level?) _____
101. Are you doing anything about these problems? Yes____ (What?) No____ (Why not?)
102. Have you ever tried to stop using alcohol? Yes____ No____
103. If yes: When? Why? Were you successful? For how long? Why did you start again?
104. If no, any reason why not? _____
105. Do other members of your family use alcohol?
Yes (who?) _____ No _____ DK _____
106. Do other people in this area use alcohol? (Habitual/recreational/medical)
Yes _____ No _____ DK _____
(If No or DK, go to Q112)
- Can you now provide us with some information about these people?*
107. Are they male or female? _____
108. How old are they? (Youth <25 /adults/ children) _____
109. Are they residents or returning refugees? _____
110. Do they belong to any specific group? (Ethnic group/ex-combatants) _____
111. How many people would you estimate use alcohol in this area? _____
112. *Have you ever used any other type of drug? (Specify: Solvents/cough syrups/ other)*
Yes____ No____ (Go to Q125)
113. When did you first start using these other drugs? (Method/where?) _____
114. Why did you start using these drugs? _____
115. How often do you use these drugs now? (Time of day/daily/weekly?) _____
(Never: when/why/how did you stop?) _____
(If never, go to Q125)
116. Why do you use these drugs now? _____
117. How much do you normally use in a day? (Method?) _____
118. How much do you pay for these drugs/where do you get the money from/source of these drugs? _____
119. Are there times when you use more, or less, than you do now? Yes____ (explain?) No____
120. Do you have any problems relating to your use of these drugs?
(Health/financial/social relationships – family and community level?) _____
121. Are you doing anything about these problems? Yes____ (what?) No (why not?)
122. Have you ever tried to stop using these drugs? Yes____ No____
123. If yes: When? Why? Were you successful? For how long? Why did you start again?
124. If no any reason why not? _____
125. Do other members of your family use other drugs?
Yes (Who?) _____ No _____ DK _____
126. Do other people in this area use other drugs? (Habitual/recreational/medical)
Yes _____ No _____ DK _____
(If No or DK, go to Q132)
- Can you now provide us with some information about these people?*
127. Are they male or female? _____
128. How old are they? (Youth <25 /adults/ children) _____
129. Are they residents or returning refugees? _____
130. Do they belong to any specific group? (Ethnic group/ex-combatants) _____
131. How many people would you estimate use other drugs in this locality? _____
132. Currently do you use your drugs in combination or separately? _____
133. Have you ever been arrested for drug use? (Specify: Where/when/what drug outcome?) _____
134. Is there anything else that you think we should know about your drug use? _____

Thank you very much for answering the questions.

Interviewer: List here any problems with this interview

Figure 3: Example of a Logic Model based on the NIDA Community-Based Outreach Model (2000)

Flow Diagram



Based on the NIDA Community-Based Outreach Model: A Manual to Reduce the Risk of HIV and other Blood-borne Infections in Drug Users. National Institutes of Health. Publication Number 00-4812. Printed September 2000. Available at <http://www.drugabuse.gov/CBOM/Index.html> (accessed September 2008)

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Website Resources:

Stanley Street Treatment and Resources (SSTAR) NIATx Mental Health Service
Change Project Profile:

<https://www.niatx.net/PDF/ENews/January%202008/sstar2.pdf>

European Monitoring Centre for Drugs and Drug Addiction: Responses to Drug use:
Drug Treatment: <http://www.emcdda.europa.eu/html.cfm/index1572EN.html>

UK National Treatment Agency for Substance Misuse (clinical guidelines, needs
assessments, good practice in care planning:

<http://www.nta.nhs.uk/publications/publications.aspx?CategoryID=36>

UNDCP (Drug Abuse Rapid Situation Assessments and Responses)

http://www.unodc.org/pdf/report_1999-03-31_1.pdf

UNODC toolkit (Treatnet training materials):

http://www.unodc.org/treatment/en/UNODC_documents.html

UNODC (Harm reduction): <http://www.unodc.org/unodc/en/frontpage/reducing-the-harm-of-drugs.htm>

UNODC Project H13, ROSA: http://www.unodc.org/india/dic_kerala.html

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World Health Organization (Rapid Assessment and Response Technical Guide TG-RAR

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