NATIONAL GUIDELINES FOR THE TREATMENT OF SUBSTANCE USE DISORDERS FOR NIGERIA
These Guidelines have been developed with funding from the European Union (EU) under the framework of the UNODC implemented project ‘Response to Drugs and Related Organized Crimes in Nigeria’
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FOREWORD

Substance use disorders present a growing problem to Nigeria's already belaboured health care system. The 2018 National Survey on Drug Use in Nigeria which was conducted by the National Bureau of Statistics (NBS) and the Centre for Research and Information on Substance Abuse (CRISA) with technical support and oversight by the United Nations Office on Drugs and Crime (UNCDC) indicates there are about 14.3 million drug users in Nigeria, representing a 14.4% prevalence rate. Juxtaposed against the global prevalence rate, which according to the 2019 World Drug Report is 5.5%, Nigeria's drug use prevalence rate is staggering and urgently needs to be addressed.

A considerable number of the growing population of drugs users in the country will develop some substance use related health disorders and there is an obvious need for our health care system to proactively respond and provide health care services to people who develop substance use disorders. Nevertheless, Preventive and early detection measures to limit the incidence, remain our first line of defense.

These Guidelines present for the first time, a holistic evidence-based national guideline for the treatment of substance use disorders, in line with international best practices. It is insightful to note that though these Guidelines represent international best practices, they have been developed largely by Nigerian subject matter experts and professionals, with oversight by world renowned experts and are therefore adopted to the Nigerian context.

Importantly, these Guidelines will increase Nigeria's coverage and quality of effective, evidence-based and ethical treatment of substance use disorders. They will also be useful in monitoring the quality of treatment provided by service providers across the country.

The Nigerian Government is committed to implementing these Guidelines and the Federal Ministry of Health urges stakeholders to adopt and ensure implementation of these Guidelines in the treatment of substance use disorders in Nigeria.

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Honourable Minister of Health (FMOH)
Federal Ministry of Health
Nigeria, 2019
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The Federal Ministry of Health wishes to express its appreciation to the United Nations Office on Drugs and Crime (UNODC) for providing its technical support for the development of the National Guidelines for the Treatment of Substance Use Disorders as part of efforts to standardize and improve quality of treatment given to persons with substance use problem in Nigeria.

We would also like to thank the European Union for their financial support over the years in making these interventions by UNODC possible.

The Ministry also acknowledges with profound gratitude the immense contributions of Nigerian and International experts who gave generously of their time, knowledge and expertise in developing these Guidelines.

A.M. Abdullahi
Permanent Secretary
Federal Ministry of Health
Nigeria, 2019
UNODC is implementing a large-scale project in partnership with the Government of Nigeria that is funded by the European Union, ‘Response to Drugs and Related Organised Crime in Nigeria’. The project aims at supporting Nigeria’s efforts in fighting drug production, trafficking and use, and in curbing related organised crime. The project adopts a balanced approach to drug control, with equal attention paid to drug interdiction and drug demand reduction, including drug prevention, treatment and care (DPTC).

These Guidelines of Substance Use Dependence have been developed as part of this project.

The following are acknowledged for their invaluable contribution to the process of development and publication of these standards.

The group of Nigerian experts for providing relevant scientific evidence, technical advice and consultation on this document including: Dr. Iteke Obiora, Federal Neuro Psychiatric Hospital, Enugu; Mr. Chinawa Francis, Federal Neuro Psychiatric Hospital, Enugu; Dr. Ojo Abayomi Moses, Federal Neuro Psychiatric Hospital, Lagos; Mrs. Chinnyere Okonkwo Celestina, Federal Neuro Psychiatric Hospital, Lagos; Dr. Sunday Osasu Olotu, Federal Neuro Psychiatric Hospital, Benin; Dr. Bawo Onesirosan James, Federal Neuro Psychiatric Hospital, Benin; Dr. Moses D. Audu, Quintessential Health Care Centre, Jos; Ms. Nendirmwa Clarita Dimka, Quintessential Health Care Centre, Jos; Dr. Duwap Makput, Jos University Teaching Hospital, Jos; Dr. Margaret Akogun, Jos University Teaching Hospital, Jos; Dr. Sodeinde Olanrewaju Olughenga, Federal Neuro Psychiatric Hospital, Abeokuta; Dr. Sunday Mauton Amosu, Federal Neuro Psychiatric Hospital, Abeokuta; Dr. Awul Sani Salihu, Aminu Kano Teaching Hospital, Kano; Mr. Tijjani Abdu, Aminu Kano Teaching Hospital, Kano; Dr. Olusola Ephraim-Oluwanuga, National Hospital, Abuja; Dr. Olusegun Shoyombo, National Hospital, Abuja; Mrs. Rifkatu Cayford Bata, National Hospital, Abuja; Ms. Adeyemi Miriam Monday, Federal Neuro Psychiatric Hospital, Kaduna; Dr. Nkereuwem William Ebiti, Federal Neuro Psychiatric Hospital, Kaduna; Mrs. Otogwung Izegbuwa, University of Port Harcourt Teaching Hospital, Port Harcourt; Mrs. Okey-Uchendu, National Agency for the Control of AIDS (NACA); Mr. James Eghaghe, Nigeria Network on People who Use Drugs (NNPUD); Mr. Aniedi Emah Akpan, Drug Harm Reduction Advocacy Network (DHRAN); Dr. Christopher Ugwu, Society for the Improvement of Rural People (SIRP); Mr. Bede Eziefule, Centre for the Right to Health (CRH); Mr. Olusesan Osahitinehin, Freedom Foundation; Prof. Isidore Obot, Centre for Research and Information on Substance Abuse (CRISA); Father Donatus Ukpong, Mobile Manna Foundation; Ms. Patricia Igbin, Society for Family Health; Dr. Shehu Sale, Federal Neuro Psychiatric Hospital (FNPH), Sokoto.

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Ms. Vanessa Barchfield edited the document and Ms. Netra Shyam provided the layout and design.

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1. Introduction

This document provides national evidence-based guidelines for the treatment of substance use disorder (SUD) for Nigeria. It is based on the International Standards for the Treatment of Drug Use Disorders (2016) and other international evidence-based guidelines.

SUD is a global health problem that causes significant burdens for the individuals affected, their families and communities. In Nigeria, there is evidence that drug use and drug use disorders are increasing, especially opioid use disorders involving opioid medication. Both the country and its population are negatively impacted by SUD. SUD is now understood to be a complex, multifactorial health problem with psychosocial, environmental and biological determinants. Treatment for SUD has been shown to be effective and cost-effective; however, globally, only one person out of six who need treatment for SUD receives it and only one out of 18 in Africa. This document aims to enable all those responsible for the planning, funding and delivery of SUD treatment in Nigeria to work in partnership to maximize resources and improve the coverage and quality of SUD treatment.

2. Internationally agreed principles of substance use disorder treatment

All 192 UN Member States (including Nigeria) signed on to the International Standards, which outline principles that should be applied by a country or service provider to ensure safe and effective care (regardless of treatment philosophy or setting). Individuals with SUD deserve “nothing less” than ethical and science-based standards of care similar to those for the treatment of other chronic diseases.

SUDs can be effectively treated using a range of evidence-based pharmacological and psychosocial interventions. Interventions that are not based on scientific evidence may be ineffective or harmful and should not be funded.

Treatment for SUD should also be consistent with Universal Declaration of Human Rights and existing UN conventions, adhere to healthcare standards and promote personal autonomy and individual and societal safety.

Treatment interventions for SUD can have a range of goals, including: prevention of harms associated with SUD; cessation or reduction of substance use and cravings; reduction in risk of relapse; or improvements in health, well-being and social functioning of individuals with SUD.

Principles from the International Standards are outlined in the table below. These principles are aspirational but have also been adopted as appropriate principles for SUD treatment in Nigeria. In 2015, experts developed the National Minimum Standards for Drug Dependence Treatment in Nigeria, based on WHO/UNODC principles.

The International Standards call for:

2. Ethical standards of care.
3. Effective coordination between health, criminal justice and social care.
4. Evidence-based SUD treatment that responds to the needs of individuals.
5. Respond to the specific needs of the specific populations with SUD.
EXECUTIVE SUMMARY

3. Developing an effective system for the treatment of SUD in Nigeria

SUD is a complex, multi-factorial health disorder that can be effectively treated. SUD treatment can be cost-effective and the International Standards recommends that countries establish effective, coordinated systems to deliver evidence-based interventions in multiple settings to meet the needs of their population with different severities of SUD. A recovery-orientated approach is advised for people with moderate to severe SUD, similar to the management of other long-term chronic health issues. Core SUD treatment modalities for Nigeria are: outreach to reduce the health and social harms and consequences of SUD; screening and brief intervention; psychosocial interventions; prescriptions or pharmacological interventions; and recovery management. Wider healthcare, social care and criminal justice systems, community agencies, peer advocates, and mutual aid groups should also play a part in the treatment and recovery of those with SUD.

Those planning and funding SUD treatment in Nigeria are advised to develop treatment systems in line with the International Standards to increase the quality, capacity and effectiveness of SUD services.

4. Screening, brief interventions and referral for treatment (SBIRT)

Screening and brief intervention can be used opportunistically to assess the needs of people who present in non-specialist settings, such as outreach or primary care. Evidence shows the effectiveness of brief interventions in reducing drug use in people who are not drug dependent. Screening tools are used to identify the need for treatment. Brief interventions – which may be a single session ranging from five to 30 minutes, carried out in a non-judgmental and motivational style – can be effective in supporting high risk people to stop or reduce their drug use. WHO recommends a nine-step approach to brief interventions following screening.

5. Outreach interventions to reduce the health and social harms of substance use

Outreach interventions to reduce the health and social consequences and harms associated with SUD should be provided to people with substance use disorders, including the essential package to prevent HIV and treat people who inject drugs. Outreach interventions include: information and links to meet basic needs; education on substance use; counselling and support; referral to healthcare; needle and syringe programmes (NSP); condom distribution and prevention of sexually transmitted diseases; HIV testing; counselling and access to antiretroviral treatment; screening and referral for treatment for hepatitis, tuberculosis and liver disease and hepatitis B vaccination; and prevention of poisoning and overdose, including provision of naloxone for opioid overdose. Outreach interventions are most effective when they are implemented as a package, with SUD service providers working in partnership to ensure a local system of outreach is implemented. Outreach services should have clear protocols, procedures, monitoring and staff support mechanisms.

6. Assessment, treatment planning and review

Assessment is a process that identifies the weaknesses and strengths that people bring to SUD treatment. Informed consent is an important part of building a collaborative therapeutic relationship. Assessment should seek to identify current needs, strengths, risks, motivation levels and potential barriers to engagement. Assessment is the start of a therapeutic process that will continue throughout the client’s experience. The assessment process should result in a treatment plan that includes psychosocial interventions and may include pharmacological interventions.
7. Psychosocial interventions

Psychosocial interventions (PSIs) are the golden thread of SUD treatment; they should always be provided either as the sole intervention or as an adjunct to pharmacological treatment. PSIs are evidence-based approaches and can be used during inpatient and outpatient client treatment programmes to address motivational, behavioural, psychological, and social factors associated with substance use. They can be delivered as individual or group-based interventions. Common psychosocial interventions include motivational interviewing, family and network interventions, contingency management, and cognitive behavioural therapy. Staff delivering PSIs must have sufficient ability; on-going supervision will support staff competency.

8. Prescribing interventions

Medication can be essential to the management of SUD. Prescribing interventions should always follow relevant assessment and be accompanied by psychosocial and recovery management interventions. Outpatient settings are as clinically effective for most patients as inpatient settings; however, those with alcohol dependence, severe dependence on other substances, polysubstance use or complex needs may require inpatient settings.

- The clinical management of opioid drug use disorder (DUD) will depend on the degree of physical dependence and the potency of opioid used. First line treatment for tramadol and codeine would normally be detoxification, with opioid maintenance treatment only considered if previous detoxification efforts have failed, or the harms associated with ongoing use warrant use of this higher potency opioid and more intensive, longer-term clinical interventions. More potent opioids, injecting opioid use or complex needs may require stabilization and opioid maintenance treatment using methadone or buprenorphine. All healthcare facilities should have naloxone to reverse opioid overdose. Treatment regimens are outlined for opioid detoxification utilizing lofexidine, clonidine or tapering doses of lower potency opioids. Detoxification from tramadol requires enhanced monitoring. Naltrexone may be helpful to prevent relapse after opioid detoxification in motivated individuals.
- Alcohol detoxification would normally feature blood tests and oral thiamine prior to detoxification, prescribing regimens featuring long-acting benzodiazepines (e.g. chlordiazepoxide or diazepam), careful monitoring and management of potential adverse effects, including seizures. Acamposate, disulfiram or naltrexone can be offered to reduce relapse in motivated patients after detoxification.
- Sedative-hypnotic withdrawal regimes are outlined featuring taper regimens with long-acting benzodiazepine and monitoring for potential adverse effects.
- Pharmacological treatment for stimulants and cannabis (if indicated) should focus on management of symptoms.

If controlled medication is prescribed, arrangements for supervised consumption by a professional may be required. Safe and effective delivery of pharmacological interventions requires robust clinical governance controls, including medicines management, clinical audit, and appropriately qualified and competent staff.

9. Recovery management interventions

Recovery-orientated treatment is advocated for people with medium to severe SUD at risk of repeated relapse. This involves a long-term approach, working with an individual to help them both gain control over their substance use (including SUD treatment) and build recovery capital, well-being, and re-integration into society. This may include help to improve housing, employment, mental or physical health, and other domains. Specific recovery management
Interventions SUD services can provide include: facilitated access to mutual aid or peer support; helping people foster recovery-orientated social support networks; discharge planning and aftercare support and relapse management; and recovery management check-ups.

10. Health considerations
People with SUDs often have comorbid physical and mental health difficulties that require interventions. In principle, people with SUD should be offered voluntary screening or assessment for commonly occurring comorbid health problems and offered treatment for those health issues. Depending on individual need this may include: blood-borne viruses and other infections; TB; liver disease; nutritional issues; sexually transmitted diseases; and a range of mental health issues. Mental health problems can co-occur either as a difficulty that led to the substance use or because of the substance use. The accurate assessment of psychiatric symptoms and mental health needs among clients with SUD is essential to distinguish independent psychiatric disorders from substance-induced disorders that will resolve with abstinence. Following identification of need, people with SUD should have the same access to medical treatment for physical and mental health issues as any other patients.

11. Population groups
In principle, all population groups in need of treatment for SUD should have equality of access to SUD treatment. Some groups may require reasonable adjustments to be made by service providers to ensure access and delivery of evidence-based treatment interventions. Service providers will also need to ensure that: protocols and policies underpin population-group adjustments; staff are trained and are culturally competent to meet the different and diverse needs of their target populations; and that discrimination by patients, clients, and staff is challenged and good relationships are promoted between population groups.

11.1 Women and pregnant women who use substances are more likely to face stigma, shame and increased barriers to SUD treatment, especially those with dependent children. Adjustments should include: access to childcare; women-focused screening, assessment and treatment planning; women-only treatment settings and women-focused programmes; and sexual and reproductive health services. Pregnant women require a dyad approach tailored to the needs of the women and her unborn child. For women with mild SUD, a brief SUD intervention may be appropriate; for those with moderate to severe SUD, special considerations may include: prescribing SUD medication; baby delivery; postnatal treatment; and breastfeeding protocols. Staff working with women and pregnant women will require competence and a non-judgmental, supportive approach.

11.2 Children and young people (CYP) are affected by substances either as users themselves or are exploited into criminal networks to traffic and distribute drugs. Children living on the streets or those growing up in areas of conflict are particularly vulnerable and often exposed to substance use. Polysubstance use is common amongst young people, especially amongst student populations. Neonates may be exposed to substances in utero and the management of neonatal abstinence syndrome includes support measures or non-pharmacological interventions followed by medication treatment. SUD should be regarded as critical paediatric illnesses, as early onset often leads to more severe forms of SUD and greater risk to health. Adolescents can benefit from interventions for substance use even if they are not dependent on any specific substance. CYP requiring SUD treatment should receive treatment separate from adults and psychosocial and prescribing interventions should be tailored to age and development stage. SUD service providers also have duties to protect CYP, as minors, from abuse and harm. Families may often be involved in accessing support for their children, and services will need to ensure consent and assent are considered.
11.3 People who use substances and are involved in the criminal justice system, including those in prison, are entitled to the same parity of access and quality of SUD treatment as other patients. NDLEA counselling services have a vital role to play; partnership arrangements and referral pathways should exist between the criminal justice system and SUD treatment providers.

12. Clinical governance

All SUD treatment providers should ensure the safety, quality and effectiveness of their services, implementing good clinical governance or a systematic approach to monitoring, and continuously improving quality and safety. Nigeria has standards for SUD treatment that should be adhered to, including those for NDLEA counselling centres, model treatment centres, draft *Essential Standards* (2019), and the *National policy for controlled medicines and implementation strategies* (FMOH 2017). Core elements of clinical governance required in SUD treatment services include: patient records and information governance systems; ensuring staff are competent, have the skills, knowledge and experience necessary for their roles and are properly managed and supervised. Patient or client involvement in both treatment and quality assurance is also recommended.
1. INTRODUCTION

SUMMARY

This document provides national evidence-based guidelines for the treatment of substance use disorder (SUD) for Nigeria. It is based on the International Standards for the Treatment of Drug Use Disorders (2016) and other international evidence-based guidelines.

SUD is a global health problem that causes significant burdens for the individuals affected, their families and communities. In Nigeria, there is evidence that drug use and drug use disorders are increasing, especially opioid use disorders involving opioid medication. Both the country and its population are negatively impacted by SUD. SUD is now understood to be a complex, multifactorial health problem with psychosocial, environmental and biological determinants. Treatment for SUD has been shown to be effective and cost-effective; however, globally, only one person out of six who need treatment for SUD receives it and only one out of 18 in Africa. This document aims to enable all those responsible for the planning, funding and delivery of SUD treatment in Nigeria to work in partnership to maximize resources and improve the coverage and quality of SUD treatment.

1.1 Substance use disorder guidelines for Nigeria

1.1.1 This document provides evidence-based guidelines for the treatment of substance use disorder (SUD), including drug and alcohol use disorders, in Nigeria. The United Nations Office on Drugs and Crime (UNODC), working in partnership with a group of Nigerian experts in SUD, developed this report. These guidelines aim to support Nigerian efforts to increase the coverage and quality of effective, evidence-based and ethical treatment for SUD. These guidelines are based on the International Standards for the Treatment of Drug Use Disorders (2016), which will be referred to throughout this document as the International Standards, and other international evidence-based guidelines on treatment for alcohol use disorders that have been reviewed and culturally adapted for Nigeria.¹

1.1.2 Drug and alcohol use disorders are major global health problems that pose significant burdens for individuals affected, their families, communities and countries. There is international agreement that drug and alcohol dependence is a complex multifactorial biological and behavioural disorder.² However, there is unequivocal scientific evidence that treatment of SUD can be cost effective and help people with these disorders either reduce or stop drug and alcohol use altogether, and achieve a range of recovery outcomes.³

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1.1.3 The target audience for the National Guidelines for the Treatment of Substance Use Disorders for Nigeria is stakeholders involved in the planning and delivery of treatment for SUD. The guidelines are also relevant to those affected by SUD and those involved in policy development, funding and monitoring of treatment for SUD in Nigeria.

1.2 Background

1.2.1 In 2013, UNODC Country Office Nigeria implemented a European Union-funded project titled Response to Drugs and Related Organized Crime in Nigeria. The following year, the Federal Ministry of Health (FMOH) and UNODC nominated 11 centres delivering drug treatment to be model drug dependence treatment centres in Nigeria. In March 2015, an assessment of service availability and standards was carried out among stakeholders implementing drug, prevention, treatment and care (DPTC) services in the country. The main DPTC stakeholders in Nigeria were: FMOH; National Drug Law Enforcement Agency (NDLEA); civil society organizations (CSOs); and the prison sector. This assessment found that standardized, nationally accepted and approved guidelines, manuals, and minimum standards of drug prevention, treatment and care were not available across different sectors in Nigeria (except, to some extent, in CSOs). Service practices tended to differ across sectors. While several centres had highly qualified staff, service practices varied in treatment interventions, as did staff qualifications and skills. In order to bridge this gap, UNODC collaborated with various stakeholders in the country and international experts to develop the National Minimum Standards for Drug Dependence Treatment in Nigeria, which the government of Nigeria adopted in 2018. In addition, UNODC was requested to support the development of the guidelines laid out in this document.

1.2.2 In March 2016, UNODC and the World Health Organization (WHO) launched the International Standards at the United Nations Special Assembly Session on Drugs (UNGASS) in New York. Key aims of the International Standards are to increase coverage and quality of treatment for drug use disorders globally. Resolution 59/4 of the Commission on Narcotic Drugs called for the promotion and dissemination of the International Standards and urged UNODC to support a systematic process of national adaptation and adoption of the standards, providing guidance, assistance and training to health professionals on their use, and developing standards and accreditation for services at the domestic level in accordance with national legislation. The International Standards were field tested in a range of countries in 2017 and 2018 and an allied quality assurance mechanism was developed and piloted. In 2019, WHO and UNODC will publish final versions of the International Standards and the quality assurance mechanism.

1.2.3 The International Standards summarize the available scientific evidence on effective treatment for drug use disorders and set out a framework for their implementation consistent with principles of public healthcare. The International Standards identify major components and features of effective systems of treatment of drug use disorders, with descriptions of scientific evidence-based treatment interventions to match people's needs at different stages and severities of drug (or substance) disorder, in a manner consistent with the treatment of any chronic disease. The International Standards are aspirational and represent best evidence-based ethical practices. WHO and UNODC do not expect countries to be able to meet all aspirations in the International Standards. However, countries are expected to, over time, improve the quality of SUD treatment. Evidence-based, cost-effective and ethical treatment is expected, no matter what level of resources is available.

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A multi-stakeholder expert group was established in 2018 to work with UNODC and international experts to develop the *Nigerian Guidelines for the Treatment of Substance Use Disorders* (2019). The expert group recommended that Nigerian guidelines should also include alcohol use disorders. The International Standards and other international guidelines have been adapted to reflect the unique systems, culture, legal and statutory frameworks, and patterns of SUD in Nigeria. This tailoring of international guidelines to the Nigerian context was undertaken to maximize the likelihood of applicability and implementation of the guidelines.

### 1.3 Substance use and substance use disorders in Nigeria

#### 1.3.1 Global trends in substance use

Drug use is increasing, with a wider range of substances becoming available. Data from the recent UNODC *World Drug Report 2018* estimate that 5.6 per cent of the global population aged 15 to 64 years used drugs at least once during 2016, with 31 million people requiring some level of support for drug use disorders. Drug use disorders are a significant contributor to premature mortality. According to WHO data, approximately 450,000 people died due to drug use in 2015 (including overdose and other risk behaviours associated with use, such as transmission of blood-borne viruses through unsafe injecting practices). An estimated 10.6 million people (around 0.22 per cent of the global population aged 15–64 years) injected drugs in 2016. Furthermore, the estimated prevalence of HIV among people who inject drugs (PWID) was 11.8 per cent, suggesting that 1.3 million PWID were living with HIV.

In addition, of the total of 1.7 million new hepatitis C virus (HCV) infections worldwide in 2015, 23 per cent (or 390,000 people) were attributable to injecting drug use. Rates of drug-related death (particularly related to pharmaceutical opioids) are also increasing globally (especially in North America).

With respect to alcohol use, the WHO *Global status report on alcohol and health* reported total alcohol consumption per capita of the global population over 15 years of age rose from 5.5 litres of pure alcohol in 2005 to 6.4 litres in 2010 and stayed at that level in 2016. In 2016, the harmful use of alcohol resulted in some three million deaths worldwide (5.3 per cent of all deaths) and 132.6 million disability-adjusted life years (DALYs) – i.e. 5.1 per cent of all DALYs in that year. Mortality resulting from alcohol consumption is higher than from diseases such as tuberculosis, HIV/AIDS and diabetes. Among men in 2016, an estimated 2.3 million deaths and 106.5 million DALYs were attributable to the consumption of alcohol. For women, 700,000 deaths and 26.1 million DALYs were attributable to alcohol consumption.

SUD is a serious health issue and a significant burden for the individuals affected and their families. There are also significant costs to countries, including low productivity, crime, increased healthcare costs and myriad negative social consequences. Data from the UNODC *World Drug Report 2016* estimate that the social cost of illicit drug use is up to 1.7 per cent of GDP in some countries.

#### 1.3.2 Substance use in Nigeria

##### a) Prevalence of drug use in Africa

Data from the UNODC *World Drug Report 2018* estimate that the annual prevalence of drug use in West and Central Africa during 2016 was 13.2 per cent for cannabis and 0.69 per cent for cocaine.

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6 Members from the multi-stakeholder expert group given in Appendix 1.


b) Nigerian national surveys of drug use

i) The National Drug Use Survey (2019) was the first large-scale, nation-wide survey of drug use in Nigeria. Key findings were:

- 14.4 per cent (around 14.3 million people) aged between 15 and 64 had used an illicit drug (excluding alcohol and tobacco) in the previous year. This was relatively high compared to the global annual prevalence of around 5.6 per cent of adults.

- The most commonly used drugs in the previous year were:
  - Cannabis: 10.6 million people (10.8 per cent).
  - Illicit prescription opioids: 4.6 million (4.6 per cent), of which 2.4 per cent had used opioid cough medicine.
  - Tranquillizers: 481,000 (0.5 per cent).
  - Amphetamines: 238,000 (0.2 per cent), of which 89,000 had used methamphetamines.
  - Cocaine: 92,000 (0.1 per cent).
  - Heroin: 87,000 (0.1 per cent), with around half smoking heroin.

- An estimated 376,000 of the people who use drugs (PWUD) were high risk – defined as those who had used opioids, crack/cocaine, or amphetamines at least five times in the previous 30 days. Of those who were high risk, around 20 per cent (80,000) had injected.

ii) Drug use was found to be higher in the southern geopolitical zones (13.8–22.4 per cent) compared to the northern geopolitical zones (10–14.9 per cent). In terms of demographics, around three quarters of PWUD were men and drug use was more common amongst those aged 25 to 39 years and lowest amongst those under 24 years.

iii) In relation to drug-related harm, the self-reported prevalence of blood-borne viruses amongst PWID were: hepatitis C (men 3.1 per cent, women 3.9 per cent), hepatitis B (men 8 per cent, women 7.4 per cent), HIV (men 9.1 per cent, women 9.8 per cent). However, it is highly likely these self-reported figures underrepresent actual prevalence. Furthermore, of those who injected drugs, almost half reported sharing injecting equipment in the previous six months, with women more likely to report sharing than men. Amongst the general population who had never used drugs, one person in eight aged 15 to 64 reported negative consequences as a result of another person’s drug use.

Table 1. NSDUH 2019 Summary of results

<table>
<thead>
<tr>
<th>National Survey on Drug Use and Health Among 15–64 year olds (2017)</th>
<th>%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual drug use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All drug use</td>
<td>14.2%</td>
<td>14 million</td>
</tr>
<tr>
<td>Cannabis use</td>
<td>10.6%</td>
<td>10.5 million</td>
</tr>
<tr>
<td>Opioid use (mainly prescription)</td>
<td>4.5%</td>
<td>4.5 million</td>
</tr>
<tr>
<td>· Opioid cough syrup</td>
<td>2.4 %</td>
<td>2.4 million</td>
</tr>
<tr>
<td>Injecting drug users</td>
<td>0.08%</td>
<td>79,000</td>
</tr>
<tr>
<td><strong>Annual regular drug use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All drugs</td>
<td>0.4%</td>
<td>376,000</td>
</tr>
<tr>
<td>· Regular opioid drug use</td>
<td>Almost 0.2%</td>
<td></td>
</tr>
</tbody>
</table>

**Note:**

95% of regular drug users reported using on average 4 drugs
66% of regular drug users reported an urgent need for DUD treatment
40% wanted treatment but could not participate. Cost and fear of stigma were major barriers to treatment access in Nigeria.

iv) An estimated 20 per cent of PWUD were thought to have a drug use disorder. This included one third of those who had used cannabis and 20 per cent of those who had misused pharmaceutical opioids. From a public health perspective, higher scores on dependency scales indicate a greater likelihood a PWUD would require structured interventions for their drug use disorder. More than 80 per cent (around 300,000) of those with high-risk drug use were thought to require a structured treatment intervention.

c) Alcohol use in Nigeria

The National Drug Use Survey (2019) found that overall, almost a quarter of the adult population had consumed an alcoholic drink in their lifetime. In the past year, 25 per cent of men and 13 per cent of women reported having drunk alcohol. Of these, more than 40 per cent reported drinking occasionally. However, of people who had drunk alcohol in the past year, a third of men and 15 per cent of women reported daily or almost daily use of alcohol. On average, men reported binge drinking on three occasions in the past year and women on two occasions. The use of alcohol and tobacco was much higher amongst those who used drugs, indicating a polysubstance using culture amongst this group.

In Nigeria, an average of 23.1 litres of pure alcohol is consumed annually, and 50.1 g of pure alcohol is consumed daily by drinkers aged 15 and above. Alcohol consumption trends from 1961 to 2010 are given in Figure 1. Alcohol use is a high risk factor for burden of disease and the greatest risk factor for road traffic accidents in Nigeria. Most alcohol-related disease occurs among young people aged 15 to 29 and most often involves liver cirrhosis, injuries from motor accidents and assaults.

Figure 1: Recorded alcohol per capita for Nigeria 1961–2010
Data refer to litres of pure alcohol per capita (15+)

<table>
<thead>
<tr>
<th>Year</th>
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<th>Wine</th>
<th>Spirits</th>
<th>Other</th>
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<td>2010</td>
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</table>


d) Cannabis use amongst offender and student populations

Nigerian studies focused on offender populations and student cohorts have yielded data regarding prevalence. Offenders who had committed armed robbery in Benin-City reported high rates of cannabis use (45 per cent) when compared to non-armed robbers (0.9 per cent).

In Abeokuta prison, the prevalence of cannabis use was 7 per cent of the population and the lifetime prevalence rate was 33.9 per cent. Most respondents were young adult males.  

**e) Emerging drug trends**

Like most countries globally, Nigeria is facing changes in drug use trends. Across the world, drugs have been primarily plant-derived substances – such as cocaine, heroin and cannabis – and consumed where they were grown or along trade routes on their destination. Increased international and Internet trade and travel have globalized drug markets of plant-based substances and newer synthetic psychoactive substances (NPS), including stimulants, have become more widely available. The non-medical use of pharmaceutical and illicit prescription drugs such as opioid pain medicines and sedative hypnotics has increased in the last 10 years, together with a dramatic global increase in opioid overdose deaths. As indicated in the **National Drug Use Survey** (2019), there is evidence of a dramatic increase in the use of opioid medication and opioid cough syrup Nigeria. Anecdotal evidence indicates codeine cough syrup mixed with soft drinks to make a concoction referred to in popular culture as “Lean”, which is now widespread amongst young people in the United States and there are reports of its use in parts of Nigeria.

**f) Blood-borne viruses and drug use**

There is no recent data on the prevalence of blood-borne viruses (including HIV) in Nigeria. Data from a 2006 study estimated PWIDs account for 9 per cent of new HIV infections and that HIV prevalence amongst PWID was 4.2 per cent compared to 3.2 per cent in the general population, varying across states from 3 per cent to 9.3 per cent. Prevalence of HIV infection in females was thought to be about seven times higher than in men. Non-injecting women who used drugs and were also engaged in commercial sex work in Lagos had a recorded HIV prevalence rate of 43 per cent.

**1.3.3 Drug trafficking and production within Nigeria**

Drug use trends have been linked to drug production and trafficking in Nigeria. Cannabis is the most common illicit drug produced in Nigeria and the country has also become a manufacturer of methamphetamine (and major importer of ephedrine). Nigerian methamphetamine is produced in large quantities mostly in Lagos and increasingly in Anambra state, where drug trafficking organizations have relocated laboratories. Drug traffickers sell cannabis in Nigeria and export it through West Africa into Europe. Nigeria is also a transit country for heroin and cocaine destined for Europe, and, to a lesser degree, the United States. The Nigerian Drug Law Enforcement Agency (NDLEA) reports frequent arrests of drug couriers at Murtala Mohammed International Airport (MMIA) in Lagos. Traffickers also use the country’s seaports and land borders to avoid detection.

Table 2 shows data obtained from an NDLEA report in 2014 relating to drug seizures and arrests at seaports, airports and land borders. In 2014, 4,529.15 hectares of cannabis farmland containing 53,719,342.32 kg of cannabis plants were also destroyed, according to the NDLEA.

**1.3.4 Data from SUD treatment providers in Nigeria**

Nigeria has data from drug use disorder (DUD) treatment providers. The National Epidemiological Network on Drug Use (NENDU) was established in 2015. Data are collected from 18 drug treatment facilities, including: 10 national hospitals (one national, six neuro-psychiatric and three teaching), one non-governmental hospital and seven NDLEA counselling centres.

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Data from the 2016 NENDU report showed 990 treatment episodes were provided in Nigeria.\(^2^0\) Data from January to December 2017 show that 12 drug treatment facilities provided 1,085 treatment episodes.\(^2^1\) Cannabis (48 per cent) was the substance most frequently used by those entering treatment, followed by opioids (34 per cent) and alcohol (11 per cent). The use of other drugs was less common: cocaine (3 per cent); crack cocaine (1 per cent); and sedatives-hypnotics (3 per cent). Most opioid use was pharmaceutical opioids such as tramadol (68 per cent of opioid use), codeine (21 per cent), and pentazocine (17 per cent). A small proportion (3 per cent of all patients) injected drugs. There were a variety of patterns of drug use across the different reporting centres, reflecting regional variations in trends. Of those in treatment, 59 per cent were inpatients. Among the 1,085 patients, 95 per cent were

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\(^{20}\) Nigerian Epidemiological Network on Drug Use (NENDU), Drug treatment information system in Nigeria: data analysis of 2015 data, Dominique Lopez, 2015, UNODC.

\(^{21}\) Nigerian Epidemiological Network on Drug Use (NENDU), Drug treatment information system in Nigeria: data analysis of 2017 data, UNODC.
male. The median age was 28 years old. Almost all reported living in stable accommodation (98 per cent). Regarding education attainment, 24 per cent and 22 per cent, respectively, had completed secondary and tertiary education. Almost half (44 per cent) were unemployed, 25 per cent had regular employment and 23 per cent were students. In 94 per cent of cases, family or friends were paying the cost of drug treatment.

1.3.5 Substance use disorders: complex multifactorial health problems

Most people who use substances once or even occasionally experience no harm (even though there may be risk of harm). Some may suffer an acute reaction or severe intoxication that can cause harm. Regular or dependent substance use is associated with increased harm. The International Standards state that approximately 10 per cent of individuals who use drugs will, over time, develop changes in their behaviour and other symptoms that constitute a SUD, either harmful substance use or substance dependence in the International Classification of Diseases 10th Revision ICD-10. Science now shows that SUDs are complex multifactorial health issues. At its most severe, substance dependence is a strong and overpowering desire to take a substance resulting in an inability to control the consumption. Over time, substance use takes on a much higher priority than other activities that once had greater value. Individuals with substance dependence deprioritize their family, friends, education, work and recreation to use substances despite being aware of the harm resulting from their use. The desire to take the substance can persist, or easily be reactivated, even after a person has achieved a prolonged period of abstinence.

SUD is now understood to be a complex, multifactorial health problem with psychosocial, environmental and biological determinants. Substance dependence is not a self-acquired bad habit but rather a result of a series of biological and environmental factors, disadvantages and adversities, which can be prevented and treated. Dependence on substances includes disruption of neuronal pathways in brain areas that regulate motivation and mood, experience of pleasure and well-being, memory and learning, and the ability to suppress unwanted impulses. Some people experience risk factors recognized to be important in the onset and continuation of SUD (and mental health problems). These may include: early childhood neglect or abuse; trauma; genetic predisposition; lack of family support or impaired parenting; lack of emotional support; household dysfunction; and social exclusion and isolation. In some communities, these risks are compounded by exposure to extreme poverty, degraded neighbourhoods, homelessness, displacement, exploitation, violence, hunger and poor working conditions.

In addition, individuals with SUD are likely to develop other medical or psychiatric problems. Those who inject drugs are likely to be exposed to blood-borne infections (including HIV and the hepatitis C virus) and tuberculosis. Individuals with moderate to severe SUD have an elevated risk of cardiovascular, liver problems and cancer. They are also more prone to traffic and other accidents, frequently experience violence, and have a much lower life expectancy. For example, the mortality rate of people with alcohol or opioid dependence is significantly higher than in the general population and death at a young age occurs more often. The World Drug Report indicates that hepatitis C, HIV/AIDS, overdose, suicide and unintentional injuries (accidents and violence), and cardiovascular diseases are the most frequent causes of death due to drug use. The relationship between psychiatrics and SUD is very complex. Often a separate psychiatric disorder exists prior to the onset of substance use, putting affected individuals at greater risk of developing drug use disorders. Psychiatric disorders may also develop secondary to the SUD, due in part to biological changes in the brain resulting from chronic use. The risk of developing SUD

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and psychiatric complications is particularly high in children and young adults who are exposed to the effects of substance before their brains fully mature in the mid-20s.

1.4 Treatment for drug and alcohol use disorders

1.4.1 According to the *International Standards*, good quality treatment for SUD has been scientifically proven to be effective and cost effective. It can significantly improve the lives of those affected by SUD as well as their families and communities, and investment in SUD treatment can increase productivity and reduce what countries must spend on criminal justice, health and social welfare programmes. However, out-dated views about SUD persist in many parts of the world. Individuals with SUD and the professionals working with them often face stigma and discrimination; this has significantly compromised the implementation of quality treatment.

1.4.2 The *World Drug Report* indicated that, globally, only one out of six people in need of drug dependence treatment has access to treatment programmes: only one out of 11 in Latin America and one out of 18 in Africa. SUD treatment in many countries is only available in large cities and not in rural areas. Unfortunately, in many places, available treatment is not effective, not based on scientific evidence, and sometimes not in line with human rights principles.

1.4.3 The *National Drug Use Survey (2019)* indicated:

- An estimated 20 per cent of PWUD were thought to have a drug use disorder. This included one third of those who had used cannabis and 20 per cent of those who had misused pharmaceutical opioids. From a public health perspective, higher scores on dependency scales indicate a greater likelihood a PWUD would require structured interventions for their drug use disorder. More than 80 per cent (around 300,000) of those with high-risk drug use were thought to require a structured treatment intervention.
- Around one person in six (12 per cent) with high-risk drug use had ever received drug treatment, with only 4 per cent receiving drug treatment in the last year. However, when asked whether they needed drug treatment, around 37 per cent of those with high-risk drug use said they had an urgent need for treatment; 43 per cent reported some need for treatment and 20 per cent reported no need for treatment.
- Significant barriers to accessing drug treatment included: cost of treatment (62 per cent); fear of stigma (50 per cent); lack of availability of treatment services (38 per cent); and lack of information about local treatment services (38 per cent).

1.4.4 Authors of the *National Drug Use Survey (2019)* concluded that a major gap exists between need and the availability and accessibility of drug treatment services in Nigeria. To bridge this gap, the report recommends: making available affordable, evidence-based DUD treatment; scaling up comprehensive packages of prevention and treatment of HIV/AIDS for PWUD in communities and prisons; addressing stigma associated with drug use; and ensuring access to pain medication for medical purposes for those who need it, while simultaneously preventing diversion and misuse.

1.4.5 This document aims to enable those responsible for the planning, funding and delivery of SUD treatment in Nigeria to work in partnership, maximize resources to ensure evidence-based SUD treatment systems and services, and improve the coverage and quality of SUD treatment. This document is in line with the *National Minimum Standards for Drug Dependence Treatment in Nigeria* and the standard policy and practice guidelines for counsellors working with NDLEA that are currently being used in Nigeria.

### 2. INTERNATIONALLY AGREED PRINCIPLES OF SUBSTANCE USE DISORDER TREATMENT

#### SUMMARY

All 192 UN Member States (including Nigeria) signed on to the *International Standards*, which outlines principles that should be applied by a country or service provider to ensure safe and effective care (regardless of treatment philosophy or setting). Individuals with SUD deserve “nothing less” than ethical and science-based standards of care similar to those for the treatment of other chronic diseases.

SUDs can be effectively treated using a range of evidence-based pharmacological and psychosocial interventions. Interventions not based on scientific evidence may be ineffective or even harmful and should not be funded. Treatment for SUD should adhere to healthcare standards, be consistent with *Universal Declaration of Human Rights* and existing UN conventions, and promote personal autonomy and individual and societal safety.

Treatment interventions for SUD can have a range of goals, including: prevention of harms associated with SUD; cessation or reduction of substance use and cravings; reduction in risk of relapse; or improvements in health, well-being and social functioning of individuals with SUD.

Principles from the *International Standards* are outlined in the table below. These principles are aspirational but have also been adopted as appropriate principles for SUD treatment in Nigeria. In 2015, officials developed the *National Minimum Standards for Drug Dependence Treatment in Nigeria*, based on WHO/UNODC principles.\(^\text{26}\)

<table>
<thead>
<tr>
<th>PRINCIPLE 1</th>
<th>PRINCIPLE 2</th>
<th>PRINCIPLE 3</th>
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<tbody>
<tr>
<td>Available, accessible, attractive and appropriate SUD treatment</td>
<td>Ethical standards of SUD treatment and care</td>
<td>Effective coordination between health, criminal justice and social services</td>
</tr>
</tbody>
</table>

SUD can be treated effectively in most people if they have access to a range of services to meet their needs.

SUD treatment must match the specific requirements of individuals with all types of SUD, whether they require outreach to reduce health and social harms, outpatient or inpatient treatment.

SUD services should be affordable, attractive, available in both urban and rural settings, and accessible with a wide range of opening hours and a minimal wait times.

SUD treatment should be based on universal ethical healthcare standards including the respect for human rights and patient dignity. People with SUD have the right to the highest attainable health and well-being and good quality treatment that is non-discriminatory and non-stigmatizing.

Treatment decisions, including the kind of treatment and when to start and stop treatment, should be made by the individual with SUD (to the extent that they have capacity to do so).

SUD should be considered primarily as a health problem rather than criminal behaviours. As a general rule, people with SUD should be treated in healthcare systems rather than in criminal justice systems.

Even though individuals with SUD may commit crimes, these are typically low-level crimes and this behaviour usually stops with the effective treatment of SUD. The criminal justice system should collaborate closely with the healthcare and social systems to encourage treatment for SUD in the healthcare system over criminal prosecution or imprisonment.

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### PRINCIPLE 1
Available, accessible, attractive and appropriate SUD treatment

Barriers that limit the accessibility of treatment should be minimized. Treatment environments should be friendly, culturally sensitive and encourage rather than deter people from attending.

Individuals should be also offered access to treatment for other health issues, social support and protection.

The legal framework of the country should not discourage people with SUD from attending treatment.

### PRINCIPLE 2
Ethical standards of SUD treatment and care

Treatment should not be forced or be against the will and autonomy of the patient and consent should be obtained before any treatment is given. Punitive, humiliating or degrading interventions should never be used.

The individual with SUD should be recognized as a person suffering with a health problem and as deserving of treatment as patients with other psychiatric or medical problems.

Patients should have accurate and up-to-date medical records and the confidentiality of records should be guaranteed. Registration of patients entering treatment outside health records should not be permitted.

### PRINCIPLE 3
Effective coordination between health, criminal justice and social services

Law enforcement, court and prison system staff should be appropriately trained to effectively engage and support SUD treatment and rehabilitation.

Treatment should be offered to people with SUD in prison and after their release as effective SUD treatment will decrease the risk of relapse and reoffending. It is of vital importance to assure continuity of care, relapse prevention and overdose prevention after release.

In all criminal justice settings, people should be provided with treatment of an equal standard to that offered in the community.

### PRINCIPLE 4
Scientific evidence-based SUD treatment that responds to the needs of individuals

Scientific knowledge should guide funding and delivery of SUD treatment. As a general rule, only treatment interventions that have been demonstrated to be effective by science or agreed upon by the international body of experts should be provided. Where there is reason to believe that other treatment interventions may be useful, they should be provided in the context of clinical trials.

Subgroups of individuals affected by SUD should be given special consideration and (if required) specialized, tailored care in every treatment setting.

Individuals from groups with specific needs may include, but are not limited to:
- Children and young people (CYP)
- The elderly
- Women and pregnant women
- People who inject drugs
- Individuals involved in sex work
- Sexual gender-orientation groups
- Different ethnicity and race groups
- Faith and religious groups
- Those in criminal justice systems
- Internally displaced or homeless
- Health workers with SUD

### PRINCIPLE 5
Respond to the needs of specific populations with SUD

Good quality and efficient treatment services for SUD should have accountable and effective methods of clinical governance.

A treatment programme, policies, procedures and coordination mechanisms should be defined in advance and made clear to all therapeutic, administrative and management staff, and patients.

### PRINCIPLE 6
Ensure good clinical governance in SUD treatment

SUD is a complex and multifaceted health problem; therefore, comprehensive SUD treatment systems should be developed to facilitate effective treatment of SUD and associated health and social problems.
<table>
<thead>
<tr>
<th>PRINCIPLE 4</th>
<th>PRINCIPLE 5</th>
<th>PRINCIPLE 6</th>
<th>PRINCIPLE 7</th>
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<tbody>
<tr>
<td>Scientific evidence-based SUD treatment that responds to the needs of individuals</td>
<td>Respond to the needs of specific populations with SUD</td>
<td>Ensure good clinical governance in SUD treatment</td>
<td>An integrated approach to SUD treatment</td>
</tr>
</tbody>
</table>

The duration and intensity (or dose) of treatment should be in line with evidence-based guidelines. Multidisciplinary teams should integrate different interventions tailored to each patient. Severe SUD is similar in course and prognosis to other chronic diseases such as diabetes, HIV, cancer, or hypertension. Thus, treatment for severe SUD should be based on a chronic care model (as opposed to short-term acute care) as long-term treatment is more likely to enable long and healthy lives.

Interventions should be adapted to the cultural and financial situation of the country without undermining the core elements identified by science as crucial for effective outcomes. Traditional treatment interventions unique to a particular country or setting may have limited evidence of their effectiveness beyond patients or clinician experience. Such treatment should learn from and adopt evidence-based interventions, and efforts should be made to formally evaluate whether traditional treatments are effective and carry acceptable risks.

Working with people from special groups requires individual treatment planning that considers their unique needs and vulnerabilities. Individuals with SUD often face stigma and discrimination, which may be increased for individuals from specific population groups.

CYP should be treated in age- and gender-appropriate facilities, not in the same setting as adults with SUD. CYP SUD services should be able to encompass broader health, learning, and social welfare issues faced by CYP, in collaboration with families, schools and social services.

Women in SUD treatment should have access to special adjustments such as women-focused treatment in a safe, single-sex settings. Women with SUD are more vulnerable to domestic violence and sexual abuse and may require additional safeguards. Their children may be at greater risk of harm, neglect or abuse, so liaison with agencies protecting women and children is helpful. Treatment programmes for all parents with SUD should recognize the paramount needs of their children and be able to accommodate children's needs and support good parenting and childcare practices. Patients may also require sexual health and contraception.

Service organization should reflect current research evidence and be responsive to its patients' needs. Treating people with SUD (who often have multiple psychiatric, physical health and social needs) may be challenging, both for individual staff and organizations. Staff attrition in this field is recognized and organizations should have in place a variety of measures to support their staff and encourage the provision of good quality services.

Where possible, a SUD treatment system should coordinate with mental healthcare, social care and other services (housing and training, employment, legal assistance), and other specialist healthcare (such as services for HIV, HCV, TB and other infections). SUD treatment systems must be constantly monitored, evaluated and adapted. This requires multidisciplinary planning and implementation of services in a logical, step-by-step sequence that ensures the strength of links between policy, needs assessment, planning of treatment systems, implementation of services, monitoring of services, evaluation of outcomes, and quality improvement.
3. DEVELOPING AN EFFECTIVE SYSTEM FOR THE TREATMENT OF SUD IN NIGERIA

SUMMARY

SUD is a complex, multi-factorial health disorder that can be effectively treated. SUD treatment can be cost-effective and the International Standards recommends that countries establish effective, coordinated systems to deliver evidence-based interventions in multiple settings to meet the needs of their population with different severities of SUD.

A recovery-orientated approach is advised for people with moderate to severe SUD, similar to the management of other long-term chronic health issues.

Core SUD treatment modalities for Nigeria include: outreach to reduce the health and social harms and consequences of SUD; screening and brief intervention; psychosocial interventions; prescriptions or pharmacological interventions; and recovery management. Wider healthcare, social care and criminal justice systems, community agencies, peer advocates, and mutual aid groups should also play a part in the treatment and recovery of those with SUD.

Those planning and funding SUD are advised to develop the SUD treatment system in Nigeria in line with ‘the International Standards’ and increase the quality, capacity and effectiveness of services and the system.

3.1 What is an effective system for the treatment of SUD?

An effective national system for the treatment of SUD requires the coordinated and integrated response of many stakeholders to deliver services and interventions based on scientific evidence in multiple settings for different stages and severities of SUD. Public health systems are normally best placed to lead the provision of effective SUD treatment, often in close coordination with social care, criminal justice and other services. SUD treatment should be: available; accessible; affordable to patients (free or within the financial means of all); and affordable for the system to be sustainable. It should also follow evidence-based guidelines and meets the diverse needs of all people, regardless of the severity or stage of their SUD.

3.2 SUD treatment is cost effective

Evidence-based treatment of SUD is cost-effective from a public health perspective, making it a good investment. The cost to countries to treat SUD is lower than the cost of untreated SUD. Countries that invest in SUD treatment must spend less on the consequences of drug-related crime, including criminal justice, law enforcement and healthcare. The ratio of savings to investments for countries ranges widely from three to one all the way to 12 to one.

3.3 Substance use and dependence: spectrum disorder

Most people who use substances once or occasionally experience few adverse effects. However, some may suffer from complications related to adverse reactions, accidents or acute intoxication.

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Regular users risk substance-related harm and dependence. SUD may be thought of as a spectrum disorder, ranging from lower to higher severity of disorder and complexity. People with SUD may move backward and forward along this spectrum during the course of their illness. WHO (2011) and ICD-10 criteria for substance use disorders differentiate between acute intoxication, harmful use and dependence syndrome (Figure 3).²⁹

**Figure 3: WHO categories of substance use**

Those responsible for developing, planning, funding for reviewing local services and systems for SUD treatment are advised to allocate available resources wisely to respond to the range of local population needs. They should develop systems in line with the key public health principle of offering “the least invasive, most effective intervention” to patients first (this is also normally the lowest cost). For example, patients with low and moderate DUD would normally receive outpatient treatment, reserving inpatient or residential treatment for those with a higher severity SUD or complexity. Interventions may be stepped up or stepped down if higher or lower intensity services are then required in a stepped care model (see Figure 4). Public funds should be invested so the volume and type of treatment corresponds to the needs of the local population, with attention to the country’s priority groups.

**Figure 4: Stepped care model**

Higher volume interventions are normally required at levels of lower intensity in community or generic settings (such as screening and brief intervention, and referral for treatment (SBIRT), can be delivered by non-specialist staff, and are less costly.

As is the case in many countries, Nigeria has a larger number of people who use substances, a smaller number of people with SUDs, and, of those, an even smaller number that have severe

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or complex SUD. *NSDUH* (2017) indicated that Nigeria had an estimated 14 million people (14.2 per cent of those aged 15-64) who used drugs and an estimated 376,000 people (0.4 per cent of the population) who used drugs regularly. Implementing low-intensity, effective interventions could divert occasional drug users from developing dependence and identify and refer those with severe disorders for SUD treatment.

UNODC/WHO recommend that SUD treatment be designed as a pyramid (see Figure 5). Outpatient treatment for SUD is generally less disruptive to patients’ lives and less costly than inpatient or residential treatment. Inpatient or residential treatment may be required for those with severe and/or complex SUD and other needs, however outpatient treatment and recovery management support is essential for those leaving inpatient or residential treatment to prevent relapse. Systems where investment is disproportionately in high-intensity, high-cost, low-volume treatment (the top of the pyramid) can lead to limited system capacity and people with moderate-to low-severity SUD being over treated. Where the range in SUD treatment does not match the population needs, resources may be inefficiently distributed and outcomes minimized.

UNODC/WHO stress that people with SUD may have diverse and multiple needs requiring general health and social services. System configuration will vary from country to country, but specialist SUD treatment providers and health and social welfare services are key partners in a wider network of treatment to meet these diverse and multiple needs. In addition, broader partnerships should be formed with criminal justice agencies and community stakeholders such as: civil society/NGOs; employers; organized groups of PWUD providing self-help; educational and research institutions; youth organizations; religious organizations and faith-based organizations and leaders; and neighbourhood associations.30

30 UNODC (2014) Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in Southeast Asia.
Figure 6 shows the Nigerian SUD treatment system organization, adapted for the country from the *International Standards*. However, this diagram is not to scale. The majority of SUD specialist treatment in 2018 was in inpatient or residential settings with relatively little outpatient SUD treatment. Table 3 below provides more detail on the interventions delivered in different settings in the SUD system in Nigeria.

**Table 3. Service levels and interventions in the Nigerian SUD system**

<table>
<thead>
<tr>
<th>SERVICE LEVEL</th>
<th>POSSIBLE INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self care</td>
<td>Those with SUD take responsibility for their substance use, help to educate themselves on harms and risks of use and modify their behaviour to prevent harm to themselves and their community and maximize their health, well-being, efficacy and community integration.</td>
</tr>
<tr>
<td>Informal community care</td>
<td>Informal support through friends and family, self-help groups, outreach interventions to reduce the health and social harms of SUD including overdose prevention, and faith-based and community organization support for those with SUD (in addition to evidence-based SUD treatment).</td>
</tr>
<tr>
<td>Primary healthcare and pharmacies</td>
<td>Primary healthcare for those with SUD, first aid, wound management, SBIRT, vaccination for hepatitis B, needle and syringe programmes (NSP), and management of acute intoxication or overdose.</td>
</tr>
<tr>
<td>Generic social welfare</td>
<td>Shelter and housing, food, social support and access to social services, SBIRT, and referral to specialist SUD and other health treatment.</td>
</tr>
<tr>
<td>Other tertiary healthcare services</td>
<td>Mental health treatment, internal medicine, dental treatment, treatment of blood-borne viruses, HIV and hepatitis treatment (which may include access to NSP and opioid substitution treatment), treatment for infections and infectious diseases such as tuberculosis, sexually transmitted diseases, and emergency services management of acute intoxication or overdose management.</td>
</tr>
<tr>
<td>Specialist SUD social welfare services</td>
<td>Family support and reintegration, vocational training and education programmes, income generation and micro-credits, leisure time planning, and recovery management services for those with SUD.</td>
</tr>
<tr>
<td>Community NGO SUD services</td>
<td>A range of outreach interventions to reduce health and social harms of SUD, peer support, advocacy and help to access SUD treatment, health and social welfare interventions, recovery management interventions, and liaison with SUD and other providers to meet patient’s needs.</td>
</tr>
<tr>
<td>NDLEA</td>
<td>Screening, assessment, SBIRT, psychosocial interventions for those with mild to moderate SUD, family interventions, liaison with SUD and other providers to meet patient’s needs including referral to specialist SUD, or outpatient or inpatient treatment for those with more severe SUD.</td>
</tr>
<tr>
<td>Specialist SUD treatment (outpatient)</td>
<td>Outpatient assessment, treatment planning, case management and coordination, psychosocial interventions, pharmacological treatment (detoxification, medication-assisted treatment, relapse prevention and overdose management), recovery management services, NSP for people who inject drugs, liaison with SUD and other providers to meet patient’s needs.</td>
</tr>
<tr>
<td>Specialist SUD inpatient treatment</td>
<td>Inpatient assessment, treatment planning, case management and coordination, psychosocial interventions, pharmacological treatment (stabilization, detoxification, medication-assisted treatment, relapse prevention and overdose management), management of comorbid mental and physical health issues, liaison with other SUD providers and other services to meet patient’s needs.</td>
</tr>
<tr>
<td>Long-term residential services for SUD</td>
<td>Post-detoxification residential programmes for severe or complex SUD and comorbid issues, housing and a protected environment, vocational and life skills training, ongoing therapeutic support, referral and throughcare to outpatient and recovery management services prior to discharge.</td>
</tr>
</tbody>
</table>
3.4 Recovery-oriented treatment for SUD

For people with moderate to severe SUD, UNODC/WHO recommend a recovery-oriented treatment approach, involving long-term management as opposed to single episode of treatment. This approach is supported by the evidence that substance dependence is best understood and managed as a chronic and relapsing disorder rather than an acute illness, similar to diseases and long-term conditions like hypertension, asthma and diabetes.

Recovery is “a process, which is different for each individual, which has key components of gaining voluntary, sustained control over substance use, whilst maximizing health and well-being and gaining social integration and contributing to society.”31 Recovery-orientated SUD treatment may therefore include both long-term pharmacological and psychosocial interventions to help people overcome substance dependence as well as interventions to help individuals build assets or make improvements in physical and mental health and well-being, social functioning and social re-integration. Although longitudinal studies have repeatedly demonstrated that the treatment of SUD disorders is associated with major reductions in substance use, drug-related problems, and costs to society, post-discharge relapse and re-admission are very common. Globally, the majority of patients admitted to SUD treatment have received treatment before. The risk of relapse appears to decrease only after four to five years of abstinence. However, sustainable recovery is possible and there is evidence that up to 40 per cent of patients with SUD achieve it.32

Recovery-oriented SUD treatment systems should develop an approach similar to long-term management of other chronic health disorders and ensure a network of SUD treatment services and community support. This approach shifts the focus of SUD treatment from 'admit, treat, and discharge' to a sustained health management partnership between services and the patient. In this model, ideally, inpatient or residential rehabilitation should be followed by a step down to community-based or outpatient treatment and recovery support. Similarly, intensive outpatient or community-based SUD treatment should be followed by a step down to a less intensive community-based treatment or recovery management that continues long term. A traditional discharge process should be replaced with post-stabilization monitoring, recovery education, recovery and coaching, active linkage to recovery communities (such as peer support), asset development, and rapid access to SUD treatment when needed. This approach is a radical change from the common practice of repeated brief episodes of SUD treatment and repeated relapse that lacks continuity and is associated with poorer outcomes and increased risk (for example, alcohol or opioid overdose).

UNODC (2008) defines eight domains of recovery capital for areas and interventions to be considered on a continuing basis.33 Interventions to support recovery should include: resolving of legal issues; income generating activities; peer recovery support; vocational training; and others. The International Standards stress that achieving recovery outcomes should be an ultimate goal at every stage of SUD treatment and promoted in all SUD treatment settings.

Individuals will require different services and interventions at different points in their recovery journey, so good referral mechanisms, throughcare and communication between SUD treatment providers are required to ensure continuity of treatment and access to recovery management.

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3.5 The patient or client journeys

It is important to view systems for the treatment of SUDs from the perspective of the client or patient. Each person with SUD has a unique journey through their disorder and associated treatment. For those requiring more than a brief intervention, there are steps on a patient journey that services providers should follow. These are: assessment; treatment plans co-produced with patients or clients; treatment provision of treatment interventions (depending on patient needs) with regular treatment plan reviews; discharge or throughcare planning if a patient is ready to be discharged from treatment or requires referral to another provider; and on-going recovery management. This journey is rarely linear as patients may relapse and require reassessment and readmission.
For those with mild SUD, a brief intervention may result in a conscious change in lifestyle. For those with moderate to severe SUD, their treatment journey may be longer and feature several periods in SUD treatment and recovery support treatment (perhaps in different settings), interspersed with periods of relapse and continued use. For those with the most complex SUD and other related problems such as mental or physical health issues, their journey may be long and complex and involve SUD treatment and recovery support and a range of other agencies including the criminal justice system or organizations providing treatment for HIV/AIDS, mental health, and liver disease. This may require coordination of outreach, treatment and care for the client to gain maximum outcomes from combined interventions.

### 3.6 SUD modalities within a substance use disorder system of treatment for Nigeria

An ideal SUD system, based on the International Standards, consists of core modalities. These are illustrated in Figure 9 and are:

- Outreach interventions to reduce health and social consequences or harms of SUD.
- Screening, brief interventions and referral to specialist SUD treatment (SBIRT) by mainstream services.
- Outpatient or community-based SUD treatment.
- Short-term inpatient or residential SUD treatment.
- Long-term residential rehabilitation.
- Recovery management support.

The five elements of an ideal SUD treatment system adapted for Nigeria are outlined in detail in Table 4.
### Table 4. Core elements of an ideal SUD treatment system in Nigeria

<table>
<thead>
<tr>
<th><strong>Recovery management, self-care, and informal community support</strong></th>
<th><strong>Screening and brief interventions and referral to SUD treatment (SBIRT) and partnership work</strong></th>
<th><strong>Outreach to reduce health and social harms of SUD for people not in SUD treatment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEFINITIONS</strong></td>
<td><strong>DEFINITIONS</strong></td>
<td><strong>DEFINITIONS</strong></td>
</tr>
<tr>
<td>Self-help and informal community support for people with SUD or recovering from SUD.</td>
<td>Screening to identity those with SUD, provision of brief assistance, referral to specialist SUD services by general health, social welfare, education, criminal justice or other services with a higher proportion of people with SUD. This may include partnership work between specialist SUD and mainstream services.</td>
<td>Community street, peripatetic or home-based interventions to reduce the health and social consequences and harms of SUD to engage and provide services to those who are not in SUD treatment because treatment may be unavailable, inaccessible, or unacceptable. Outreach may target people with SUD or those impacted by the SUD of others.</td>
</tr>
<tr>
<td><strong>INTERVENTIONS</strong></td>
<td><strong>INTERVENTIONS</strong></td>
<td><strong>INTERVENTIONS</strong></td>
</tr>
</tbody>
</table>
| - Self-management of SUD.  
- Mutual aid (e.g. 12-step groups, SMART) and peer support groups.  
- Family support for people with SUD or in recovery from SUD.  
- Community support (individual or informal community agencies) for people with SUD or in recovery from SUD, or families impacted by SUD.  
- Support from spiritual and religious organizations and individuals.  
- Community advocacy for people with SUD.  
- Community initiatives that include people with or recovering from SUD and enable re-integration or build recovery capital. | - Provide drug and alcohol educational materials.  
- Screening.  
- Brief Interventions.  
- Referral to SUD treatment centres.  
- Emergency healthcare for acute episodes of SUD.  
- Partnership or shared care, working with specialist SUD treatment services to provide specific SUD treatment services within their generic setting.  
- Ensure provision of healthcare, social and other services to people with SUD who may be marginalized or discriminated against in mainstream settings.  
- Recovery interventions in line with the type of services provided, including healthcare and housing. | - Ensure access to food, shelter, and safety.  
- Basic counselling and social support.  
- Referral to health and social welfare services, as required.  
- Drug and alcohol education for individuals and communities.  
- Screening, brief interventions and referral for treatment for SUD (SBIRT).  
- Needle exchange (including provision of injecting equipment, safe injecting advice, first aid and wound management).  
- Condom distribution and sexual health screening and referral for treatment.  
- Hepatitis/TB screening and vaccination referral for treatment.  
- Overdose prevention, including naloxone for opioid overdose, and referral to emergency services.  
- Target group specific initiatives and adaptations (pregnant women, for example). |
| **SETTINGS** | **SETTINGS** | **SETTINGS** |
| Informal community settings, religious/faith-based organizations, sports and leisure facilities, art or music venues, people’s homes, public spaces, retail venues, businesses, etc.  
Virtual, online, video-conferencing or telephone-based delivery may be used. | Interventions are provided within generic or mainstream services settings, sometimes in partnership with SUD specialist treatment providers (in-reach).  
Virtual, online, video-conferencing or telephone-based delivery may be used. | Outreach settings may include: on the streets, in community agencies, or in peoples’ homes.  
Outreach workers range from health or SUD professionals to those with lived experience of SUD. They are commonly indigenous to the community they serve. Outreach acknowledges the influence of environments and social networks and utilizes them to promote healthier behaviour.  
Virtual, online, video-conferencing or telephone-based delivery may be used. |
Specialist community or outpatient SUD interventions

DEFINITIONS
Outpatient or community-based specialist SUD services that provide assessment, treatment planning, care-management and coordination, psychosocial and/or pharmacological, recovery management interventions.

INTERVENTIONS
- Comprehensive SUD assessment.
- Treatment planning, coordination and review, case management, and discharge planning.
- Interventions to reduce health and social harms: access to food, shelter, safety, drug education; needle syringe programmes (NSP); condoms/sexual health interventions; BBV/TB screening and treatment; wound management, overdose prevention training, and naloxone.
- Psychosocial interventions as core: one-to-one keywork, EBIs, short programmes, longer programmes, day programmes, contingency management, and family interventions.
- A range of pharmacological interventions: opioid detoxification, maintenance, relapse prevention, overdose prevention, alcohol detoxification and relapse prevention, benzodiazepine detoxification, and ameliorative prescribing for stimulant and NPS.
- Recovery management: mutual aid, intervention to build recovery capital (education/training/self-efficacy/jobs), social networks, and recovery check-ups.
- Liaison/joint work with primary, acute and mental health services (e.g. HIV/AIDS, TB, hepatitis).
- Liaison/joint work social care services (housing, children/familyservices, social welfare etc.).
- Liaison/joint work with criminal justice services including throughcare from NDLEA and prisons.
- Outreach into health, social care and criminal justice services to provide SUD interventions.
- Target group specific initiatives and adaptations.

Specialist inpatient and residential SUD interventions

DEFINITIONS
Inpatient specialist SUD treatment or residential rehabilitation programmes for those with SUD, half way housing or supported living environments with specialist SUD case management, psychosocial and recovery management support.

INTERVENTIONS
Inpatient and residential rehabilitation units:
- Comprehensive SUD assessment.
- Treatment planning, coordination and review, case management, and discharge planning.
- Interventions to reduce health and social harms: drug education; BBV/TB/sexual health screening and treatment; and overdose prevention training.
- Recovery management: mutual aid, intervention to build recovery capital (education/training/self-efficacy/jobs), social networks, and recovery check-ups.

Specialist inpatient
- Medical assessment for SUD and complex needs.
- Pharmacological interventions for SUD: opioid stabilization, opioid, alcohol/sedative detoxification/assisted withdrawal, ameliorative prescribing, opioid overdose (naloxone) on discharge.
- Pharmacological interventions for mental/physical health (if competent), including psychosis and HIV/AIDS.
- Target group specific initiatives (pregnant women, for example).

Residential rehabilitation programmes:
- Residential psychosocial programme interventions to treat SUD and recovery management interventions to build recovery capital (mutual aid/peer support/co-production, vocational training/activities/life-skills training etc.).
- Target group specific initiatives and adaptations (for example women or young adults).
- Discharge planning to ensure continuity of care to community-based SUD treatment and/or recovery management to reduce the risk of relapse following inpatient or residential treatment.

Note: Residential services that hold people with SUD against their will, engage in forced restraint or provide non-evidence-based interventions are NOT SUD treatment and should NOT be provided.

NDLEA COUNSELLING CENTRES PROVIDING COMMUNITY-BASED AND RESIDENTIAL INTERVENTIONS
NDLEA counselling centres take self-referrals and referrals from family, community leaders, schools, and workplaces. They also receive referrals via raids. NDLEA provides screening and assessment. Client consent is required for counselling and parental/family support. NDLEA counselling centres refer those assessed with higher severity SUD to specialist SUD services.

SETTINGS
Community-based buildings, hospital inpatient or residential rehabilitation services that also provide outpatient appointments, interventions or in-reach into generic services.
Virtual, online, video conferencing or telephone-based delivery.
NDLEA counselling centres.

SETTINGS
Ideal settings for inpatient services are dedicated SUD units. Some, however, may be a ward within a psychiatric hospital (for those with comorbid mental health issues) or a health setting (for those with liver disease, HIV/AIDS, or pregnant women).
Residential rehabilitation units may be stand-alone services, or half-way houses may combine supported housing with SUD in-reach into those facilities or have dedicated SUD staff.
NDLEA counselling centres.
3.7 Treatment system organization in Nigeria

3.7.1 Nigerian substance use disorder service providers organization

Nigeria has a range of services that are involved in substance use disorder treatment and SUD-related work. These are outlined below. A map of those providing data to NENDU data centres is given in Figure 10.

Figure 10: SUD treatment providers contributing to NENDU data

![Map of SUD treatment providers in Nigeria]

a) NDLEA counselling centres

The only statutory SUD services that are present in most states are the NDLEA counselling centres. These services provide residential and outpatient counselling services for those with mild to moderate SUD. People assessed as having severe SUD requiring medical input or complex needs are referred to hospital inpatient units. NDLEA take self-referrals and referrals from family, community leaders, schools, and workplaces. They also receive referrals via raids. NDLEA provides screening and assessment. Client consent is required for counselling and parental/family support. Parents or guardians may bring their adolescent or young adult children for residential or outpatient counselling. NDLEA counselling centres refer those assessed with higher severity SUD to specialist SUD services. If residential care is provided, clients/families pay for room and board but treatment interventions are free.

b) Model SUD treatment centres

There are 11 model specialist SUD treatment centres in Nigeria, of which 10 are federal government specialist SUD hospital-based services and 1 is an NGO centre.
Of the 11 centres:

- Six are within psychiatric hospitals: Federal Neuro-Psychiatric Hospital Maiduguri; Federal Neuro-Psychiatric Hospital Kaduna; Federal Neuro-Psychiatric Hospital Benin; Federal Neuro-Psychiatric Hospital Enugu; Federal Neuro-Psychiatric Hospital Aro; Federal Neuro-Psychiatric Hospital Yaba.
- Four are teaching hospitals: Aminu Kano Teaching Hospital (AKTH); University Teaching Hospital (UPTH), Port Harcourt; Jos University Teaching Hospital (JUTH), Jos; and the National Hospital Abuja.
- One is an independent NGO centre: Quintessential Healthcare Center (QHC).

The treatment centres provide a range of psychosocial interventions and pharmacological interventions (focused on detoxification) for moderate and severe or complex patients. All 11 facilities provide inpatient treatment and, have a combined total of 330 SUD dedicated beds. The treatment centres also provide outpatient services. Some also provide treatment for concomitant conditions such as mental health (dual diagnosis), and some provide a range of recovery management interventions. In 2015, NENDU data show 1,044 patients were admitted for treatment; in 2017, the number was 990.\(^{34}\) These services are not free of charge.

**c) NGO residential rehabilitation units and community SUD services**

Around 35 community service organizations (CSOs) also provide residential and community treatment of SUD (psychosocial interventions and recovery support), according to the Community Intervention Network on Drugs (CIND). UNODC supports a further six community-based SUD drop-in centres, which provide some interventions to reduce health and social harms of substance use disorders, psychosocial interventions and recovery management support.

**d) PWUD advocacy and support networks**

There are two main PWUD advocacy and peer support networks: the Drug Harm Reduction Advocacy Network Nigeria (DHRAN) and Nigerian Network of People Who Use Drugs (NNPUD).

**e) Faith-based or spiritual counselling and support services**

There are also a range of faith-based or spiritual counselling and support services helping those with SUD and some private SUD service providers. These are of unknown quantity and quality.

### 3.7.2 Planning and funding SUD treatment systems in Nigeria

The planning, design and implementation of SUD treatment and recovery systems requires involvement from a range of stakeholders, including: health and social care providers, criminal justice, patients and advocacy groups, and NGOs and community groups. Systems to treat SUD should not be thought of in isolation from wider health, social care, criminal justice systems or local services, as their design and delivery is likely to be influenced and inextricably linked to wider local public services and provision.

The *Nigeria National Drug Control Master Plan* (NDCMP) 2015-2019 aimed to strengthen responses to drugs in order to contribute to the enhanced health, security and well-being of all Nigerians.\(^{35}\) The NDCMP 2015-2019 was designed to encompass the rule of law and human rights-based approaches in addressing the public health and criminal justice challenges in Nigeria. It had three pillars that recognized different aspects of drug-related work: drug supply suppression, drug demand reduction (DDR), and the availability, access and control of narcotic drugs, psychotropic substances and precursor chemicals for medical and scientific purposes.

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\(^{34}\) Nigerian Epidemiological Network on Drug Use (NENDU), Drug treatment information system in Nigeria: data analysis of 2017 data, UNODC.

The DDR component of the NDCMP acknowledged the importance of increasing the reach of evidence-based drug prevention and sensitization programmes, increasing the availability and accessibility of evidence-based drug treatment and continuing care services, increasing access to HIV prevention, treatment and continuing care services for people who use drugs in all settings, including in prisons and detention centres, as well as establishing a national drug monitoring system.

A mid-term review of the NDCMP showed significant progress had been made in implementation of the Master Plan, but that almost all the activities were supported by the European Union-fund and UNODC-implemented project *Response to drugs and related organized crime in Nigeria*, and that there was inadequate funding by the Nigerian government. Supporting the objectives of the NDCMP 2015-2019 and subsequent National Drug Control Master Plans will require a consolidated and coordinated approach from the government of Nigeria, civil society, the private sector, and other national and international stakeholders.

From a systems perspective, there are notable gaps in a system of SUD treatment in Nigeria, including: limited emergency responses to SUD overdose and acute emergencies; naloxone is not commonly available to reverse opioid overdoses; there are few SBIRT interventions in primary care or generic healthcare services; there is a lack of training and competence in SUD amongst medical and nursing staff (and other professional groups); there are no formal needle and syringe programmes (though syringes are available to buy in retail pharmacies); no opioid substitution treatment provided in community or inpatient settings; and treatment for people with SUD is not available in prisons (apart from one pilot project). Antiretroviral treatment (ART), used in the treatment of HIV/AIDS, is free of charge in Nigeria but it is unknown how many people who receive ART are current or former PWUD or PWID.

These guidelines and the forthcoming updated *National Drug Control Master Plan* present an opportunity for Nigeria to review and reshape SUD treatment systems and increase the quality and capacity of SUD treatment to minimize the negative impact of substance use in Nigeria. UNODC/WHO stress the importance of the allocation of resources, and treatment system design should be informed by a needs assessment using available data on drug demand and treatment supply at various levels.  

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4. SCREENING, BRIEF INTERVENTIONS AND REFERRAL FOR TREATMENT (SBIRT)

SUMMARY

Screening and brief intervention can be used opportunistically to assess the needs of people who present in non-specialist settings, such as outreach or primary care settings. Evidence shows the effectiveness of brief interventions in reducing drug use in people who are not drug dependent. Screening tools are used to identify the need for treatment. Brief interventions – which may be a single session ranging from five to 30 minutes, carried out in a non-judgmental and motivational style – can be effective in supporting high risk people to stop or reduce their drug use. WHO recommends a nine-step approach to brief interventions following the screening.

4.1 Background

4.1.1 Brief definition and description of SBIRT

Screening, brief intervention, and referral to treatment (SBIRT) is an evidence-based intervention used to identify, reduce, and prevent drug use disorders, particularly in health settings, which are not specialized in the treatment of SUD (i.e. primary care, emergency care, hospitals, antenatal care, social welfare services, school health services, prison health services, mental health facilities, etc.). Screening and brief interventions (SBI) can be implemented in a rapid and cost-efficient manner. Brief interventions can be used opportunistically in a variety of settings for people not in contact with drug services and can provide a pathway to reduce the harms of SUD and treatment via signposting. Screening should use internationally recognized tools such as the Alcohol Use Disorders Identification Test (AUDIT). Staff should be competent to identify harmful drinking and alcohol dependence and provide an opportunistic brief intervention or referral to specialist SUD interventions. Table 5 below details the WHO recommendations for the management of drug use disorders.

<table>
<thead>
<tr>
<th>Table 5. WHO mhGAP evidence-based recommendations for management of drug use disorders in non-specialized health settings: brief psychosocial interventions (2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals using cannabis and psychostimulants should be offered brief intervention when they are detected in non-specialized healthcare settings. Brief intervention should comprise a single session of five to 30 minutes duration, incorporating individualized feedback and advice on reducing or stopping cannabis/psychostimulant consumption, and the offer of follow-up. People with ongoing problems related to their cannabis or psychostimulant drug use who do not respond to brief interventions should be considered for referral for specialist assessment.</td>
</tr>
</tbody>
</table>

4.1.2 Goals

Brief interventions can be used opportunistically in a variety of settings for people not in contact with drug services to support early identification of individuals experiencing drug use disorders, the initiation of interventions to encourage behaviour change and referral to specialized treatment. For people who screen positive for drug use, a brief intervention, carried out in a non-judgmental and motivational style, can be effective in supporting the cessation or reduction of drug use.

4.1.3 SBIRT settings and clients

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

- Primary care settings in all areas.
- Counselling centres, drop-in centres for people using drugs.
- Faith-based organizations that are working with people who use drugs.
- Internally displaced populations.
- Universities and college settings.
- Community-based outreach programmes.
- Mental healthcare settings.
- Hospitals, including emergency services.
- Sexual health clinics.
- Hepatitis services.
- Infectious disease clinics.
- Social service and welfare agencies that work with populations that include those: experiencing insecure housing conditions; living and working on the street; and transitioning from institutions.

In Nigeria, NDLEA settings offer an opportunity to screen clients on a large scale, identify problems and signpost treatment services.

4.2 Screening

Screening is primarily used as a means of establishing the need for treatment. Screening provides staff with information concerning the use and harm of drugs. In some occupational settings, screening may be used as a safety measure where no drug use is expected (for example, pilots may be routinely screened for drug use as part of their terms of conditions of employment). Screening tools can be grouped in two categories:

4.2.1 Self-report tools

Self-report tools have the advantage of being physically non-invasive and inexpensive. A good self-report screening tool should be brief, easy to administer and to interpret, address alcohol and other drugs, and have an adequate clinical sensitivity and specificity for identifying people who need a brief intervention or referral for treatment. Staff using such instruments should have the appropriate training in order to evaluate and provide feedback on results from screening assessments.

A range of validated tools exists for screening drug use disorder, including the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). ASSIST consists of eight questions concerning alcohol, tobacco and drug use (including injecting drug use). The questions identify whether an individual's use is hazardous, harmful or dependent. It has been especially developed for a primary care setting and is recommended for either interview or self-completion.

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4.2.2 Biological markers

A biological marker is a measurable indicator of drug use as indicated by urine, blood, saliva and hair analysis. Markers may be useful when a client is not able to respond to an in-person interview, but information is required to attain a screening result (for example, an unconscious client in intensive care).

4.3 Brief intervention

A brief intervention is a client-centred and strength-based approach intervention of short duration (typically five to 30 minutes but may be extended for one or two sessions) with the aim of assisting an individual to cease or reduce the use of psychoactive substances, or, less commonly, to deal with other life issues. It is designed for general practitioners and other primary healthcare workers.42

The components of effective brief interventions can be summarized in the FRAMES framework:43

- Feedback is given to the individual about personal risk or impairment
- Responsibility for change is placed on the individual
- Advice to change is given by the provider
- Menu of alternative self-help or treatment options is offered
- Empathic style is used in counselling
- Self-efficacy or optimistic empowerment is engendered

During routine contacts, staff should provide harm reduction information and advice, including on reducing sexual and injection risk behaviours. Staff should consider offering testing for blood-borne viruses.

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

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

4.4 Referral to treatment

Persons who are screened and subsequently assessed as having a clinically significant drug use disorder should be referred immediately for treatment to the most appropriate facility. Starting and maintaining treatment at the same setting where a brief intervention was delivered makes the intervention more effective. Despite screening for harmful substance use, some individuals may not be motivated to change their substance using behaviour. Providing a choice of accessing interventions that seek to enhance intrinsic motivation to change should be routinely offered.

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5. OUTREACH INTERVENTIONS TO REDUCE THE HEALTH AND SOCIAL CONSEQUENCES AND HARMS OF SUBSTANCE USE

SUMMARY
Outreach interventions to reduce the health and social consequences and harms associated with SUD should be provided for those with SUD who are not receiving SUD treatment, including the essential package to prevent HIV and treat people who inject drugs. Outreach interventions include: information and links to meet basic needs; education on substance use; counselling and support; referral to healthcare; needle and syringe programmes (NSP); condom distribution and prevention of sexually transmitted diseases; HIV testing; counselling and access to antiretroviral treatment; screening and referral for treatment for hepatitis, TB and liver disease and hepatitis B vaccination; and prevention of poisoning and overdose, including provision of naloxone for opioid overdose. Outreach interventions are most effective when they are implemented as a package, with SUD service providers working in partnership to ensure a local system of outreach is implemented. Outreach services should have clear protocols, procedures monitoring and staff support mechanisms.

5.1 Background

5.1.1 Brief description
Community-based outreach interventions are designed to approach, engage with and offer interventions to people who use substances and are not currently receiving SUD treatment because treatment may be unavailable, inaccessible or unacceptable to people with SUD. Outreach interventions aim to reduce health and social consequences and harms associated with SUD and provide referral to meet SUD and other immediate needs. Outreach may also target individuals who are affected by the substance use of others (for example, sexual partners, needle-sharing partners, etc.). Outreach workers are often indigenous to the community they serve and should be familiar with local drug or alcohol use subcultures. They may be health workers (who, for example, administer hepatitis B vaccinations) or people with a history of SUD. Outreach workers may have specific locally tailored education and support strategies co-produced with members of the same subculture, community or group of people.

Outreach acknowledges the influence of social networks on individuals experiencing SUD and recognizes that networks are important determinants of health and social outcomes. Outreach seeks to utilize networks and influence them and promote healthier behaviour. Many outreach models use a mixture of individual and network-based interventions. Outreach work is possible in any community, including online or virtual communities. An outreach programme should be flexible, adaptive, have a clear mission statement, mechanisms for monitoring and evaluation, and clear monitoring data and relevant documentation.

The following interventions may be delivered through outreach as a delivery mechanism. However, it is important to recognize that these interventions may also be delivered in other settings, such as community-based or inpatient SUD services or mainstream services including primary care (for example, blood-borne virus screening, counselling, vaccination and treatment). Outreach programmes vary enormously according to the local situation, but typically the following core or essential services should be provided: information and linkage to services caring
for basic needs (safety, food, shelter, hygiene and clothing); needle and syringe programme (NSP) and condom distribution; HIV/HCV testing and counselling; hepatitis B vaccination; screening for sexually transmitted infections and TB; education on substance effects and risks involved in substance use; screening and/or assessment of substance use disorders; brief intervention to motivate change in substance use; referral to treatment for substance use disorders; basic counselling and social support; interventions to prevent poisoning and overdose (including naloxone for opioid overdose); and referral to physical and mental health and social welfare services, as needed.

Outreach services may provide the essential package of interventions recommended by UNODC, WHO and UNAIDS to ensure reduction of drug-related disease and overdose management and prevention, (which also contains targets for universal access). These evidence-based and cost-effective interventions achieve most impact when implemented as a package. Therefore planners, funders and service providers should work together, in partnership, to ensure a local integrated system of outreach and SUD treatment is implemented. The essential interventions include:

- Needle and syringe programmes (NSP).
- Opioid substitution treatment and other substance use disorder treatment.
- HIV testing and counselling.
- Prevention and treatment of sexually transmitted infections.
- Antiretroviral treatment (ART) for HIV/AIDS.
- Condom distribution for people who inject drugs and their partners.
- Targeted information education and communication for people who inject drugs and their partners.
- Vaccination, diagnosis and treatment of viral hepatitis.
- Prevention, diagnosis and treatment of tuberculosis.
- Overdose management and prevention.
- SBIRT may also be provided in outreach settings.

These interventions are described below in detail. Please refer to Section 4 of this document for descriptions of SBIRT and Section 8 for descriptions of opioid substitution prescribing.

### 5.2 Information and linkage to services caring for basic needs

People with SUD, particularly those with serious or complex needs who are homeless or displaced, may require help to get their basic needs met (safety, food, shelter, hygiene and clothing). Outreach services can provide information, linkages and support. Organizations or voluntary groups can help meet basic needs and prevent human rights abuses of these often highly vulnerable and marginalized people.

### 5.3 Education on drug and alcohol effects and risks involved in substance use

Education on substance use effects, risks and strategies to mitigate risk is an important element of outreach work to reduce harms. It is important that the information given is factual, evidence-based and targeted to the needs of the population group. Education may be verbal or through written or illustrated leaflets, posters and materials. It is critical that educational materials are culturally adapted to the target audience, with focus on their levels of literacy and understanding.

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5.4 Basic counselling and social support
Outreach interventions seek to build a relationship with the person with SUD, build trust and provide highly targeted interventions to help meet their needs. Basic counselling skills may be required in this type of intervention, for example: the ability to listen, focus on solutions and look for ways to elicit social support. This may include peer, informal community or family support, or formal health, social care or welfare support.

5.5 Needle and syringe programmes (NSP)
NSP may be delivered in a variety of setting (on the streets, in homes, community resources, SUD services, pharmacies, etc.). Effective NSP should provide advice and information on safer injecting, risk of infection and overdose, plus sterile injecting equipment that is suitable to the local drug use context. This includes syringes, safe disposal boxes for used equipment, filters, sterile water, single-use cooking utensils, acidifier powders, tourniquets, bleach and other disinfectants for needles and syringes (only as an adjunct to, rather than a substitute for, sterile needles and syringes), foil, and male and female condoms. Ideally, low dead space syringes (those with minimal space between the syringe hub and plunger) should be provided, as they are associated with less risk of disease transmission. NSP should be determined in conjunction with people who inject drugs (PWID). NSP may also provide or offer referral for other services to reduce harm, including SUD treatment and healthcare.

5.6 Condom distribution and the prevention of sexually transmitted disease for PWID and their partners
Sexual health education, male and female condoms and lubricants, and screening and treatment for sexually transmitted diseases (which may include contact tracing) are core interventions. These interventions are particularly important for certain sub-groups of PWID, in particular, PWID with infections such as HIV/AIDS (and their partners), those involved in sex work, or who are sexually exploited. This work will normally require close liaison with local sexual health services and HIV/AIDS service providers.

5.7 HIV testing and counselling and access to treatment
HIV is a preventable disease. Preventing the spread of the virus and providing appropriate, effective and voluntary treatment are essential components of national responses to curtail the spread of HIV in this population group and reduce the spread to other population groups. Outreach interventions for testing for HIV may include health education, distribution of condoms, NSP, and blood or dry-spot blood testing. Pre- and post-test counselling is advised, as this can be a life-changing diagnosis. Antiretroviral treatment (ART) medication is effective and provided free of charge in Nigeria. Efforts should be made to contact PWUD/PWID through outreach to test for HIV/AIDS and provide ART (together with treatment for opioid SUD, if opioid dependence is present).

5.8 Screening for hepatitis, hepatitis B vaccination and treatment for hepatitis C and liver disease
Hepatitis B and C are highly infectious blood-borne viruses that disproportionately affect PWID. People with alcohol use disorders are likely to suffer from liver disease. Globally, most people living with HIV are also living with hepatitis. Outreach interventions and SUD services should provide education and advice on hepatitis, screening and provision of or referral for the hepatitis B vaccination, and hepatitis and liver disease treatment. Recent advances in treatment for hepatitis C have made treatment faster with fewer side effects.
5. OUTREACH INTERVENTIONS TO REDUCE THE HEALTH AND SOCIAL CONSEQUENCES AND HARMS OF SUBSTANCE USE

5.9 Screening and treatment for tuberculosis (TB)
Health education, screening and treatment for TB are advised as part of a package of outreach interventions, either by outreach services or by facilitated referral to TB treatment.

5.10 Referral to healthcare services as needed
Referral and facilitated referral to local healthcare (for acute treatment, to primary care or specialist treatment such as sexual health) is a core part of outreach. The outreach team should pre-agree on referral mechanisms and linkages to make referral as smooth as possible for the service user. Permission to share information may be required from the service user to make and follow-up referrals.

5.11 Alcohol poisoning and drug overdose prevention services, including emergency naloxone
The prevention of poisoning or overdose from drugs, alcohol or polysubstance use – particularly from depressant drugs, alcohol and opioids – is core to SUD treatment in all settings, including outreach. Interventions may include: providing information and advice on the risks of drug overdose or alcohol poisoning and how to prevent them; helping people recognize their risk of poisoning or overdose and developing personal strategies to avoid these; and overdose and first aid training for people with SUD, their peers and their families. Distributing naloxone to people who use opioids or to people who have overdosed can save lives. Building capacity and competence of local service providers to recognize the signs and symptoms of overdose and providing evidence-based responses to prevent overdose, including outreach services, pharmacies and acute response services (health, criminal justice, social care), is advised.
6. ASSESSMENT, TREATMENT PLANNING AND REVIEW

**SUMMARY**
Assessment identifies the difficulties and strengths that people bring to SUD treatment. Informed consent is an important part of building a collaborative therapeutic relationship. Assessment should seek to identify current needs, risks, motivation levels and potential barriers to engagement. Assessment is the start of a therapeutic process that will continue throughout the client’s experience. The assessment process should result in an initial treatment plan that includes psychosocial interventions and may include pharmacological interventions.

6.1 Assessment
People with moderate to severe SUD may have multiple needs across a number of domains that include health, social welfare and psychological well-being. Assessing needs and strengths can help engage the client and identify risks. Assessment can take place over several sessions and is a continual process with adjustments to treatment plans based on changes in presentation and substance use behaviour.

6.1.1 Informed consent
Service providers have a responsibility to continuously provide evidence that the client consents to treatment. Obtaining informed consent requires the individual to understand, consider and weigh the costs and benefits of undertaking treatment. Consent may change over the course of treatment. Clients have the right to decline treatment if they are considered to have capacity. Consideration needs to be given to how consent is obtained if the person is a minor or they show indications that they may lack capacity to consent (such as a learning disability or brain injury). If there are concerns that the client may lack capacity, alternative ways of presenting information should be considered alongside best interest checks.

**CONSENT**
For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision. These terms are explained below:

- **Voluntary** – the decision to either consent or not to consent to treatment must be made by the patients themselves, and must not be influenced by pressure from medical staff, friends or family.
- **Informed** – the person must be given all the information in terms of what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen without treatment.
- **Capacity** – the person must be capable of giving consent, which means they understand the information provided and can use it to make an informed decision.
  - If an adult has the capacity to make a voluntary and informed decision to consent to or decline treatment, their decision must be respected.

Consent can be given:
- **Verbally** – for example, by saying they consent to have an X-ray.
- **In writing** – for example, by signing a consent form.
Consent from children and young people:
» If they are able to, patients themselves usually give consent.
» However, someone with parental responsibility may need to give consent for a child.

Some treatment interventions in Nigeria are mandated and whilst attendance might be compulsory, gaining consent at all stages helps build trust and supports the development of a positive therapeutic relationship. If the client gives informed consent, then involving family members or significant others might support the assessment process. In Nigeria, influence of families in seeking treatment is important; service providers need to confirm that the client consents and is not being pressured by the family to seek treatment. In some cases, an individual's substance use may cause the family considerable distress and anxiety, and they may pressure the individual to seek help for substance use against their wishes. In these cases, services will need to establish that the client consents to treatment and is not overly pressured by others.

CAPACITY TO CONSENT
There may be occasions when a person lacks capacity to consent to treatment. In these instances, it must be proven that the adult is suffering from some sort of mental impairment or disturbance. A person may be deemed to lack decision-making capacity they are unable to: understand information relevant to decision-making; retain information long enough to make a decision; use or weigh information; and communicate a decision.
If an individual has capacity and can consent but refuses treatment (and is not compelled to undergo treatment for legal reasons), then it is unethical to coerce the individual into treatment. When consent is declined service providers should offer alternative outreach interventions to reduce health and social harm. They should also refer the person to alternative SUD services. It is not advisable for alternative, non-evidence-based interventions to be offered to individuals who do not consent to treatment.
There are some situations when services may deliver interventions without consent, such as the administration of naloxone as an emergency intervention for an unconscious individual.

ASSENT
Despite being under the age that is legally required to consent, some children and young people (CYP) may be asked for their assent to receive treatment. Assent means that they agree to receive the treatment. They may also dissent, which means they do not agree to receive treatment. To take part in the assent process, CYP must be mature enough to understand treatment. As with the informed consent process, the assent process is meant to be an ongoing conversation between the CYP and the treating team. This team may include doctors, nurses, social workers, and other healthcare providers. During the assent process:
» Parents or guardian give informed permission for their CYP to join treatment.
» Treatment staff explains the proposed treatment to the child in language the child can understand, including benefits, side effects and what to expect.
» Treatment staff may use written forms, videos, graphics, and other visual aids to help explain treatment.
» CYP should be encouraged to ask questions.
6.1.2 Co-produced assessment and core skills for staff

Assessment processes require staff to have core psychosocial skills, including building a therapeutic alliance and enhancing client motivation, and a range of other specific psychosocial interventions that underpin the assessment process. In this sense, the client is an active collaborator in the assessment process, encouraged to take responsibility for setting goals rather than having treatment needs dictated to them. Treatment and care should consider clients’ needs, level of motivation and preferences. People who misuse drugs should have the opportunity to make informed decisions about their care and treatment. When making an assessment and developing and agreeing to a treatment plan, staff should consider the client’s:

- Medical, psychological, social and occupational needs.
- History of substance use.
- Experience of previous treatment, if any.
- Goals in relation to his or her substance use.
- Treatment preferences.
- Support network (including family members or spiritual leaders).

Assessment should seek to identify current needs and risks, gauge motivation levels, and understand potential barriers to engagement. Assessment is the start of a therapeutic process that will continue throughout the client’s experience; the assessment process should not delay access to treatment.

6.1.3 Comprehensive assessment components

Comprehensive assessment of those seeking SUD treatment should include:

- Understanding the client’s level of motivation to engage and change behaviour, understanding of the treatment process and choice of treatment options.
- Identifying potential risks, including those that could compromise the immediate safety of the person seeking support for their substance use or children who may be under the care of the person seeking treatment.
- Confirming the client is taking psychoactive substances (based on history, examination and drug testing, and through accessing any relevant additional information from clinical records). Examples of assessments that provide this information are ASSIST and the Addiction Severity Index (ASI).
- Identifying the degree of problematic use or dependence.
- Forensic history, including previous offences and current risks to self or others.
- Assessing the family history for substance use and dependence and relevant medical, psychiatric or psychosocial factors.
- Identifying physical and mental health problems.
- Understanding the family network and family concerns.
- Identifying social problems.
- Exploring and identifying client strengths or assets.
- Determining any need for substitute medication or other prescriptions for dependence.
- Assessing risk behaviour, including those associated with injecting.
- Assessing capacity and best interests, particularly with young people, people with cognitive impairment, suspected learning difficulties or learning disabilities.
- Assessing local resources that might support the person (e.g. leisure and employment opportunities).

If an individual cannot consent, is finding it difficult to make a decision, or to speak up for themselves, then service providers may wish to enlist an advocacy service to support the individual. Advocacy services are separate from SUD treatment providers. The role of the advocate
6. ASSESSMENT, TREATMENT PLANNING AND REVIEW

is to listen to the individual’s concerns, help them make choices regarding their treatment and provide information so they can make informed choices about treatment. Advocacy could be sought from peer groups, professional organizations, or family and friends.

Assessment duration and format will be determined by the service provider’s resources (including office space, psychometric test availability and time). Some settings, like community settings, may require briefer assessment methods; others, like inpatient settings, lend themselves to more detailed assessments.

6.2 Treatment planning and review

The assessment process should result in an initial care of treatment plan. Treatment should be the least intrusive and most effective option and reviewed at regular intervals. It is important that the relationship between client and clinician remain supportive. Person-centred care means placing the needs of the client first and always acting in their best interest.

Goals, treatment and recovery domains commonly include:
- Identification of treatment goals, unmet needs.
- Reducing dependency, problematic use and gaining control.
- Minimizing any current health, social and criminal justice concerns.
- Achieving abstinence from primary substance of choice.
- Identifying recovery and social capital.
- Managing and reducing risks associated with substance use.
- Abstaining from all substances.
- Reducing and coming off all pharmacotherapy for drug use disorders.
- Building relationships, reintegrating back into communities.
- Optimising personal, social and mental health.

Good treatment and recovery treatment plan goals are usually SMART (specific, measurable, agreed-upon, realistic and time-limited) and should reflect client choice regarding what interventions they wish to receive and at what point in their recovery journey.

6.3 Coordination in treatment planning

Effective communication between stakeholders is essential in coordinating care, managing risks and ensuring continuity of care. One service might start treatment before the client is referred to another setting. Information concerning interventions that the client has received should follow them along their recovery journey. To ensure that clients are linked and referred to appropriate services that suit their needs, treatment planning and case management and coordination are essential. Case managers must monitor and review progress with the client.

6.4 SUD treatment phases

The illustration below (Figure 11) outlines SUD treatment phases for those with moderate to severe SUD and describes treatment start, stabilization of SUD, recovery support and aftercare post discharge.
Figure 11: SUD treatment phases

TREATMENT START

1. First contact/s with client:
   - How to engage client – Using MI and brief interventions (1–3 sessions).
   - Screening.
   - Risk reduction advice.

2. Assessment:
   - Extended brief interventions (MI/MET strategies to resolve ambivalence).
   - Make use of family and networks.
   - Utilise contingency management to engage high risk service users.

3. Physical health assessment.

4. Pharmacological interventions: OST

STABILIZATION AND MAINTENANCE

1. Extensive interventions, for common mental health problems (CBT for anxiety and depression, anger management, emotional regulation interventions).

2. Identifying and utilising social networks including families, religious centers (behavioral couples therapy, support network therapy).

3. Identifying social recovery capital e.g. housing, employment, education.

RECOVERY SUPPORT


2. Employment and activities.

3. Family and network interventions. Parenting skills.

AFTER CARE


2. Regular recovery check-ups.

3. Relapse prevention medication.

4. Mutual aid and peer support. Employment as expert by experience in service.
7. PSYCHOSOCIAL INTERVENTIONS (PSIs)

**SUMMARY**

Psychosocial interventions (PSIs) are the golden thread of SUD treatment; they should always be provided either as the sole intervention or as an adjunct to pharmacological treatment. PSIs are evidence-based approaches and can be used during inpatient and outpatient client treatment programmes to address motivational, behavioural, psychological, and social factors associated with substance use. They can be delivered as individual or group-based interventions. Common psychosocial interventions include motivational interviewing, family and network interventions, contingency management, and cognitive behavioural therapy. Staff delivering PSIs must have sufficient ability; on-going supervision will support staff competency.

7.1 Background

7.1.1 Evidence-based psychosocial and behavioural interventions to treatment substance use disorders

Psychosocial interventions (PSIs) are the golden thread of substance use disorders treatment; they should always be provided either as the sole intervention or as an adjunct to pharmacological treatment. PSIs are evidence-based approaches that can be used during inpatient and outpatient client treatment programmes to address motivational, behavioural, psychological, and social factors; they have been shown to reduce substance use, promote abstinence and prevent relapse. PSIs can also be used to increase adherence to treatment and medications and are delivered as either high or low intensity interventions. The choice of PSI will be determined by: the goals of specific treatment packages; client need; the availability of staff trained in a relevant PSIs to meet this need; and whether skilled supervisors able to assure consistency of and fidelity to the intervention. PSIs can be delivered on an individual or group basis. Mutual aid is another form of group-based support. PSIs are evidenced-based interventions that have clear competency frameworks and are delivered by staff with the necessary training and practice.

7.1.2 Severity and intensity of interventions

Clients with mild SUD will only require low to mid-intensity PSIs, including motivational support, to address their treatment plan goals. The frequency and intensity of interventions will likely be more intense at the beginning and then moderate as the client moves through stages of a treatment. In this sense, considering interventions as low-, mid- or high-intensity helps allocate a particular PSI to a stage of treatment.

*Low-to mid-intensity interventions*

Lower intensity interventions are generally delivered on an outpatient basis and may involve weekly group support sessions, individual psychological treatment, health and drug education, peer support, and lower intensity social support. These interventions will generally be delivered by case managers. Drug-specific interventions are defined as motivational and treatment engagement tools to minimize use.
Mid- to high-intensity interventions

High-intensity interventions are defined as formal psychological therapies delivered by a specialized psychological therapist. This may include cognitive behavioural therapy and psychodynamic interventions.

The above is not intended to be prescriptive and the choice and frequency of the delivery of PSI needs to consider the client’s needs, desires and readiness. More severe SUD may require more lengthy interventions, whereas mild types of SUD may only require brief interventions, particularly in non-specialist settings. The needs of the family can also be taken into consideration when planning therapeutic support. The case manager will need to respond to family members affected by SUD. Family members in these circumstances often suffer significant levels of physical and psychological stress-related symptoms. In Nigeria, the family is potentially a useful form of support. Table 6 below sets out guidance for the delivery of PSI, which should be set in the context of patient or client treatment plans (which may also include prescribing and recovery management interventions).

7.2 Therapeutic alliance

The therapeutic alliance between client and worker can operationally be defined as the client-therapist relationship, in terms of the feelings and attitudes that therapists and clients have toward one another and how these are expressed. The bond between therapist and client is an essential ingredient in the effectiveness of any talking therapy intervention. Empirical research shows that one common process factor, the therapeutic relationship, helps determine positive treatment outcomes when compared to modality specific technique, such as the ability of the therapist to use Socratic questioning. Delivering person-centred care involves a negotiation between client and clinician, establishing mutually agreeable goals in the context of a trusting, genuine therapeutic alliance. The components of a positive therapeutic alliance can be hard to quantify but do share some defining features:

- **Partnership**: treatment is not a passive process, wherein the client is done to, rather with and for a person. The clinician’s role is to provide support and guidance.
- **Acceptance**: recognize and support the client’s autonomy, express accurate empathy for the other’s perspective, and affirm the person’s strengths and efforts.
- **Compassion**: deliberate commitment to support the client’s well-being.
- **Evocation**: elicit treatment goals from the client.

7.3 Motivational interviewing (MI) and motivational enhancement therapy (MET)

Motivational interviewing (MI) is a directive, client-centred counselling style for eliciting behavioural change by exploring and resolving ambivalence. Compared with non-directive counselling, it is more focused and goal oriented. The examination and resolution of ambivalence is its central purpose, and the counsellor is intentionally directive in pursuing this goal. The clinician assumes an advisory, rather than an authoritative, role and seeks to understand what the client values, building empathy and a therapeutic alliance. In this process, the client may realize that their substance use behaviour is inconsistent with the things that are important to them. Their role is to elicit behaviour change by exploring and resolving ambivalence. MI is also an approach to reduce high-risk behaviours such as unprotected sex and sharing needles.

MI can be delivered in one or two sessions for less severe forms of substance use, or the approach can be extended (in which case it is called MET) over six or more sessions, for more severe forms of SUD.

MI for people who misuse cannabis or stimulants, and who are not in formal substance treatment, appears to produce benefits both in terms of increased abstinence and reduced substance use.
Table 6. Description of the recommended PSI by substance type.

<table>
<thead>
<tr>
<th>Substance Type</th>
<th>Psychosocial intervention</th>
<th>Recommended level of intervention (brief, high or low Intensity)</th>
<th>Staff required to deliver intervention</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>Cognitive behavioural therapy</td>
<td>For mild to moderate use: brief interventions (between one and six sessions)</td>
<td>Competent staff with supervision from a clinical psychologist or other professional with suitable experience</td>
<td>Mild to moderate: outreach and community as a brief or extended brief intervention</td>
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<td></td>
<td>Motivational enhancement therapy</td>
<td>For moderate to severe levels of use: six to 12 sessions</td>
<td>Family interventions to be delivered by appropriately trained family practitioners</td>
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<tr>
<td></td>
<td>Family and network interventions</td>
<td>For family interventions: between six and 12 sessions</td>
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<tr>
<td>Alcohol</td>
<td>Cognitive behavioural therapy</td>
<td>For mild to moderate use: brief interventions (between one and six sessions)</td>
<td>Competent staff with supervision from a clinical psychologist or other professional with suitable experience</td>
<td>Mild to moderate: outreach and community as a brief or extended brief intervention</td>
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<tr>
<td></td>
<td>Couples therapy</td>
<td>For moderate to severe levels of use: six to 12 sessions</td>
<td>Family interventions to be delivered by appropriately trained family practitioners</td>
<td></td>
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<tr>
<td></td>
<td>Psychodynamic therapy</td>
<td>For family interventions: between six to 12 sessions</td>
<td>Psychodynamic therapy interventions to be delivered by an appropriately trained clinician or other professional with suitable experience</td>
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<td></td>
<td>Behavioural therapies</td>
<td>For psychodynamic therapy: 12 sessions or more, to be agreed by therapist</td>
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<td></td>
<td>Social behavioural network therapy</td>
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<td></td>
<td>Contingency management</td>
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<td></td>
<td>Motivational interventions</td>
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<td>12-step facilitation</td>
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<tr>
<td>Stimulants</td>
<td>Contingency management</td>
<td>For mild to moderate use: brief interventions (between one and six sessions)</td>
<td>Competent staff with supervision from a clinical psychologist or other professional with suitable experience</td>
<td>Mild to moderate: outreach and community as a brief or extended brief intervention</td>
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<tr>
<td></td>
<td>Family and network interventions</td>
<td>For moderate to severe levels of use: six sessions or more</td>
<td>Family interventions to be delivered by appropriately trained family practitioners</td>
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<td></td>
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<td>For family interventions: between six and 12 sessions</td>
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<tr>
<td>Opioids</td>
<td>Cognitive behavioural therapy</td>
<td>For mild to moderate use: brief interventions (between one and six sessions)</td>
<td>Competent staff with supervision from a clinical psychologist or other professional with suitable experience</td>
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The technical aspects of MI include three elements: client-centred counselling skills, reflective listening statements and directive questions; strategies for eliciting internal motivation from the client, supporting the client to explore their ambivalence towards change and find their own solutions to change; and strategies for ensuring that client resistance is minimized.

MI is guided by a number of general principles:

- Expressing empathy using reflective listening.
- Developing discrepancy between client goals and current problem behaviour by use of reflective listening and objective feedback.
- Avoiding argumentation by assuming that the client is responsible for the decision to change.
- Rolling with resistance, rather than confronting or opposing it.
- Supporting self-efficacy and optimism for change.

When working with clients who are mandated into treatment or may attend because of pressure from family members, it is important for clinicians to develop a therapeutic relationship first and use MI skills to elicit intrinsic motivation to change substance using behaviour. Workers will need to have the technical skills to work with clients who may lack motivation to change their substance using behaviour.

### 7.4 Cognitive behavioural therapy (CBT)

CBT is based on the understanding that behavioural patterns and cognitive processes around substance use are learned and can be modified. During treatment, clients are introduced to new coping skills and cognitive strategies to replace the maladaptive behavioural and thinking patterns. CBT therapy sessions are structured with specific goals to be accomplished at each session and focused on immediate problems faced by the substance user. CBT can be used as a short-term approach of between six and 12 sessions, which can be adapted to a wide range of client needs and a variety of settings. It can be administered in both individual and group treatment sessions. CBT can be combined with a range of other psychosocial and pharmacological treatments.

The primary goal of CBT is to initiate abstinence or reduction in substance use and prevent relapse by addressing potential precipitants of relapse and high-risk factors, and teaching the individual alternative coping mechanisms and the necessary skills to effectively exercise control. The client is encouraged to achieve and maintain abstinence and then to develop the necessary psychosocial skills to continue recovery as a lifelong process. CBT helps clients become aware of their own substance use patterns by identifying triggers, addressing the reasons for and negative consequences of their substance use, and recognizing the benefits of stopping substance use. Another essential component of CBT is the identification and development of coping skills to prevent relapse.

### 7.5 Contingency management (CM)

Contingency management (CM) is a set of techniques that focus on changing specific behaviour. When applied to people who use substances, it often involves offering incentives for positive behaviours such as abstinence from or a reduction in substance use, as well as participation in health-promoting interventions. To sustain client engagement, CM also provides a framework for staff to engage and elicit motivation that comes from the client rather than from externally imposed sources. Delivering this intervention at the start of contact and in a targeted way with high risk cohorts (homeless, pregnant women and young people) helps prevent premature...
dropout from treatment, improves treatment completion and reduces the risk associated with impaired treatment engagement.

CM is a psychological intervention, based on the principles of operant conditioning, a method of learning that occurs through rewards and punishments for behaviour. It involves the systematic application of positive reinforcement to promote positive behaviour (such as attendance at appointments, reduction of substance use and engaging in group work) that is consistent with treatment goals and intensifies client’s engagement in treatment by reducing the relative value of the contingencies that support substance use through increasing the incentives that support abstinence. CM involves giving clients concrete rewards to reinforce positive behaviours such as abstinence, treatment attendance, compliance with medication, or a client's own goals. The following principles underlie the effective delivery of CM:

- Target behaviour should be agreed upon in collaboration and with the client’s consent through a behavioural contractual agreement, which is an integral part of his/her treatment plan.
- Incentives should be provided in a timely and consistent manner.
- The relationship between the goal and the incentive schedule should be understood by the client.
- Incentives should be seen by the client as reinforcing and supportive of a healthy substance-free lifestyle.

Contingency management interventions can potentially be delivered in any setting, the focus could be on engaging clients who have a history of non-engagement or are at risk of drop out. Providing incentives for engagement that are linked to wider treatment goals improves treatment participation and reduces risk.

7.5.1 Contingency management to improve physical healthcare

For people at risk of physical health problems (including transmittable diseases) resulting from substance use, material incentives should be considered to encourage reduction of harm. Incentives should be offered on a one-off basis or over a limited duration, contingent on concordance with or completion of each intervention, in particular for: hepatitis B/C and HIV testing; hepatitis B immunization; and TB testing.

7.5.2 Implementing contingency management

Service providers should ensure that, as part of the introduction of contingency management, staff are trained and competent in the delivery of contingency management.

7.6 Family-orientated treatment approaches

In Nigeria, the family has a key role to play in supporting clients in treatment. Provided the family is supportive, family members can be included in treatment interventions. Family members may also include other network members such as concerned significant others. The family would need to be open to working under a framework in which the client is the identified person and their needs remain at the centre of the intervention. Supporting people who use substances to develop and sustain positive relationships with family, friends and community is a common goal of recovery and should be supported in all phases of care.

Formal family-oriented treatment approaches recognize the importance of family relationships and cultures of behaviour that harness or utilize family systems or relationships to positively influence the behaviour of those with SUD. Systematic reviews of the clinical and cost effectiveness of interventions involving families and friends in substance misuse treatment led to a higher percentage of abstinent days and improved family functioning. Effective family-oriented approaches identified include: behavioural couples therapy (BCT), brief strategic family therapy (BSFT), multisystemic therapy (MST), and multidimensional family therapy (MDFT). MDFT appears
to be particularly effective in treating cannabis dependence in adolescence. There is evidence that BCT is associated with reduced opioid and cocaine use amongst clients in treatment and follow-up. Working with the family to use approaches such as unilateral family therapy (UFT) or community reinforcement and family training (CRAFT) can also be helpful when the client refuses to be involved in treatment. The family is an agency of change on behalf of the client.

Community reinforcement approach (CRA) is a behavioural program for treating SUD. It is based on the theory that environmental contingencies can play a powerful role in encouraging or discouraging drinking or drug use. Consequently, it utilizes social, recreational, familial, and vocational reinforcements to assist clients to reduce substance use, make a sober lifestyle more rewarding than using substances, and aid the recovery process.

### 7.7 Staff supervision, governance and ongoing support to ensure fidelity

As part of treatment fidelity, clinical supervision should be offered to all staff that have responsibility for delivering treatment to clients. Clinical supervision is the predominant method by which the quality of PSIs is assured. Supervision should be planned, occur at regular intervals and should support staff members in their delivery of interventions. Audits should be repeated periodically, depending on the local audit strategy and the time required to implement any necessary action arising from the first audit.

Table 7 below outlines WHO recommendations for psychosocial interventions for people with SUD.

<table>
<thead>
<tr>
<th>Table 7: WHO Recommendations: Psychosocial interventions for SUD (2015)</th>
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<tbody>
<tr>
<td><strong>Psychosocial interventions including contingency management, cognitive behavioural therapy (CBT) and family therapy can be offered for the treatment of psychostimulant dependence.</strong></td>
</tr>
<tr>
<td><strong>Psychosocial interventions based on cognitive behavioural therapy, motivational enhancement therapy (MET) or family therapy can be offered for the management of cannabis dependence</strong></td>
</tr>
<tr>
<td><strong>Behavioural interventions for children and adolescents, and caregiver skills training, may be offered for the treatment of behavioural disorders.</strong></td>
</tr>
<tr>
<td><strong>Psychosocial interventions including cognitive behavioural therapy (CBT), couple’s therapy, psychodynamic therapy, behavioural therapies, social network therapy, contingency management and motivational interventions, and 12-step facilitation can be offered for the treatment of alcohol dependence.</strong></td>
</tr>
</tbody>
</table>
8. PRESCRIBING INTERVENTIONS

SUMMARY
Medication can be essential to the management of SUD. Prescribing interventions should always follow relevant assessment and be accompanied by psychosocial and recovery management interventions. Outpatient settings are as clinically effective for most patients as inpatient settings; however, those with alcohol dependence, severe dependence on other substances, polysubstance use or complex needs may require inpatient settings.

- The clinical management of opioid drug use disorder (DUD) will depend on the degree of physical dependence and the potency of opioid used. First line treatment for tramadol and codeine would normally be detoxification, with opioid maintenance treatment only considered if previous detoxification efforts have failed, or the harms associated with ongoing use warrant use of this higher potency opioid and more intensive, longer-term clinical interventions. More potent opioids may require stabilization and opioid maintenance treatment using methadone or buprenorphine. All healthcare facilities should have naloxone to reverse opioid overdose. Treatment regimens are outlined for opioid detoxification utilizing lofexidine, clonidine or tapering doses of lower potency opioids. Detoxification from tramadol requires enhanced monitoring. Naltrexone may be helpful to prevent relapse after opioid detoxification in motivated individuals.

- Alcohol detoxification would normally feature blood tests and oral thiamine prior to detoxification, prescribing regimens featuring long-acting benzodiazepines (e.g. chlordiazepoxide or diazepam), careful monitoring and management of potential adverse effects, including seizures. Acamposate, disulfiram or naltrexone can be offered to reduce relapse in motivated patients after detoxification.

- Sedative-hypnotic withdrawal regimes are outlined featuring taper regimens with long-acting benzodiazepine and monitoring for potential adverse effects.

- Pharmacological treatment for stimulants and cannabis (if indicated) should focus on management of symptoms.

If controlled medication is prescribed, arrangements for supervised consumption by a professional may be required. Safe and effective delivery of pharmacological interventions requires robust clinical governance controls, including medicines management, clinical audit, and appropriately qualified and competent staff.

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

8.2 Opioids
As outlined in Section 1, opioid use trends are changing in Nigeria. The illicit use of prescription opioid medication has grown in prevalence as evident in NSDUH (2019) and NENDU (2017).
Amongst those using opioids who receive treatment for SUD, tramadol, codeine, pentazocine and opioid cough syrup were the most common opioids of use in 2019. These guidelines therefore address both heroin and more traditional opioid drugs and illicit opioid medication. The global spread of synthetic, illegally produced and stronger opioids including fentanyl should also be noted. Increasingly, specialist SUD clinicians may need to develop competence to be able to provide SUD treatment for people with a range of opioid use disorders, from opioid cough syrup and tramadol to heroin (including heroin injecting) and strong synthetic opioids.

8.2.1 Opioid disorder management

- The appropriate clinical management of opioid use will depend on the degree of physical dependence, and the potency of the opioid that is being misused. The first line of treatment for lower potency opioids, such as codeine and tramadol, will normally be detoxification, and opioid maintenance treatment would only usually be considered if previous detoxification efforts have failed, or the harms associated with ongoing use warrant use of this higher potency opioid and more intensive, longer-term clinical intervention. Treatment of more potent opioids such as heroin or morphine would typically require a period of stabilization and maintenance treatment.

- Essential pharmacological treatment options should consist of opioid agonist maintenance treatment and the management of opioid withdrawal. At a minimum, this should include either methadone or buprenorphine for opioid agonist maintenance and outpatient withdrawal management, naltrexone for relapse prevention, and naloxone for the treatment of overdose.

- The setting for delivery for opioid disorder management will depend on a variety of factors relating to the circumstances and needs of the patient and availability of treatment in different settings. Most opioid prescribing treatment can be provided in outpatient settings unless the patient has severe and/or complex opioid use disorder and other issues such as significant comorbid health issues.

- Drug testing to ensure patients are using specific substances and for the monitoring of progress and compliance with the treatment is good practice. Where it is not available, the physician should rely on thorough clinical assessment and review.

- Drug service providers should have defined policies and procedures, including the management of specific risk situations (including intoxication or suicide risk).

- Information about 24-hour emergency facilities (if available) should be provided to patients and their relatives who are being treated on an outpatient basis.

- For outpatients, take-home medication is recommended when the patient is on a stable dose of medication, when the patient has a stable social situation and when there is a low risk of diversion.

- Non-compliance with a treatment programme rules alone should not generally be a reason for involuntary discharge. Involuntary discharge from opioid treatment is likely to cause relapse in patients with allied risk of overdose and death. Involuntary discharge from treatment may be justified to ensure the safety of staff and other patients, but before involuntary discharge, reasonable measures should have been taken to improve the situation, including re-evaluation of the treatment approach used.

8.2.2 Opioid overdose prevention

Opioid overdose can be identified by a combination of three symptoms: pinpoint pupils; unconsciousness; and respiratory depression. The opioid antagonist naloxone can completely reverse the effects of opioid overdose within minutes and is a lifesaving treatment. With a long history of clinical success and extremely rare adverse effects, naloxone should therefore be available in all healthcare facilities and SUD service providers that may be called upon to respond to opioid overdose. Naloxone can be injected intramuscularly, subcutaneously, intravenously,
or can also be administered intranasal. Concentration and doses required may vary depending on route of administration, and multiple doses may be required until the overdose situation is reversed (see Table 8).

### Table 8: WHO Recommendations: Naloxone (2014)

Naloxone should be available in all healthcare facilities that may be called upon to respond to opioid overdose.

Uses of a range of treatment options for opioid dependence include psychosocial support, opioid maintenance treatments such as methadone and buprenorphine, supported detoxification and treatment with opioid antagonists such as naltrexone.

Naloxone should be made available to people likely to witness an opioid overdose, as should training in the management of opioid overdose.

In addition to the administration of naloxone, the treatment of opioid overdose includes attempting to rouse the person, to call an ambulance, give oxygen via mask, resuscitation techniques such as rescue breathing, and to stay with the person until they are fully recovered. Naloxone and resuscitation training should be distributed to patients, family members and other people likely to witness an opioid overdose.

#### 8.2.3 Opioid detoxification

- The main goal of detoxification is to stabilize a patient’s physical and psychological health while managing the symptoms of withdrawal on cessation or reduction of opioid use.
- Detoxification is a particularly vulnerable time for patients, as recent periods of abstinence are major risk factors for fatal opioid overdose due to a reduction in tolerance and inaccurate judgment of what is a ‘safe’ dose of opioid to use. Detoxification should always be planned and followed by psychosocial treatment and recovery management.
- Opioid detoxification should be integrated with psychosocial interventions for each patient plus other treatment options, depending on need.
- Where available, reducing daily supervised doses of methadone and buprenorphine over one to two weeks can be done safely and effectively for opioid detoxification. Otherwise, low doses of clonidine or lofexidine, or a gradual reduction of weaker opioid medications can be used, along with specific medications, to treat the symptoms of opioid withdrawal as they emerge.

**Management of tramadol and codeine dependence**

Tramadol and codeine can be considered lower potency opioids; however, they both have dependence-forming potential. As they are opioids, generally the detoxification can be managed in the same way as other opioids, with starting dosages adjusted to take into account their lower potency profile.

In a minority of cases, tramadol withdrawal can take an atypical presentation with symptoms related to its effect on serotonin and norepinephrine receptors. This can be associated with seizures and other symptoms of a severe serotonin syndrome. It is therefore important to monitor for these symptoms during tramadol withdrawal and treat arising symptoms as necessary.

**Opioid withdrawal syndrome management**

It is important to recognize that people with moderate to severe opioid dependence generally have better outcomes with long-term opioid agonist or maintenance treatment, as they are at increased risk of overdose following detoxification. If a patient decides to detoxify from opioids, the effectiveness of treatment is greater when psychosocial interventions and recovery management interventions are made available during and after withdrawal management.
Pharmacological treatment of opioid withdrawal or detoxification includes either short-term treatment with methadone and buprenorphine, or alpha-2 adrenergic agonists (clonidine or lofexidine), see Table 2. If neither of these is available, reducing doses of weak opioids can be used, as well as medications to treat the specific symptoms that arise. As outlined above, tramadol withdrawal can result in atypical symptoms, in rare cases serotonin syndrome and seizures, so patients withdrawing from tramadol may require additional monitoring and treatment of symptoms. Clinicians should only prescribe sedating medications for short periods and closely monitor treatment response as the risk of tolerance and medication misuse may develop for some medications with longer use.

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

<table>
<thead>
<tr>
<th>Table 9: WHO Recommendations: Opioid withdrawal or detoxification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard recommendations</strong></td>
</tr>
<tr>
<td>For the management of opioid withdrawal, tapered doses of opioid agonists (methadone or buprenorphine) should preferably be used, although alpha-2 adrenergic agonists may also be used.</td>
</tr>
<tr>
<td>Clinicians should <em>not routinely</em> use the combination of opioid antagonists and minimal sedation in the management of opioid withdrawal.</td>
</tr>
<tr>
<td>Psychosocial services should be routinely offered in combination with pharmacological treatment of opioid withdrawal.</td>
</tr>
</tbody>
</table>

**8.2.4 Opioid maintenance**

The primary aim of opioid agonist maintenance treatment (OAMT) is to reduce injecting opioid use and/or the use of illicit opioids and help the patient establish medication-assisted abstinence from illicit opioids by preventing withdrawal symptoms, reducing drug craving, and decreasing effects of additional opioids (if they are consumed). OAMT can provide a platform that enables patients with moderate to severe opioid dependence to move away from a drug use and gain stability in their life. It is important to note that opioid maintenance treatment for codeine or tramadol dependence would only usually be considered if previous detoxification efforts have failed, or the harms associated with ongoing use warrant use of this higher potency opioid and more intensive, longer-term clinical intervention. Table 10 outlines WHO recommendations for OAMT.

The following sections outline methadone and buprenorphine OAMT in detail.

**a) Methadone maintenance treatment**

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

Methadone should be commenced following the general rule ‘start low, go slow’. The initial dose should generally be 20 mg or less, depending on the level of opioid tolerance, allowing a high margin of safety to minimize the risk of methadone overdose. Small additional doses can be given, if necessary, up to 30 mg. Once inducted safely, the goal is to achieve an optimal dose for longer-term maintenance to prevent craving and the use of illicit opioids. The initial dose should be gradually adjusted upwards to reach the optimal dose that eliminates opioid cravings while
8. PRESCRIBING INTERVENTIONS

### Table 10: WHO recommendations: Opioid agonist maintenance treatment

<table>
<thead>
<tr>
<th>Standard recommendations</th>
<th>Strong recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average buprenorphine maintenance doses should be at least eight mg per day. Take-away doses may be provided for patients when the benefits of reduced frequency of attendance are considered to outweigh the risk of diversion, subject to regular review.</td>
<td>For opioid agonist maintenance treatment, most patients should be advised to use methadone in adequate doses in preference to buprenorphine. During methadone induction, the initial daily dose should depend on the level of neuroadaptation; it should generally not be more than 20 mg, and certainly not more than 30 mg. On average, methadone maintenance doses should be in the range of 60–120 mg per day. Methadone and buprenorphine doses should be directly supervised in the early phase of treatment. Psychosocial support should be offered routinely in association with pharmacological treatment for opioid dependence.</td>
</tr>
</tbody>
</table>

### Table 11: WHO Recommendations: Methadone in opioid maintenance treatment

Pharmacological treatment options should consist of both methadone and buprenorphine for opioid agonist maintenance and opioid withdrawal, alpha-2 adrenergic agonists for opioid withdrawal, naltrexone for relapse prevention, and naloxone for the treatment of overdose. The initial methadone dose should be 20 mg or less, depending on the level of opioid tolerance, allowing a high margin of safety to reduce inadvertent overdose. The dosage should be then quickly adjusted upwards if there are ongoing opioid withdrawal symptoms and downwards if there is any sedation. A gradual increase to the point where illicit opioid use ceases; this is likely to be in the range of 60–120 mg methadone per day. Patients should be monitored with clinical assessment and drug testing. Psychosocial assistance should be offered to all patients. Methadone use should be supervised initially. The degree of supervision should be individually tailored and in accordance with local regulations; it should balance the benefits of reduced dosing frequency in stable patients with the risks of injection and diversion of methadone to the illicit drug market.

producing neither sedation nor euphoria and allows patients optimal functioning in all areas of their life. The dose should be adjusted upwards if there is ongoing heroin or other opioid use and downwards if there is any sedation, or if the person is ready to cease treatment.

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

In order to maintain adequate plasma levels and avoid opioid withdrawal, it is important that methadone is administered daily and that patients are regularly monitored for adherence to the medication regime. At the start of treatment, methadone should be administered under supervision. Once the patient is stabilized, take home doses can be introduced according to local laws and an individual risk-benefit assessment.
As methadone is an opioid, some people may try to illicitly sell or divert their prescribed methadone. This can be reduced by a range of measures, such as supervised consumption or diluting the supervised or take home dose of methadone to a point at which it is less likely to be injectable.

**b) Buprenorphine and buprenorphine/naloxone combination**

The aims and principles of buprenorphine maintenance treatment are similar to those of methadone maintenance treatment: prevent craving and the use of illicit opioids. When initiating treatment with buprenorphine, the first dose should be administered with a range of two to four mg at least eight to 12 hours after the last use of opioid and only when symptoms of opioid withdrawal occur. In contrast with the premise for methadone induction (‘start low, go slow’), buprenorphine induction should proceed rapidly once the first dose been well tolerated, as the risk of toxicity is low because of its partial agonist action. The main risk during buprenorphine initiation is precipitated withdrawal, which can occur when the first dose is administered too soon after the last use of opioid.

Effective maintenance doses for buprenorphine range from eight to 24 mg per day, not surpassing a maximum daily dose of 32 mg. Alternate-day dosing, using double the daily dose, may be considered in patients who require supervised dosing and do not require an alternate daily dose of more than 32 mg. Compared to methadone, buprenorphine interacts less with other commonly administered medications. As with methadone, buprenorphine doses should be administered under supervision until the patient is stable and then take-home doses can be introduced according to local laws and individual risk-benefit assessment.

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

<table>
<thead>
<tr>
<th>Table 12: WHO Recommendations: Prescription opioid SUD (2009)</th>
</tr>
</thead>
</table>

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

**8.2.5 Opioid relapse prevention**

Naltrexone can be useful to patients who: do not have access to treatment with agonists; have high motivation for abstinence from all opioids; are unable to take agonist treatment due to adverse effects; and/or have been successful on agonist treatment but want to discontinue agonist treatment and be additionally protected against relapse. Treatment with the long acting opioid antagonist naltrexone can only be initiated following detoxification in individuals who have not used opioids for one week or more (typically those leaving residential treatment). Naltrexone is used to prevent relapse as it blocks the effects of opioids for one to two days. However, unless the patients are sufficiently motivated, the rates of treatment dropout can be high.

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

### Table 13: WHO Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence (2009)

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

### 8.3 Alcohol

#### 8.3.1 Alcohol detoxification

Supported withdrawal from alcohol is advised in patients with alcohol dependence as a precursor to psychosocial treatment. Medically-assisted detoxification from alcohol is indicated for people who are dependent or who experience physical withdrawal symptoms following a reduction or cessation of alcohol consumption, and/or suffer from marked medical complications of alcohol use. People who present with very severe or life-threatening alcohol withdrawal symptoms should always be referred to a medical hospital for urgent medical attention.

**a) Treatment setting for alcohol-assisted detoxification**

A community setting for assisted detoxification is as clinically effective and safe for the majority of people as an inpatient setting. However, unlike detoxification from some other drugs, complications during alcohol detoxification treatment can be potentially serious, even life threatening. Therefore, an assessment of suitability should be made when choosing setting for treatment. Caution should be taken when the patient has concurrent significant physical or mental illness, polysubstance use, and/or a history of epilepsy. In these circumstances, it would be advisable to consider treatment in an inpatient setting.

**b) Preparation for alcohol detoxification**

Prior to initiating alcohol detoxification, comprehensive assessment should be undertaken including: history of current medicines prescribed; whether there are any drug sensitivities and allergies; and any medical conditions or social conditions that may make it unsuitable to carry out a community detoxification or contraindicate specific treatments. Blood tests for liver function, including gamma GT, urea and electrolytes, and full blood count, will be required. Oral thiamine is to be prescribed normally two weeks prior to commencing detoxification. The patient should also receive psychosocial interventions to help them prepare for detoxification and life without alcohol, including recovery management.

**c) Prescribed medication for alcohol withdrawal**

Benzodiazepines are recommended as front-line medication for the management of alcohol withdrawal in alleviating withdrawal discomfort and preventing seizures and delirium. Long-acting benzodiazepines (e.g. chlordiazepoxide or diazepam) are recommended over shorter-acting ones (e.g. lorazepam or oxazepam), except in cases of impaired hepatic metabolism (e.g. liver failure or the elderly). The dose and duration should be individually determined, according to the degree of dependence, the severity of withdrawal symptoms, and the presence of other medical disorders.

An example of severity adjusted alcohol detoxification prescribing regimens is given in Table 14. If dispensing benzodiazepines in the community, consider doing so on an instalment basis to improve compliance with the treatment plan and to reduce the risk of misuse. Other medications, such as oral or parenteral vitamins, should either be routinely included as part of the alcohol detoxification regime or may be required depending on the clinical situation.
**d) Monitoring requirements**

During alcohol detoxification, there should be ongoing monitoring of alcohol intake and physical health. It is especially important to watch for signs of confusion, nystagmus, ophthalmoplegia, and ataxia, which may indicate incipient Wernicke’s encephalopathy. The presence of dehydration, marked tremor, paranoid responses and/or response to hallucinations may indicate incipient delirium tremens.

**Table 14. An example of severity-adjusted chlordiazepoxide prescribing regimens for alcohol detoxification.**

<table>
<thead>
<tr>
<th>Severity of Alcohol Dependence</th>
<th>Moderate SADQ score 15–25</th>
<th>Severe SADQ score 30–40</th>
<th>Very severe SADQ score 40–60</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>15 mg four times a day</td>
<td>25 mg four times a day</td>
<td>30 mg four times a day</td>
</tr>
<tr>
<td>Day 2</td>
<td>10 mg four times a day</td>
<td>20 mg four times a day</td>
<td>25 mg four times a day</td>
</tr>
<tr>
<td>Day 3</td>
<td>10 mg three times a day</td>
<td>15 mg four times a day</td>
<td>20 mg four times a day</td>
</tr>
<tr>
<td>Day 4</td>
<td>5 mg three times a day</td>
<td>10 mg four times a day</td>
<td>15 mg four times a day</td>
</tr>
<tr>
<td>Day 5</td>
<td>5 mg twice a day</td>
<td>10 mg three times a day</td>
<td>10 mg four times a day</td>
</tr>
<tr>
<td>Day 6</td>
<td>5 mg at night</td>
<td>5 mg three times a day</td>
<td>5 mg four times a day</td>
</tr>
<tr>
<td>Day 7</td>
<td>5 mg twice a day</td>
<td>5 mg at night</td>
<td>5 mg three times a day</td>
</tr>
<tr>
<td>Day 8</td>
<td>5 mg at night</td>
<td>5 mg twice a day</td>
<td>5 mg three times a day</td>
</tr>
<tr>
<td>Day 9</td>
<td>5 mg at night</td>
<td>5 mg three times a day</td>
<td>5 mg at night</td>
</tr>
<tr>
<td>Day 10</td>
<td>5 mg twice a day</td>
<td>5 mg three times a day</td>
<td>5 mg at night</td>
</tr>
<tr>
<td>Day 11</td>
<td>5 mg three times a day</td>
<td>5 mg at night</td>
<td>5 mg at night</td>
</tr>
<tr>
<td>Day 12</td>
<td>5 mg at night</td>
<td>5 mg at night</td>
<td>5 mg at night</td>
</tr>
<tr>
<td>Day 13</td>
<td>5 mg at night</td>
<td>5 mg at night</td>
<td>5 mg at night</td>
</tr>
</tbody>
</table>

**e) Managing adverse outcomes**

Confusion and disorientation can occur during detoxification as a result of several different complications of alcohol dependency, including (but not limited to): severe alcohol intoxication; delirium tremens; Wernicke’s encephalopathy; hepatic encephalopathy; head injury; and hypoglycaemia. A presumptive diagnosis of Wernicke’s encephalopathy should be made if any of the following supervene during alcohol detoxification: ataxia; confusion; memory disturbance; hypothermia; hypotension; ophthalmoplegia; nystagmus; or coma or unconsciousness. All of these conditions are potentially life-threatening and the occurrence of acute confusion in the person who is detoxifying should be treated as a medical emergency.
Withdrawal convulsions are likely to occur over the first 72 hours of detoxification, although they may occur later. The best predictor of likely occurrence is a past history of withdrawal convulsions. The client should be placed in the recovery position and transferred by ambulance to a medical hospital immediately or as soon as possible. Benzodiazepines, and not anticonvulsants, should be used following an alcohol withdrawal seizure for the prevention of further alcohol withdrawal seizures.

No alcohol dependent client should be advised to stop drinking immediately due to the potentially life-threatening complications of delirium tremens (DTs), seizures and Wernicke’s Korsakoff syndrome.

<table>
<thead>
<tr>
<th>Table 15: WHO Management of alcohol withdrawal recommendations.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strong recommendations</strong></td>
</tr>
<tr>
<td>Antipsychotic medications should not be used as stand-alone medications for the management of alcohol withdrawal.</td>
</tr>
<tr>
<td>Benzodiazepines, and not anticonvulsants, should be used following an alcohol withdrawal seizure for the prevention of further alcohol withdrawal seizures.</td>
</tr>
<tr>
<td>Psychoactive medication used for the treatment of alcohol withdrawal should be dispensed in small doses, or each dose supervised, to reduce the risk of misuse.</td>
</tr>
<tr>
<td>Patients at risk of severe withdrawal, or who have concurrent serious physical or psychiatric disorders, or who lack adequate support, should preferably be managed in an inpatient setting.</td>
</tr>
<tr>
<td>Patients with suspected Wernicke's encephalopathy, parenteral thiamine should be administered twice daily for five days.</td>
</tr>
</tbody>
</table>

**8.3.2 Alcohol relapse prevention**

Acamprosate, disulfiram or naltrexone should be offered as part of treatment to reduce relapse to alcohol use in alcohol dependent patients. The decision to use of acamprosate, disulfiram or naltrexone should be made taking into consideration patient preferences and availability. Disulfiram should be offered to motivated patients when treatment personnel, carers or family members can monitor medication adherence, and when non-specialist healthcare providers are alert to potential adverse effects, including the disulfiram-alcohol reaction.

**8.4 Benzodiazepines: detoxification**

Patients admitted to a short-term residential treatment programme should be asked about polysubstance use, including alcohol and sedative use, and monitored for the emergence of withdrawal symptoms or treated prophylactically if deemed high-risk (heavy or regular use, or history of past withdrawal episodes). Sedative-hypnotic withdrawal can be effectively treated with long-acting benzodiazepines starting at a dose sufficient to relieve withdrawal and tapering slowly over a period of days, weeks or, in some cases, months. Patients need to be monitored for the emergence of severe manifestations of alcohol or sedative-hypnotic withdrawal, including seizures, cardiovascular instability and delirium. It should be ensured that the treatment is not simply prolonging sedative-hypnotic use.
8.5 Stimulants: ameliorative prescribing

Psychostimulants such as amphetamines and cocaine are one of the most frequently used and problematic illicit substances in many parts of the world. Stimulant withdrawal (the 'crash') is less well defined than syndromes of withdrawal from central nervous system depressant substances, though depression is prominent and is accompanied by malaise, inertia and unstable mood. Pharmacological treatment of stimulant withdrawal (if indicated) should be symptomatic or focused on management of symptoms. To date, no medication has proved consistently efficacious for the treatment of psychostimulant use disorders. Therefore, psychosocial interventions and recovery management are recommended for treatment. At present, medications are primarily used to manage co-occurring psychiatric disorders and withdrawal symptoms. If a stimulant withdrawal syndrome is observed, symptomatic medications can be used to treat withdrawal symptoms, as required. However, clinicians should prescribe these medications for short periods of time only and closely monitor the treatment response as the risk of tolerance and medication misuse may develop with a longer use. Antipsychotic and sedative medications may be used to manage psychotic symptoms resulting from acute psychostimulant intoxication. As more than half of the patients with a psychostimulant use disorder may have a co-occurring major psychiatric disorder (e.g. major depressive disorder, bipolar disorder, or schizophrenia), appropriate psychotropic medications play a major role in their treatment. Frequently, patients with a psychostimulant use disorder also have polysubstance use disorder, (e.g. alcohol or opioid dependence), which should be treated using pharmacological as well as psychosocial approaches.

<table>
<thead>
<tr>
<th>Table 16: WHO Recommendations: Psychostimulant dependence (2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dexamphetamine should not be offered for the treatment of stimulant use disorders in non-specialized settings.</td>
</tr>
</tbody>
</table>

8.6 Cannabis: ameliorative prescribing

A cannabis withdrawal syndrome can occur in heavy users (those with severe dependence), typified by insomnia, headaches, depressed mood and irritability. Pharmacological treatment of cannabis withdrawal (if indicated) should be symptomatic or focused on management of symptoms. To date, there is no approved pharmacological treatment of cannabis use disorders and psychosocial treatment remains the primary approach. If a cannabis withdrawal syndrome is observed, symptomatic medications can be used to treat withdrawal symptoms as required; however, clinicians should prescribe these medications for short periods of time only and closely monitor the treatment response as the risk of tolerance and medication misuse may develop with a longer use.

8.7 New psychoactive substances

As discussed in Chapter 1, there are global trends in production, distribution and use of a range of new synthetic drugs, sometimes called new psychoactive substances or NPS. This term describes a diverse set of substances with different actions. Many are produced illegally in non-sterile environments and may be mixed with or cut with a variety of other chemicals. Risk of harm from these substances may therefore come from the NPS themselves, from mixing agents, or from people consuming non-sterile products not meant for human consumption. NPS cover substances from many drug groups including stimulants, depressants, opioids, hallucinogens and synthetic cannabinoids. There are gaps in current international knowledge about how to treat acute and long-terms harms from NPS. There is emerging guidance (45) on the assessment, management, and interventions to reduce harm and management of the following NPS: gamma-hydrobutyrate (GHB) and gamma-butyrolactine (GBL); ketamine and ketamine-like NPS; nitrous oxide; stimulants (cocaine-like and piperazines, amphetamine-like substances,
methamphetamine, synthetic cathinones, ecstasy-like NPS, pipadrols); and hallucinogens and synthetic cannabinoid receptor agonists (SCRAs).46

Assessment and clinical management should follow the principles of good clinical practice in relation to users of NPS. Clinicians are advised to assess and treat symptoms in acute health cases. If it is possible to identify the drug group of an NPS (e.g. a stimulant or a depressant), this may give clinicians an indication of treatment regimens. However, challenges are posed by the rapidly changing profiles of NPS, the ever-increasing numbers of NPS available, new populations being affected, new trends (such as chemsex amongst some men who have sex with men), and new emerging harms (e.g. ketamine-related ulcerative cystitis). Clinicians are advised to seek the latest international guidance in this rapidly changing area.

8.8 Polysubstance use considerations: withdrawal

The treatment of withdrawal, or detoxification, is typically the foremost concern if a patient has had a protracted and severe recent history of opioid, alcohol, benzodiazepine, barbiturate, or polysubstance dependence. In these cases, evidence-based withdrawal protocols usually employing pharmacotherapy combined with rest, nutrition and motivational counselling should be used. Unrecognized and untreated withdrawal is likely to drive a patient out of treatment. Thus, staff of short-term inpatient treatment programmes need to be knowledgeable about the various withdrawal syndromes and polysubstance withdrawal, and be prepared to be psychologically supportive, motivating patients to get through the withdrawal phase, and able to prescribe effective pharmacological treatments for withdrawal. It may be preferable to manage polysubstance use in a staged approach. An example would be to stabilize someone on opioid agonist treatment to address opioid dependence while conducting a detoxification from alcohol. If the individual remains abstinent from alcohol they can then return, at a later date if appropriate, to complete a planned withdrawal from opioid agonist therapy. Short-term inpatient service providers need to be either capable of the medical management of the severe symptoms of withdrawal syndrome or have the ability to transfer such patients to a medical hospital.

8.9 Supervised consumption of controlled medication

Supervision of consumption by an appropriate professional is the best guarantee that a medicine is being taken as prescribed. The principal reason for using supervision is to ensure the safety of the patient and to minimise the risk of toxicity. It should be delivered in a way that protects patients' privacy and dignity, and not be used or viewed as a punishment. Provision for supervised consumption may not always be available, but this should not prevent initiation of clinically indicated treatment. Instead, other measures to mitigate risks should be employed such as more frequent instalments and more regular clinical observations. For most cases, it will be appropriate for new patients (or those starting a new treatment episode) being prescribed methadone or buprenorphine to be required to take their daily doses under the direct supervision of a professional for a period of time to allow monitoring of progress, stability, and an ongoing risk assessment. Duration of supervision should be dependent on assessed clinical need and should not be applied in an arbitrary way. The clinical need for supervised consumption should be reviewed regularly by the prescriber. Relaxation of supervised consumption and instalment dispensing should be a stepped process in which a patient normally remains on daily dispensing with reduction or cessation of supervision and progression to less frequent instalment collection. It is recommended that no more than one week of take-home doses is supplied as a single instalment.

See Clinical governance section for medicines management (Chapter 12).

9. RECOVERY MANAGEMENT INTERVENTIONS

SUMMARY

Recovery-orientated treatment is advocated for people with medium to severe SUD at risk of repeated relapse. This involves a long-term approach, working with an individual to help them both gain control over their substance use (including SUD treatment) and build recovery capital, well-being, and re-integration into society. This may include help to improve housing, employment, mental or physical health, and other domains. Specific recovery management interventions SUD services can provide include: facilitated access to mutual aid or peer support; helping people foster recovery-orientated social support networks; discharge planning and aftercare support and relapse management; and recovery management check-ups.

9.1 Background

A recovery-orientated approach to SUD treatment is advocated, particularly for those with medium and severe or complex SUDs featuring substance dependence.

Recovery-orientated SUD treatment requires:

- a long-term management approach that includes working in partnership with the person with substance dependence and helping them gain voluntary control over their substance use
- help for the individual to build recovery capital such as improvements in physical and mental health and well-being, social functioning (supportive networks), self-efficacy (employment), identity change, and social re-integration into a local community.

Recovery-orientated SUD treatment approaches are strength or asset-based and seek to empower people with SUD to take control over their lives.

Recovery interventions to build recovery capital may be included in any stage or setting of SUD treatment. For example, treatment for HIV/AIDS to improve health, vocational training whilst in long-term residential rehabilitation and facilitated access to mutual aid. In SUD treatment, the case manager should encourage the client in recovery interventions such as engagement in mutual aid and family support to help manage stressful situations that arise. Case managers should help connect the client with other professionals who can help meet particular needs (like health or housing).

A long-term recovery management or continuing care approach should offer patients or clients aftercare or ongoing contact with SUD service and other services (for example, primary care). Aftercare or post-SUD treatment recovery management interventions may include: recovery check-ups by case managers, recovery coaching, or engagement with self-help recovery community groups. Agreed mechanisms for rapid access back to SUD treatment are important and can prevent relapse to dependent substance use.

9.2 Principles of recovery management interventions

In principle, recovery management interventions:

- Have primary goals of enabling the client to build recovery capital to improve their life, enable sustained recovery and maintain benefits obtained in SUD treatment.
9. RECOVERY MANAGEMENT INTERVENTIONS

- **Focus on increasing strengths rather than reducing deficits.** Recovery-oriented approaches seek to identify, support and develop skills, talents, resources, and interests instead of emphasizing needs, deficits, and pathologies.
- **Flexible rather than fixed programmes.** Recovery management interventions must respond to patient changes over time, by offering choice and providing a flexible range of support and services to meet changing needs of the individual patient.
- **Consideration for patient's autonomy.** Recovery management is a self-directed approach that encourages and supports clients to make informed choices about their life and treatment. The incorporation of a patient’s choices has proven to be important in other health areas, especially in the management of chronic diseases, where it increased the individual’s responsibility for their recovery.
- **Participation of community.** As opposed to overcoming SUD in isolation, recovery management tries to involve family members, friends, and the community to strengthen social aspects of recovery. Others are encouraged to play a role in the recovery process and resources of the community are actively sought and utilized, such as: NGOs, mutual aid or peer support, faith-based organizations, sports or leisure facilities, educational organizations, arts and music community initiatives, and local businesses.

9.3 Patients suitable for recovery management interventions

Most people with history substance dependence may benefit from recovery management interventions and long-term recovery management, at an intensity matching the needs of each individual. Patients that may particularly benefit include those with a history of:

- Multiple relapse episodes.
- Physical health issues (for example, people living with HIV/AIDS, liver disease or hepatitis C).
- Those with mental health disorders (especially severe problems).
- People with poor family and community support.
- Those living in poverty or with financial problems.
- Those with legal problems or repeatedly involved with the criminal justice system.
- Displaced and homeless populations.
- Vulnerable people or those living with violence or abuse.

People with high complexity generally require more intensive recovery management interventions. The principles of providing recovery-orientated treatment should also apply to those on long-term medication such as OST and patients should receive interventions to enable them to build recovery capital and avoid relapse to illicit drug or alcohol use, like other patients who have been able to achieve abstinence.

9.4 Building recovery capital

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

- Strengthening individual’s resilience, self-efficacy and self-confidence to manage daily challenges and stress while maintaining commitment to recovery and avoiding relapse to substance use.
- A supportive social network (i.e. partner, family members, friends or peers) that can help monitor the stability of recovery, substance dependence and compliance with SUD and other treatment.
- Engagement with individuals and social networks of friends, peers or work colleagues who have abstinence-oriented norms and are supportive of recovery goals.
- Self-efficacy or being able to support oneself financially, with meaningful and appreciated work (that helps replace stigma and discrimination).
- Social participation and integration in educational and vocational pursuits, including volunteering or community involvement.
- Active involvement in self-help, religious or other support groups.
- Political, humanitarian or spiritual involvement that provides a way to achieve a stronger purpose in life.
- Stable accommodation.

9.5 Specific recovery management interventions

9.5.1 Individual treatment plans with goals to build recovery assets

Individual treatment planning and review are key mechanisms to ensure the treatment and interventions each patient receives are recovery-orientated and tailored to their unique needs. Treatment plans should be consistent with the management of other chronic illness and have an expanded focus of building health and well-being, self-efficacy and community re-integration, not just ameliorating the substance use disorder.

9.5.2 Post-treatment discharge, recovery management or aftercare plans

Towards completion of community, inpatient or residential treatment, aftercare planning should be consolidated into individual recovery management plans. This would normally include personal strategies to: prevent relapse to drug or polysubstance use (and overdose); maintain housing; gain or maintain employment; have supportive positive social networks; and community re-integration. Plans should also include rapid access back to treatment if the patient relapses.

9.5.3 Recovery management check-ups

Ideally, recovery management involves regular monitoring, follow-up meetings (check-ups), or phone calls, made by a SUD treatment case manager, psychologist, primary care physician, or nurse. Recovery check-ups have been demonstrated to promote sustained recovery and prevent relapse. During the check-up, the client may be asked to provide an update on their work and living conditions, their coping mechanisms around stress, and how they are maintaining healthy relationships. Recovery check-ups may include voluntary drug toxicology testing, where patients can be screened in the community to incentivize being drug free, to detect relapse, and, if needed, to receive early re-intervention.

9.5.4 Mutual aid or peer support

There is evidence that people with substance dependence can greatly benefit from mutual aid or peer support. Attending 12-step fellowship meetings has been shown to improve sustained abstinence from drug and alcohol dependence. Substance misuse treatment can improve sustained recovery outcomes (including abstinence) by actively encouraging clients to engage with mutual aid. However, there is also emerging evidence that coerced engagement with mutual aid is counter-productive. The primary mechanism of change appears to be the community of recovery itself, and the acts of peers with histories of substance dependence.

collaborating to support one another in recovery. There is a lack of research into informal peer support and other forms of recovery communities, though these may also offer similar benefits.

9.5.5 Fostering recovery-orientated social supports

Social networks influence patterns of substance use and good social support can help patients to maintain recovery goals. Patients should be educated and made aware of social network factors that contribute to harmful substance use and be equipped with strategies to create and maintain a supportive social environment that promotes health and recovery. This may include becoming involved in mutual aid or peer support as outlined above. It may also include interventions with the families of people with SUD. Whilst there is evidence that past and current family dysfunction can be an impediment to recovery, there is also evidence that for some people the family may enable recovery and be part of the solution. For example, non-using family members who engage in behavioural couples therapy (BCT) and support the person with dependence can have a positive impact on recovery outcomes for their dependent relative. Similar principles may apply to friends and wider social networks.
10. HEALTH CONSIDERATIONS

SUMMARY

People with SUDs often have comorbid physical and mental health difficulties that require interventions. In principle, people with SUD should be offered voluntary screening or assessment for commonly occurring comorbid health problems and offered treatment for those health issues. Depending on individual need this may include: blood-borne viruses and other infections; TB; liver disease; nutritional issues; sexually transmitted diseases; and a range of mental health issues. Mental health problems can co-occur either as a difficulty that led to the substance use or because of the substance use. The accurate assessment of psychiatric symptoms and mental health needs among clients with SUD is essential to distinguish independent psychiatric disorders from substance-induced disorders that will resolve with abstinence. Following identification of need, people with SUD should have the same access to medical treatment for physical and mental health issues as any other patients.

10.1 Physical health considerations

10.1.1 Acute medical conditions

Acute medical conditions may be life threatening, require emergency medical attention, and symptom-based monitoring and treatment. The provision of naloxone for opioid overdose has been addressed elsewhere in this document.

10.1.2 A higher prevalence of physical health conditions amongst those with SUD

People with SUDs are more likely to suffer from a range of other physical health problems, many related to SUD and associated lifestyles including deprivation, poor nutrition, abuse, trauma and violence. Blood-borne viruses and other infections are common amongst many groups who use drugs – particularly people who inject drugs (PWID). Earlier in this report, data on the higher prevalence of HIV/AIDS, hepatitis and TB amongst people with SUD was outlined. International data consistently indicates there are higher rates of liver disease (related to alcohol use disorders and hepatitis), cancer, sexually transmitted disease (especially amongst sex workers) and coronary and pulmonary heart disease related to smoking tobacco and drugs.49

10.1.3 Health interventions for those with SUD: an imperative to improve health and well-being

In principle, those with SUD, irrespective of treatment setting, should receive screening or assessment (depending on the competency of staff) for a range of commonly occurring health conditions. Facilitated access, with agreed referral pathways for treatment of health issues, should be a core function of SUD service providers, particularly for: blood-borne viruses and infections (HIV/AIDS and hepatitis); TB; liver disease; sexually transmitted diseases; and smoking cessation services. Joint work and coordination of treatment and care may be essential, particularly if there is an interaction between physical health medication or conditions and SUD pharmacological

medication. Depending on local conditions, mechanisms for treating opioid dependence should be combined, if necessary, with treatment for TB, HIV and hepatitis, to prevent the spread of these diseases. If SUD service providers do not have expertise in the management of physical health conditions, consultation and referral and joint work with primary care or specialist treatment providers should be in place.

In Nigeria ART treatment for HIV/AIDS is free and service providers for PWID should make every effort to provide ART in the context of SUD treatment (including opioid substitution treatment).

Hepatitis B is also common and SUD treatment can be an opportunity to vaccinate against hepatitis B. An accelerated vaccination schedule, consisting of two or three doses, may be administered to people who have not had a complete course of hepatitis B vaccination before and without necessarily testing serology beforehand. Hepatitis C (HCV) is the biggest global cause of death amongst people who use drugs. Access to HCV screening and treatment should be maximized by SUD services, particularly given the improvements in technology in HCV treatment regimes.

Acute and chronic pain may be another common issue amongst people with SUD, which may contribute to their motivation to use (particularly opioids) and add to the risk of relapse and overdose. Referral for further evaluation of the source of the pain and specific pain management strategies should be arranged, and, whenever possible, pain and drug-use disorders should be treated as distinct clinical needs.

10.2 Mental health considerations

10.2.1 Mental health and SUD

Mental health problems and substance use often occur together. Substance use, persistent use and dependence can lead to the onset of mental health difficulties, make existing mental health problems worse and generally make accessing treatment more complicated. Psychiatric disorders, including depression, anxiety, post-traumatic stress disorder, psychotic episodes or disorders, are associated with drug use disorders and may hinder engagement in treatment. Psychiatric symptoms, including depression, anxiety, and psychosis, may be caused or exacerbated by the use of different drugs and alcohol and may resolve when drug use is stopped. Clients with comorbid problems demonstrate reduced functioning across a variety of domains, have longer and more frequent hospitalizations, more severe symptomatology – including disorders of mood and reality distortion – greater treatment non-compliance, reduced self-efficacy, increased suicidal behaviours, and are less likely to recover from a psychotic episode. Comorbidity is highly predictive of negative treatment outcomes, such as poor physical health and decreased life expectancy. In addition to these multiple pathologies, there may be decreased motivation to change, difficulty in engaging in treatment, higher dropout rates, limited or maladaptive coping strategies and typically slower treatment gains.

10.2.2 Assessment of mental health issues

A critical first step in the accurate assessment of psychiatric symptoms among clients with drug (or polysubstance) use disorders is a full assessment of mental health needs. This is important in order to distinguish independent psychiatric disorders from substance-induced disorders that will resolve with abstinence. Short-term inpatient treatment can provide an opportunity to observe whether psychiatric symptoms are resolved when abstinence from substances


is achieved, and to initiate medical or psychosocial treatment for disorders that persist after cessation of substance use. Given the high prevalence rates of drug use disorders and coexisting mental health difficulties, service providers need to work in partnership to assess and manage both disorders.

Assessments are useful in community and inpatient settings and it will be up to the clinical team to decide which assessments are most useful. Potentially useful tools in the assessment of comorbid mental health problems include:

- Patient Health Questionnaire (PHQ-9), which can be used for screening for depression.
- Generalized Anxiety Disorder Scale (GAD-7), which can be used for anxiety disorders.
- Eating Disorder Examination – Questionnaire (EDE-Q), which can be used to screen for eating psychopathology.
- Impact of Events Scale (IES-r), which can be used by an appropriately trained clinician to screen for PTSD.

See Appendix 1 for a list of mental health assessment tools.

10.2.3 Trauma and substance use

Nigeria has displaced populations that have been subjected to traumatic events as part of conflict within the country. It is likely that many of these displaced populations have unmet needs in relation to psychotrauma, particularly where young people have been coerced into combat. Similarly, other people who use drugs may have experienced trauma, particularly women. Substance use may be a way of trying to manage symptoms of psychotrauma and it is important that psychotrauma is screened for routinely in these populations. Access to specialist psychological support for trauma should also be made available. Substance use disorder services staff should be trained in trauma and provide treatment in psychologically informed environments, where possible.

10.2.4 Pharmacotherapy of comorbid mental disorders

Soon after cessation of drug use, many clients experience psychiatric symptoms such as anxiety or insomnia, which may be treated with symptomatic medications. However, sedative-hypnotic medications such as benzodiazepines should be used with caution as a first line of treatment as they have a high dependence potential. Rather, alternative medications such as sedating antidepressants or low-dose neuroleptics should be considered in addition to psychological intervention. High-intensity psychological interventions that target comorbid mental health problems such as anxiety and depression such as cognitive behavioural therapy techniques support the client to manage their mood and address their drug use. Staff should have the requisite skills and experience to deliver such interventions. Where a client presents with comorbid mental health and SUD, care coordination will usually be the responsibility of the local mental health service with joint care provided by the substance use service.

10.3 Recovery-orientated SUD treatment: improving mental health and well-being

In keeping with a recovery-orientated approach, SUD service providers should also motivate services users to improve their health and well-being and provide access to interventions to support them in this endeavour. This may include treatment for health conditions such as those outlined above, but also interventions that have been shown to improve health such as eating healthily, exercising regularly as well as other proven well-being interventions such as mindfulness training, relaxation, and sleep hygiene. These should be part of recovery-orientated treatment planning and review.
11. POPULATION GROUPS

SUMMARY

In principle, all population groups in need of treatment for SUD should have equality of access to SUD treatment. Some groups may require reasonable adjustments to be made by service providers to ensure access and delivery of evidence-based treatment interventions. Service providers will also need to ensure that: protocols and policies underpin population-group adjustments; staff are trained and are culturally competent to meet the different and diverse needs of their target populations; and that discrimination by patients, clients, and staff is challenged and good relationships are promoted between population groups.

11.1 Working with diverse populations groups

The International Standards recognize that different countries and localities may have a range of population groups that have special treatment and care needs and may require consideration and tailored interventions for drug (and polysubstance) use disorders.

In principle, when designing SUD systems of treatment and recovery, all countries, including Nigeria, are asked to identify all population groups with SUD and provide equality of access and provision, together with strategies to reach those not accessing treatment for SUD.

In addition to the guidance given in this document, amendments and reasonable adjustments may be required to ensure delivery of evidence-based SUD interventions for a diverse range of groups. This may be due to particular: patterns of drug, alcohol or polysubstance use; particular health needs (such as people living with HIV, women who are pregnant); age (from children and young people to the elderly); sexual orientation or gender identity (including men who have sex with men, lesbian, gay, bisexual, transgender, queer or intersex people); social care needs populations (such as people who are displaced or homeless); geography (such as people living in remote areas); gender; language spoken and levels of literacy; culture; race or ethnicity; and faith or religion (with particular note of how drugs and alcohol are regarded).

People with SUD face stigma and discrimination to a greater degree than people with other health conditions. Marginalized and/or underrepresented population groups with SUD may face multifaceted stigma and discrimination and have even greater difficulty in accessing appropriate SUD treatment and care.

It is important that those responsible for planning and delivering SUD treatment in Nigeria define the target groups in the country that require special consideration. Once defined, SUD treatment systems and service providers should:

- Decide what reasonable adjustments are required to meet the needs of the population groups.
- Ensure that staff members are trained and competent to meet the diverse needs of specific population groups. This may require cultural intelligence and cultural competence, deploying different strategies to reach and deliver services, utilizing targeted methods of communication etc.
- Ensure that target group adjustments and interventions are underpinned by protocols, procedures, monitoring and clinical governance mechanisms.
- Actively promote equality of access and equality of quality of service provision.
- Challenge discrimination in staff, other clients and communities and promote good relationships between groups.
In Nigeria, the national expert group advised that different population groups with SUD requiring adjustments should include (but not be limited to) the following groups: women and pregnant women; infants, children and young people; commercial sex workers; internally displaced people – particularly those impacted by conflict; PWID; those incarcerated in the criminal justice system or in closed settings; sexual orientation and gender identity including men who have sex with men and lesbian, gay, bisexual, transgender, queer and intersex people; the elderly; people with disabilities; and those in jobs with higher prevalence of SUD (particularly safety critical jobs such as drivers and health workers).

With each of these groups, adjustments may need to be made in terms of:

- Outreach interventions both in relation to how people are reached and the interventions they receive to reduce health and social harms.
- Assessment content and processes including consent and capacity (particularly for children and young people and those without capacity).
- Patient records and sharing of information.
- Interventions delivered (psychosocial, pharmacological and recovery management).
- The place of service delivery.
- Joint working arrangements with other agencies and codelivery or joint delivery of a range of services to meet needs.
- Through care and discharge planning; arrangement for recovery support.

UNODC quality assurance frameworks recommend that services develop protocols for working with groups that specify the reasonable adjustments, additional safety, information, or clinical governance and staffing requirements.

Some considerations for different groups for Nigeria are outlined below in Table 17; service providers are recommended to use these as a basis for local population but explore the needs of these population groups in consultation with members of the group and codesign delivery and intervention adjustments with them to ensure interventions appropriate and effective.

### 11.2 Women and pregnant women

**SUMMARY**

Women who use substances are more likely to face stigma, shame and increased barriers to SUD treatment, especially those with dependent children. Adjustments should include: access to childcare; women-focused screening, assessment and treatment planning; women-only treatment settings and women-focused programmes; and sexual and reproductive health services. Pregnant women require a dyad approach tailored to the needs of the women and her unborn child. SUD and antenatal; for women with mild SUD a brief SUD intervention may be appropriate; for those with moderate to severe SUD, special considerations may include: prescribing SUD medication; baby delivery, postnatal treatment and breastfeeding protocols. Staff working with women and pregnant women will require competence and a non-judgemental, supportive approach.

This section provides additional guidance on pregnant women given the unique needs of this group of Women and their unborn children: guidance on the treatment of neonates in section 11.3 children and young people.
### Table 17. Populations groups with SUD in Nigeria requiring reasonable adjustments

<table>
<thead>
<tr>
<th>TARGET GROUP</th>
<th>KEY REASONABLE ADJUSTMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women/pregnant women</td>
<td>Different treatment settings; sexual and reproductive health links; economic empowerment human rights training; child care; specific programmes for pregnant women (specialist SUD pharmacological interventions, safe delivery services/mother and baby unit, antenatal care, involvement of significant other).</td>
</tr>
<tr>
<td>Infants with SUD</td>
<td>Safe delivery services for mother and baby unit; treatment for SUD in a specialist centre including prescribing for withdrawal, nutritional support, vaccinations, and safeguarding the child.</td>
</tr>
<tr>
<td>Children and young people</td>
<td>Separate SUD treatment from adults; specialized services with age-appropriate assessment, consent/assent, family involvement, interventions tailored to age, and education; special interventions for street children (temporary housing, screening and treatment, basic facilities including water, food, clothing, shelter, human rights and security, healthcare including psychological and psychiatric treatment); safeguarding the child.</td>
</tr>
<tr>
<td>Commercial sex workers</td>
<td>Mobile outreach interventions to reduce health and social harms including access to sexual health and blood-borne viruses screening and treatment.</td>
</tr>
<tr>
<td>Internally displaced or homeless people with SUD</td>
<td>Basic facilities (water, food, clothing, shelter); security; outreach SUD psychosocial treatment and referral; health and economic empowerment; trained staff for different categories of clients (women, children etc.).</td>
</tr>
<tr>
<td>PWID</td>
<td>Needle and syringe programmes; free HIV testing and ART; hepatitis and TB screening; hepatitis B vaccination and treatment; legal services; economic empowerment; gender-based support; nutritional support; SUD treatment including opioid treatment, rehabilitation and reintegration support; naloxone for opioid overdose.</td>
</tr>
<tr>
<td>Those incarcerated in the criminal justice system or in closed settings</td>
<td>Free medical care; access to SUD treatment with parity of services (inpatient and outpatient); human rights; legal services; vocational/occupational services; reintegration interventions with free transport for aftercare; naloxone for opioid overdose.</td>
</tr>
<tr>
<td>Lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) and men who have sex with men</td>
<td>Targeted outreach that is culturally sensitive and tailored to pattern of substance use including chemsex*; free HIV testing and ART; hepatitis and TB screening; hepatitis B vaccination and treatment; sexual health screening and treatment; SUD treatment that is tailored to the specific needs of LGBTQI and men who have sex with men including substance trends and peer support.</td>
</tr>
<tr>
<td>Elderly</td>
<td>Assessment and treatment of long-term conditions associated with a long history of SUD; specialist polypharmacy vis-à-vis drug interactions; health and social care for elderly SUD including disability, age-related cognitive impairment and long-term conditions.</td>
</tr>
<tr>
<td>Workers with a higher prevalence of SUD</td>
<td>Bespoke SUD treatment programmes for workers with additional monitoring for safety critical jobs such as health workers, drivers.</td>
</tr>
<tr>
<td>People with physical disabilities</td>
<td>Services are provided with additional support e.g. accessible for people with visual and hearing impairments.</td>
</tr>
</tbody>
</table>

* Chemsex refers to an emerging trend featuring groups of people who engage in high-risk sexual behavioural and substance use (normally including injecting stimulants such as methamphetamine and other substance use such as GHB/GBL) with multiple partners over several hours or days.
11.2.1 Women and pregnant women adjustments

Stigma, shame and the lack of positive and supportive relationships are issues that may have a more adverse impact on women, especially women with dependent children or who are pregnant, and are key reasons why women with SUD often do not seek, enter or engage in SUD treatment. Women are more likely than men to have experienced child abuse and/or neglect, undergone repeated exposure to interpersonal violence, be economically dependent on others for survival, and have not been able to access formal educational or vocational opportunities. Considerations in the treatment of all women with SUD should include:

- How significant interpersonal relationships and family history may play an integral role in the initiation and continuation of substance use.
- How stigma can deter treatment entry for women.
- The wide range of referral sources for women often enter treatment for SUD.
- Women are more likely to encounter obstacles seeking and during SUD treatment as a result of caregiver roles, gender expectations, and socioeconomic hardships. These barriers may result in a delayed treatment entrance at a more severe stage with additional medical and psychiatric pathology.
- Women may be more likely to engage in help-seeking behaviour and when engaged in treatment, are more likely to attend.
- Women may require women-focused treatment in a safe single-sex setting to obtain maximum benefit.
- Women may need training or support on sexual health, contraception, parenting and childcare.
- Women and children are more vulnerable to risk of domestic violence and sexual abuse. Screening and treatment for trauma may be needed. Liaison with social agencies protecting children and women may be required to safeguard both the children of women with SUD at risk of significant harm and the women.
- Service providers should provide childcare or partner with childcare facilities to allow mothers to receive treatment.

The opportunity to provide treatment for SUD to pregnant women has tremendous potential for positive life-improving changes for the mother and the fetus or newborn if both receive services. However, with pregnancy, these barriers may become more prominent and mitigate against SUD and antenatal treatment entry, engagement and positive outcomes. The vast majority of pregnant women are conflicted, ashamed, and guilt-ridden about what they often see as their inability to control their substance-using behaviour. Substance use may impact both the mother and the fetus and then the mother and newborn. Once the baby has been delivered, the child may need medical and other services, given the possibility of having experienced adverse fetal circumstances.

The World Health Organization stresses the unique needs of pregnant women with SUD. Pregnant women with drug use disorders have the same rights for treatment as other patients. They should not be ejected from, nor prevented from receiving SUD treatment because of pregnancy. Women with SUD should not be forced to have involuntary abortions or sterilizations. Moreover, SUD treatment programmes must have procedures and safeguards in place to prevent detention and forced treatment of pregnant women.

11.2.2 Treatment issues and adjustments for pregnant women

Women (and pregnant women) have better long-term outcomes when they receive treatments that focus on the issues more commonly found in women with drug use disorders compared to treatments that lack such a women-centred focus.

a) Screening and entry into SUD treatment
For pregnant women with SUD, in addition to receiving women-focused screening and entry, SUD services should:

- Be aware of additional risk factors and the need for urgent medical attention, if the pregnant woman is in withdrawal, seeking detoxification or at risk of harm. She may require referral or transfer to a more specialized medical or psychiatric unit to manage these risks.
- Have a written policy regarding intake procedures for pregnant women with SUD and include: screening; assessment (and how additional information may be acquired if needed); staff training requirements; eligibility criteria or policy on procedures for admission or non-admission; and referral to alternative services for pregnant women.

b) Comprehensive assessment adjustments for pregnant women should include:
- Pregnancy specific information such as the due date, past pregnancies and baby delivery plans.
- An initial assessment followed by more frequent assessment and review.

c) Treatment planning adjustments for pregnant women should include:
- Additional reviews of treatment plans, with women fully involved, given the rapid changes in physical, psychological and social status and functioning that occur throughout pregnancy and after birth, adapting treatment plans to match those changes.
- Liaison and joint working with maternity and antenatal services, social services and others that may be involved in the treatment and care of the mother and newborn. This may, with consent from the pregnant women, also include concerned and supportive relatives.
- It is important that the pregnant woman with SUD is not seen as a passive patient who is only informed of her health status. Rather, she should be actively participating in treatment decisions that affect her and her child, to facilitate retention in treatment.

d) Treatment approaches adjustments for pregnant women should include:
A comprehensive women-centred treatment approach consists of treating the whole person and the mother-child dyad. Treatment approaches for pregnant women with drug use disorders depend in large part on the amount and patterns of drugs (or polysubstances) used. In circumstances where the pregnant woman has mild SUD (e.g. occasional cannabis use), a brief intervention that focuses on education and risk review administered by a primary care provider or obstetrician may be appropriate. Most SUD treatment programmes for pregnant women with SUD focus on those with moderate to severe SUD where there is more potential harm to the fetus and the mother. As with other patients, pregnant women may receive treatment for SUD in either outpatient treatment or inpatient or residential settings; treatment interventions should include psychosocial interventions and recovery management, and may include pharmacotherapy, depending on the type of substances used and severity or complexity of problems.

e) Special considerations for pharmacological treatments during pregnancy
- Pharmacological considerations are especially important for women with opioid use disorder where opioid treatment is needed.
- **It is important to note that medical withdrawal or detoxification from opioid agonist during pregnancy is not recommended.** Withdrawal is associated with high rates of treatment dropout and relapse with associated risk to the woman and the fetus, and opioid withdrawal increases the risk of miscarriage.
- A woman should not be denied treatment with opioid maintenance because of her pregnancy. Opioid medication choices should be made on a patient-by-patient basis, considering individual characteristics. Both methadone and buprenorphine are effective treatments with favorable risk to benefit ratio (but their effects are not always comparable in every patient). Research shows that buprenorphine exposure in utero leads to less severe neonatal abstinence syndromes (NAS) than methadone. However, NAS is an easily identifiable and treatable condition that is only one aspect of the risk and benefit decision to consider for a woman and her doctor when making medication decisions during pregnancy.
Both methadone and buprenorphine effectively reduce opioid use and enable patients to benefit from psychosocial treatment in pregnant women. Medication dose should be reassessed frequently during pregnancy for adjustments, usually upward, in order to maintain therapeutic medication plasma levels and thereby minimize the risk of opioid withdrawal and craving, reduce or eliminate drug use, and maintain abstinence. If a woman becomes pregnant while on either methadone or buprenorphine, treatment should be continued on the same medication, especially when treatment response is good.

In withdrawal management for pregnant women with stimulant dependence, medications may be useful to assist with symptoms of psychiatric disorders but are not routinely required. In withdrawal management for pregnant women with stimulant dependence, medications may be useful to assist with symptoms of psychiatric disorders but are not routinely required.53

f) Baby delivery protocol
Service providers working with pregnant women with SUD should have a written baby delivery protocol that specifies potential issues with both delivery and patient management. This may be jointly agreed with maternity, antenatal and social services involved in the welfare of the mother and newborn. At a minimum, discussion of where delivery will be conducted, who will be notified, what provisions she and her child need, and how she will get these provisions should be included. Appropriate pain management procedures must also be in place. Many women with opioid use disorders are actually more sensitive to pain than women without such disorders. Untreated pain can trigger drug use relapse and other adverse outcomes for the mother and the infant if the mother is not able to care for the child.

g) Postnatal treatment protocol
SUD service providers working with pregnant women with SUD should have a postnatal treatment plan in place for each woman. This may be jointly agreed with maternity, antenatal and social services involved in the welfare of the mother and newborn. Women should not be discharged from SUD treatment due to pregnancy or postpartum status alone. Methods to support the mother-infant dyad, including at least basic parenting skills, should be also outlined.

h) Breastfeeding
Although every effort should be made to encourage breastfeeding in new mothers with SUD, the decision about breastfeeding should be evaluated on a case-by-case basis. Breastfeeding may be contraindicated in the case of mothers with HIV and for mothers with other medical conditions who take certain psychotropic medications. The WHO has published specific guidelines on this issue (see Table 18 below).

<table>
<thead>
<tr>
<th>Table 18: WHO substance use and pregnancy women: Evidence-based recommendations for breastfeeding with maternal alcohol and/or substance dependence (WHO 2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothers with SUDs should be encouraged to breastfeed unless the risks clearly outweigh the benefits (author addition: codeine is contraindicated).</td>
</tr>
<tr>
<td>Breastfeeding women using alcohol or drugs should be advised and supported to cease alcohol or drug use; however, substance use is not necessarily a contraindication to breastfeeding.</td>
</tr>
<tr>
<td>Skin-to-skin contact is important regardless of feeding choice and needs to be actively encouraged for the mother with a SUD who is able to respond to her baby’s needs.</td>
</tr>
<tr>
<td>Mothers who are stable on opioid maintenance treatment with either methadone or buprenorphine should be encouraged to breastfeed unless the risks clearly outweigh the benefits.</td>
</tr>
</tbody>
</table>

Codeine should not be used by breastfeeding mothers because it can pass to the baby through breast milk and potentially cause harm. Codeine is converted to morphine in the liver by the CYP2D6 enzyme. There are many genetic variations of CYP2D6, which affect the extent of this conversion in individuals. People can be classified as: poor; intermediate; extensive; or ultra-rapid metabolizers. Prevalence of ultra-rapid metabolizers varies by ethnic origin and is particularly common in people of Africa descent (29 per cent), and far less common in those of northern European descent (1-2 per cent). When a mother is an ultra-rapid metabolizer of cytochrome P450 2D6, she produces much more morphine when taking codeine than most people do. In this situation, newborns might be exposed to toxic levels of morphine when breastfeeding. It is recommended that clinicians have clear, written agreements with mothers about their breastfeeding practices.

i) Staff competence in working with pregnant women with SUD

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

j) Patient records and documentation for pregnant women with SUD

As with other patients, proper documentation of the treatment of pregnant women with SUD patient records is required. Diligent, up-to-date record keeping of all medical, psychiatric, and treatment interventions is needed to facilitate close coordination between various treatment and care services and the implementation of all recommended care for the mother and the child.

11.3 Children and young people

**SUMMARY**

Children and young people (CYP) are affected by substances either as users themselves or are exploited into criminal networks to traffic and distribute drugs. Children living on the streets or those growing up in areas of conflict are particularly vulnerable and often exposed to substance use. Polysubstance use is common amongst young people, especially amongst student populations. Neonates may find themselves exposed to substances in utero and the management of neonatal abstinence syndrome includes support measures or non-pharmacological interventions followed by medication treatment. SUD should be regarded as critical paediatric illnesses, as early onset often leads to more severe forms of SUD and greater risk to health. Adolescents can benefit from interventions for substance use even if they are not dependent on any specific substance. CYP requiring SUD treatment should receive treatment separate from adults and psychosocial and prescribing interventions should be tailored to age and development stage. SUD service providers also have duties to protect CYP, as minors, from abuse and harm. Families may often be involved in accessing support for their children, and services will need to ensure consent and assent are considered.
11.3.1 Introduction

Drugs affect young people in every part of the world. Young people may use drugs, be involved in the cultivation or production of drugs, or be used as couriers. Drug use amongst young people differs from country to country and depends on the social and economic circumstances of those involved. Many street children are exposed to physical and sexual abuse, and substance use is part of their coping mechanism in the environment they are exposed to on the streets. In Nigeria, there are reports of children being used as soldiers in combat zones.54

Worldwide, cannabis remains the most widely used drug amongst young people, although polydrug use is also common. A global estimate, produced by UNODC, based on available data from 130 countries, suggests that, in 2016, 13.8 million young people (mostly students) aged 15–16 years, equivalent to 5.6 per cent of the population in that age range, used cannabis at least once in the previous 12 months. In Nigeria, there is a trend towards the illicit use of cough syrup amongst students. A recent paper identified that recreational use amongst young people in Northwestern states in Nigeria is high and influenced by peer pressure and mental health difficulties.55 More recently, Federal Ministry of Education, NDLEA, FMOH, NAFDAC and UNODC have collaborated on a randomized control trial on a drug prevention programme in school settings called Unplugged.56 This study involved 32 schools that were selected from the six geopolitical zones in the country. Initial results show that the programme has been successful. Analysis of the data showed the use of tobacco, alcohol and illicit drugs among school children in Nigeria. The proportion of pupils who smoked cigarettes at least once in their life was on overall quite low (5.1 per cent) except in the North West zone where it was 13.4 per cent. In all the geopolitical zones of Nigeria, alcohol was the most used substance (33.6 per cent of pupils reported lifetime use). The highest prevalence of lifetime cannabis drug use was observed in the North West zone of Nigeria (21.2 per cent) followed by North East (14.2 per cent). Overall, lifetime use of cannabis was lower at 7.5 per cent. For all substances, a general tendency to an increase of prevalence of users was observed with the increase in age. For all substances, the prevalence of use was much lower in females than males.

These guidelines discuss neonates and CYP (up to the age of 18 years) who are either passively introduced to substances in utero or who develop SUD problems during childhood or adolescents. Services for CYP are different to those provided to adults and service provision should consider the needs of CYP in all stages of assessment, treatment planning and treatment. Issues of informed consent, safeguarding and the role of the family in accessing treatment need to be considered.

11.3.2 Neonates

11.3.2.1 Neonatal abstinence syndrome (NAS)

The rates of neonates born following intrauterine chronic exposure to opioids and other substances is unknown. If no support is provided for the mother, the infant is at risk for prematurity, intrauterine growth restriction (IUGR), neonatal sepsis, stillbirth, perinatal asphyxia, poor mother/infant attachment, deprivation, neglect, failure to thrive, and sudden infant death syndrome (SIDS). NAS is one of the major conditions that may exist in 50 to 80 per cent of in utero opioid-exposed newborns. The condition results in transient alterations in the central nervous

system (e.g. irritability, high pitched cry, tremors, hypertonia, hyperreflexia, sleep disturbances),
gastrointestinal system (e.g. regurgitation, loose stools, increase sucking reflex, dysrhythmic sucking
and swallowing, poor intake with weight loss), respiratory system (e.g. nasal stuffiness, tachypnea), and
the autonomic nervous system (e.g. sneezing, yawning), that manifest in the days and weeks following
birth in babies exposed to opioids or other sedatives in utero.

Newborn babies may develop NAS from maternal use of alcohol. There is strong evidence that alcohol
consumption in pregnancy can cause fetal harm (e.g. fetal alcohol syndrome); however, there is
insufficient evidence regarding fetal safety or harm at low levels of alcohol consumption in pregnancy.
Additionally, there is insufficient evidence to define any threshold for low-level drinking in pregnancy.

11.3.2.2 Treatment of NAS
After appropriate assessment, the treatment of NAS should include support measures or non-
pharmacological interventions followed by medication treatment.

a) Supportive measures include: rooming-in, breastfeeding, offering a pacifier (non-nutritive
sucking), swaddling snugly with hands available for sucking without overdressing, and skin-to-
skin contact with the mother. Newborns’ naso-pharynx should be aspirated, and feeding should
include frequent offerings (every two hours) of lesser amounts (if poor feeding persists) without
overfeeding with positioning right-side lying to reduce aspiration if vomiting or regurgitation
occurs (both are prominent symptoms of NAS).

b) Pharmacological treatment initiation for NAS should not be delayed. The goal of medication is
to alleviate the symptoms of abstinence and calm the baby so that the usual functions of eating,
sleeping and elimination are normal. The medication dose should be promptly escalated when
needed, preferably in response to the frequent assessments of NAS severity using validated
instruments, and similarly promptly reduced as NAS symptoms decrease.

c) Opioid-related NAS: the most commonly used medications for NAS due to opioid exposure are
oral morphine or methadone according to body weight and score.

d) Non-opioid NAS: with neonatal abstinence from other substances (e.g. barbiturates, ethanol,
and sedative hypnotics), generally phenobarbital is administered.

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

11.3.2.3 CYP with SUD
a) Types of children and adolescents who may present to treatment
Many children and young people around the world may find themselves in positions where they are
exploited by others and exposed to physical, sexual and emotional abuse; often not consenting to
engage in activities, they are coerced through fear of violence. Children are used in war, terrorism, are
subjected to many forms of violence, kept illiterate, trafficked for profit, and used in the drug trade.
They may also be vulnerable and exploited due to gender-based discrimination, displacement and
various mental and physical health conditions often resulting in deprivation, poverty, homelessness
and famine. Children coerced into the drug trade industry are exploited continuously. They are used in
growing, manufacturing, selling, buying, and distribution. Children living in areas of conflict are often
coerced to participate in violence as child soldiers and have easy access to drugs to keep them awake,
make them fight and perform other terrorizing behaviours. Drugs also help them cope with the trauma
and violence they experience.

b) Issues to consider when treating children and adolescents
SUDs should be regarded as critical paediatric illnesses, as early onset often leads to more severe forms
of SUD and greater risk to health. Children who use drugs are not likely to seek help themselves or
consider the risks of continued use. Safeguarding young people from harm is a key priority for services.

Children may reside with their families, may live on the streets, being orphaned or rejected by their families, may be conscripted into the military, or live in correctional system institutions. As a result, treatment circumstances and settings for these latter two groups of children may be quite different than traditional outpatient or residential treatment and may involve more outreach and drop-in centres than is typically found in treatment of adults with SUDs. In Nigeria, the family has a vital role to play in supporting young people in treatment. Adolescents may be brought to treatment by their parents who are concerned about recent substance use it is important to remember that this still needs to be with their consent, or, if they are unable to consent, family members must act in their best interests.

Research on SUD treatment for this population is limited and although there is encouraging evidence that age-appropriate psychosocial treatment is effective in older children, guidance regarding treatment for younger children has often been based on research findings from treatments provided to adults or adolescents. Adolescents can benefit from interventions for substance use even if they are not dependent on any specific substance. Early intervention might halt the progression to dependent use.

Issues to consider when providing treatment for SUD in children and adolescents include:

» The different legal status of children and adolescents in countries in relation to competency to consent to treatment and capacity should be observed and parental consent or involvement may be required.

» Children and adolescents with SUD have unique treatment needs related to their immature brain and cognitive functioning and limited coping skills related to incomplete psychosocial development.

» Adolescents can have high levels of risk-taking, novelty seeking and be very responsive to peer pressure.

» Adolescents with SUD have high prevalence of comorbid psychiatric disorders and family dysfunctions, which need to be a focus of treatment.

» Children and adolescents may be less likely than adults to see the value of talking about their problems; they are more concrete in their thinking, less developed in their language skills, and may be less introspective than adults.

» Behavioural treatment interventions must be adapted, taking into account the limited cognitive abilities of children and adolescents.

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

c) SUD treatment adjustments for CYP

Treatment for SUD for CYP should:

» Be delivered in separate settings to adult SUD treatment.

» Take into account legal issues concerning a CYP competency to consent to treatment and capacity, with parental consent or involvement as appropriate.

» Be tailored to the unique needs of the adolescent and address the needs of the whole person, not only the substance use.

» Violence, child abuse, and risk of suicide and harm should be identified and action should be taken to safeguard or protect the child or adolescent at the earliest opportunity in treatment.

» Treatment should also include strategies such as: social skills training, vocational training, family-based interventions, sexual health interventions including prevention of unwanted pregnancy and sexually transmitted diseases.

» Treatments should attempt to integrate other areas of social involvement of adolescents such as school, sports and hobbies, and recognize the importance of positive peer relationships.
» Treatment of adolescents should promote positive parental involvement when appropriate.
» Access to child welfare agencies must be available.

d) Outreach services: adjustments for CYP
Outreach programmes aim to identify high risk children and young people who might be in need of health-related services and SUD treatment. Staff may offer age appropriate screening and brief intervention. Staff should collect sufficient information to determine the need for referral to a range of agencies to meet the multiple needs of children (e.g. those living on the street) and be active agents in arranging for such treatment.

e) Screening and assessment: adjustments for CYP
Screening and assessment should be sensitive to the age and capacity of the CYP, whether adults with parental responsibility should be involved in assessment and the ability of the CYP to consent. Particular attention should be paid to risk of abuse (emotional, sexual and/or physical), risk of self-harm and risk of harm to others. Standards use in screening and assessment of children should be no different than those used for other patient populations.

f) Treatment planning: adjustments for CYP
Treatment plans need to consider the cognitive ability of the child, be reasonable to their level of functioning and involve the child’s network. The child should be included in all decisions regarding their care, and interventions should be age appropriate and delivered by staff and clinicians who are competent to work with CYP. SUD treatment planning may need to dovetail with other plans to meet the wider health, social care and educational needs of the CYP, and multi-agency coordination may be required to meet multiple needs.

g) Treatment approaches
Treatment approaches for children with SUD depend in large part on the substances used. As with other patient populations, treatment should always involve psychosocial interventions and recovery management in combination with medication when appropriate. Psychosocial interventions should, as for adults, involve motivational and engagement techniques, including building a therapeutic alliance to work collaboratively with the young person and their family. Psychosocial approaches for the treatment of SUD in children and adolescents should cover as wide a range of their lives as possible, using an individualized approach that considers their vulnerabilities and strengths. Examples of treatment approaches for SUD in children and adolescents include the life skills approach, family-based interventions (e.g. brief strategic family therapy, family behaviour therapy or multisystemic family therapy) and basic education. Adolescents will benefit from training in self-control, social skills and decision-making.

Pharmacological interventions are different for children. There is little research regarding the efficacy of pharmacotherapies in the treatment of adolescents, and even less for CYP SUD, and therefore none of the medications are approved for use in this population. There is some support for the use of opioid agonists, such as methadone and buprenorphine, in adolescents when they are considered able to consent to such treatment, and should be used for adolescents with severe opioid dependence with high risk for continuing drug use. Adolescents with a short duration of opioid use disorder who have a significant family and social support may respond to opioid withdrawal with or without naltrexone as a relapse prevention strategy. Appropriate pharmacotherapy should also be used to treat co-occurring psychiatric disorders as a part of integrated treatment plan that also involves psychosocial treatments. Age-appropriate pharmacological interventions for substance misuse need to involve specialist services such as paediatricians, young people’s clinicians and child and adolescent addiction psychiatrists and psychologists.
h) Gender issues in the treatment of adolescents
Recognition of sexual orientation and gender identity and gender differences should be included as an integral part of treatment in adolescents. Boys typically prefer mixed-gender groups, while girls may prefer girls-only groups, reflective of differences in both the socialization and substance use histories of girls and boys. Given the much higher rates of physical abuse, sexual abuse and the exchange of sex for drugs among girls than boys, at least part of a treatment programme should be gender specific. In girls, treatment may focus on unique vulnerabilities of girls such as depression and a history of physical and sexual abuse, while treatment for boys may focus on impulse control issues, disruptions in the school and the community, and a history of learning and behavioural problems. However, many of these issues will need to be addressed in all children and adolescents.

11.4 People involved with the criminal justice system

SUMMARY
People who use substances and are involved in the criminal justice system, including those in prison, are entitled to the same parity of access and quality of SUD treatment as other patients. NDLEA counselling services have a vital role to play and partnership arrangements and referral pathways should exist between the criminal justice system and SUD treatment providers.

11.4.1 Introduction
Crime and drug use are closely associated; substance dependency is associated with offending and incarceration. In addition, prison populations tend to have higher rates of health and mental health problems. Incarceration often interrupts treatment for people with drug use disorders and they are at considerable risk when exiting prison due to high chance of overdose.

People with substance use disorders with involvement with the criminal justice system have the right to receive the same level of care and treatment as those not involved with the criminal justice system. Services will need to consider treatment responses in line with local legal frameworks. The decisions of criminal justice officials should not deprive a person of the right to access needed healthcare and services. When an offender with drug dependence comes into contact with the criminal justice system, there is a high likelihood that he/she has not been receiving adequate treatment. In Nigeria, the NDLEA has a vital role to play in reducing drug-related crime and supporting offenders who use drugs in treatment. NDLEA counselling centres also see clients who have been mandated into treatment; therefore, strategies that focus on enhancing motivation to engage and consider consent are important as some people may enter treatment following raids.

11.4.2 Assessment and treatment considerations
Treatment and care for those with drug and alcohol problems in the criminal justice system (CJS) should aim to be excellent, safe, effective and broadly equivalent to those in the community.

- If the patient is in a secure setting such as a police cell, staff should check if the patient is showing signs of withdrawal. If they are (particularly alcohol withdrawal) they should be offered the appropriate intervention to manage symptoms and any dependence disorder assessed and treated.
- If the patient is on opioid substitution treatment, they should continue to receive their medication in consultation with appropriately trained prescribers.
Opioid dependence on the first day or night in prison is usually treated with continuation of community OST or initiation in prison, with regular monitoring and enhanced observation over the subsequent five days of stabilization.

Polypharmacy with two or more sedative or depressant medications should only be used with considerable caution on the first night and for the first few days.

As part of the assessment process upon entry into the secure setting, any intervention, including the continuation or onset of prescribing, should be linked to treatment plans and considered throughout the stay in secure settings.

For offenders with opioid severe dependence given a short sentence, continued opioid maintenance prescribing in prison, along with plans for seamless follow-up in the community, is usually the most appropriate and evidence-based approach.

Opioid detoxification in prison should be discussed with patients to enable them to consider the benefits and risks, based on the risks of relapse to opioid use after release.

There should not normally be mandatory opioid reduction regimes for dependence.

Withdrawals in prison should be actively managed using opioid substitute, adjunctive and/or symptomatic medication, equivalent to provision elsewhere.
12. CLINICAL GOVERNANCE

SUMMARY
All SUD treatment providers should ensure the safety, quality and effectiveness of their services, implementing good clinical governance or a systematic approach to monitoring, and continuously improving quality and safety. Nigeria has standards for SUD treatment that should be adhered to, including those for NDLEA counselling centres, model treatment centres, draft Essential Standards (2019), and the National policy for controlled medicines and implementation strategies (FMOH 2017). Core elements of clinical governance required in SUD treatment services include: patient records and information governance systems; ensuring staff are competent, have the skills, knowledge and experience necessary for their roles and are properly managed and supervised.

Patient or client involvement in both treatment and quality assurance of the service is also recommended.

12.1 Principles of clinical governance

Clinical governance is a systematic approach to monitoring and continuously improving the quality and safety of clinical interventions. Components of clinical governance include:

- Clinical effectiveness: does the treatment achieve expected outcomes?
- Information governance.
- Client or patient and carer experience of treatment and their involvement in treatment.
- Staff competence: training, education and continuing professional development.
- Staff capacity and management.
- Safety and management of risk.
- Clinical audit against quality standards and criteria.

Clinical audits or quality assurance in healthcare services involve a process of comparing aspects of that healthcare against agreed standards or criteria for that healthcare. Audits or clinical audits are recommended for most types of healthcare and should be used to ensure adherence to standards and quality. Implementation of a quality assurance cycle is good practice, including regular cycles of audit, action planning to improve care where it falls short of standards, quality improvement programmes, and re-audit to check progress ensure that interventions meet standards.

In many countries, the provision of health and social care services (including services for SUD) are required to be part of regulation, inspection or accreditation mechanisms demonstrate that a service meets agreed quality standards. This may involve regular audit and/or inspection and implementation of quality assurance or continuous improvement cycles. The development of sustainable continuous or regular reliable systems of data collection, audit data and patient satisfaction and feedback data are bedrocks of quality assurance. Nigeria has several sets of standards for SUD treatment including those based on the International Standards, standards for NDLEA counselling centres and draft Essential Standards, developed and piloted in 2019 for all SUD services, based on UNODC quality assurance mechanisms.57

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12.2 Patient records and information governance

a) Information governance key points
SUD service providers should:
- Keep patient records.
- Ensure confidentiality of patient information and appropriate information-sharing and data protection.
- Routinely collect and analyze data on treatment service quality and utilization, and make effective use of data to inform service improvement and development.
- Have information governance policies and procedures that are agreed upon with relevant bodies and partners if joint protocols are included.

b) Patient records documentation
Written or electronic patient records should be kept in a secure location, only available to the staff directly involved in treatment. Proper documentation should include at minimum:
- Patient assessment.
- Patient signed consent to treatment and agreement on programme rights and responsibilities (or parental/legal guardian consent for minors).
- Patient signed confidentiality, information-sharing and ethics policy.
- Next of kin or family contact details.
- Patient treatment plans with goals for each patient, codeveloped with the patient.
- Regular treatment reviews and updates of treatment plans, with details of treatment, progress and any changes to the original goals, codeveloped and agreed upon with patients.
- Details of referral and coordination between health, social care, housing, criminal justice agencies and others involved in the patient's treatment and care.
- Patient discharge planning and discharge records with a completion summary.

Patient confidentiality is the general rule for information that identifies the patient. Information sharing (with patient consent) can be very helpful to the patient as it can allow the service to refer and coordinate treatment care between different services to meet the diverse needs of the patient. An example is referral and joint work in relation to a serious health condition, such as treatment for liver disease.
There may be occasions when it is necessary to share patient information against their consent if there is risk of serious harm to the patients or others. Examples include: patients with suicide ideation requiring immediate mental health treatment or parents with SUD who have children at risk of significant harm who require protection. Decisions to share information without patient consent should be made by a multi-disciplinary team rather than an individual staff member, should be in line with the information governance policy, and the patient should be informed and supported.

12.3 Staff competence (qualifications, skills, supervision, management)

Ensuring staff working in SUD service are competent is of critical importance to the effectiveness of treatment. SUD treatment managers should ensure that all staff have appropriate qualifications or certification, training, skills and attitude for their jobs. SUD treatment is a quickly changing and evolving area of healthcare and all staff providing psychosocial or pharmacological interventions (clinical staff) have an obligation to update their knowledge and skills in line with emerging evidence-based practice. As outlined in Chapter 6, the therapeutic relationships staff form with patients are of critical importance to patient engagement and outcomes. Staff values and attitudes towards those with SUD are as important as competence, and services should foster staff who are positive, motivational, proactive and can work in partnership with patients in recovery-orientated models. Non-clinical roles, such as leadership and management, are also important for senior staff and lead clinicians.

SUD services should also ensure that staff are properly recruited and managed, receive regular supervision, and have annual appraisals and personal development plans. Staff competence and welfare is critical to service quality. Services should ensure that staff are fully informed of treatment policies, protocols or manuals and are regularly supervised to ensure fidelity to the service model and interventions. Supervisors should be qualified to supervise staff or have been assessed to ensure they have sufficient competence and expertise to do so.

Staff working in specific settings such as outreach may require dedicated protocols to ensure staff and client safety and adherence to models.

12.4 Medicines management

In Nigeria, SUD service providers should operate medicines management in line with the National policy for controlled medicine and its implementation strategies.58 Most of the medicines required for treatment of SUD are controlled substances in Nigeria and have been agreed upon as suitable for use in SUD treatment.

There is explicit national guidance on the roles and responsibilities of healthcare personnel in prescribing and dispensing of controlled medication and this should be observed by all SUD treatment staff and services. Explicit roles and responsibilities may be summarized as:

- The Federal Ministry of Health (Department of Food and Drug Services), in collaboration with NAFDAC, is responsible for the importation and procurement of Schedule 1 narcotic medicines for use by health, training and research organizations. These medicines are stored at federal medical stores. SUD services can request medication to meet their needs from the director of pharmaceutical services. Other controlled medications apart from Schedule 1 narcotics are imported and approved by corporate bodies after approval from NAFDAC.

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Doctors are responsible for the proper filling in, signing, and stamping of the controlled medicine prescription forms. Registered pharmacists import, manufacture, procure, store, distribute, sell, compound, and disperse controlled medicines and substances in accordance with the rules and laws in Nigeria. These pharmacists should ensure rational dispensing and use of controlled medicines.

It is the duty of the registered pharmacist to ensure proper handling of controlled medicines. This is to ensure the quality and potency of the medication is maintained throughout its shelf life. The pharmacist should take all appropriate steps to prevent diversion of controlled medicines and substances in his/her custody.

At a facility or service level, the pharmacist in charge is responsible for stocking narcotics and psychotrophic medicines, dispensing to wards and patients in accordance with prescriptions. They will require all information on the prescription to be complete before dispensing. The pharmacist will ensure the consumed amount is indicated and any balance properly discarded, documented, signed and stamped. The pharmacist in charge shall inspect and audit stock periodically (weekly and monthly), including expiration dates. A monthly report of consumed medication should be prepared for the facility.

At a SUD facility level, it is the duty of the licensed medical practitioner to prescribe controlled drugs and other medication to SUD patients.

The head nurse should be responsible for keeping custody of Schedule 1 narcotic medication for emergency ward supply under lock and key in a designed cupboard/box for emergency or routine use within 24 hours.

Where a doctor is absent, a licensed community health officer (CHO), community health extension worker (CHEW) or junior community health extension worker (JCHEW) shall be responsible for the prescription of controlled medicines at primary healthcare centres, clinics and health posts, respectively.

Prescription by these categories of health workers shall be in adherence with the Standing Order for primary healthcare and provisions in the Essential Medicines List in Nigeria. The Standing Order is reviewed, and workers trained to ensure consistent application of the policy.

It is the duty of the registered pharmacist or licensed pharmacy technician (under supervision) to dispense controlled medication at primary health centres, clinics and health posts.

In addition, this document has detailed guidance that SUD treatment centres and staff should follow, on:

- Pharmacovigilance or drug safety: to ensure that there is a process and data on the detection, assessment, monitoring and prevention of adverse reactions to medication.
- Rational prescribing: to ensure there is a standard process of prescribing, prescription forms completion practices; use of up-to-date information of medicines to achieve the desired goal for patients; standard operating procedures and guidance to support prescribers (dose, routine of administration, and duration to fit patient needs); providing patient information; and standard protocols to monitor therapeutic and adverse effects.
- Good dispensing practice: licensed premises and people; minimum information requirements; patient education; medication given in suitable containers; monitoring responses to medication; documentation of dispensing in designated registers; and retention of prescriptions for controlled drugs for three years.
- Concordance: patient privacy.
- Drug information services: drug information units and equipment to guarantee access and dissemination of current and accurate drug information.
12.5 Patient or client involvement in their treatment and quality assurance

Client or patient involvement in their treatment and recovery, and in the design, delivery and quality assurance of SUD services, is good practice and advised in international guidance documents including the *International Standards* and the UNODC quality assurance mechanisms.

Fully involving clients or patients in their SUD treatment as active partners, not passive recipients, is good practice, associated with better outcomes, and is essential in recovery-orientated SUD treatment models. At a minimum, service users or patients should be:

- Fully involved in assessment processes with their choices and goals considered.
- Facilitated to make informed choices about treatment options including being provided with adequate information on risks and potential benefits of options.
- Give informed consent to SUD treatment (noting the service user or patient has the right to withdraw that consent at any time).
- Be fully involved in treatment planning and treatment plan reviews with these being co-produced with clients or patients and sensitive to their individual needs.
- Be viewed as having assets they can enhance to build recovery capital, with SUD services being helpful to the client in enabling them achieve their recovery goals and take responsibility for their lives.
- Provided with facilitated access to peer support and self-help and exposure to staff or volunteers with lived experience of SUDs who have achieved recovery outcomes.

Furthermore, in relation to SUD service delivery and quality assurance, it is good practice to involve clients or patients at a range of levels in the design and development, planning and management, delivery, and quality assurance of SUD services. Examples include:

- **Involvement in design and development** of SUD treatment interventions via formal consultation or SUD working groups on service design with explicit coproduction of services to meet the diverse needs of different population groups.
- **Involvement in the planning and management** of SUD services may involve patient representative groups that formally meet with service managers on a regular basis; patient representatives on senior management teams and boards of services as full members of those groups.
- **Involvement in service delivery** can include explicit and deliberate inclusion of people with lived experience of SUD in staff teams (such as in residential rehabilitation units, or as outreach workers or peer support workers) plus visible peer support volunteers to provide mutual aid groups, meet and greet functions, recovery coaching, etc.
- **Quality Assurance**: should routinely include client complaint mechanisms, client satisfaction surveys and other service use feedback. Client involvement in clinical governance meetings and processes can also help identify underlying issues in services and enable codesign of solutions.

12.6 Establishing quality assurance cycles

Quality assurance mechanisms can ensure that services provided are evidence-based, ethical, provided within human rights frameworks, and have the desired outcome on the people they are designed to serve. All SUD treatment services in Nigeria are advised to establish quality improvement cycles irrespective of the types of intervention or the setting they provide. Standards that SUD treatment services should adhere to include: Nigerian standards for SUD treatment, Nigerian Essential Standards for SUD treatment and NDLEA counselling centre standards. Services should be clear about which standards apply to them and implement a
process by which the service, once it has agreed its standards or criteria, has regular (e.g. quarterly or annual) routine mechanisms for collecting data, comparing practice with standards using data and making plans to improve areas that fall short of standards.

Key areas to examine in a quality assurance cycle is:

- **Effectiveness**: does the service provider achieve expected outcomes for clients or patients; is there routine monitoring of client/patient utilization of services or drop-out or completion rates; is there outcome monitoring of patients of services users.

- **Does the service have operational procedures** in place that can ensure good: information governance; risk management; medicines management (if applicable); health and safety; suitable environments; etc.

- **Client or patient and carer experience** of treatment and their involvement in treatment.

- **Staff competence and functionality**: audits of staff recruitment processes; complaints; disciplinary issues; levels of sickness; staff satisfaction; staff training; education; and continuing professional development.

- **Does the service have enough staff and are they well managed and well led?**

- **Are policies and procurement and the treatment manual adhered to**, ensuring fidelity to the model and good practice?

- **Is there a regular cycle of audit against quality standards and criteria?**

When implementing quality improvement changes, SUD services are advised to use proven quality improvement methods, such as plan, do, study, act (PDSA): a tried and tested method that helps services plan their chosen improvement, test it and then review it before proceeding with wider implementation.

### 12.7 Research in SUD treatment services

All research, evaluation or audit by external parties conducted in SUD treatment centres should be conducted in accordance with and adherence to ethical and research governance policies and procedures.
APPENDIX 1: GLOSSARY OF VALIDATED MENTAL HEALTH ASSESSMENTS

The following is a sample of assessments and validated instruments that have been used to assess mental health difficulties. This glossary is provided for example purposes only; it is the treating clinical team's decision to use a particular instrument and is left to their clinical decision-making. Some of the assessments listed here may not have been validated on Nigerian samples. A wide range of screening tools is available to detect common mental disorders (CMDs), but few have been specifically developed for populations in low and middle income countries (LMIC). Cross-cultural application of a screening tool requires that its validity be assessed against a gold standard diagnostic interview. For a review, refer to Ali, G.C., Ryan, G. and De Silva, M.J., 2016. Validated screening tools for common mental disorders in low and middle income countries: a systematic review. *PloS one*, 11(6).

For general common mental health difficulties

Self Reporting Questionnaire 20-Item (SRQ-20)

K10 scale

General Health Questionnaire

Depression
PHQ-9

Beck Depression Inventory – Short Form (BDI-SF)

Hospital Anxiety and Depression Scale

Anxiety
GAD 7

Beck Anxiety Inventory

Trauma
Impact of events scale-revised
APPENDIX 2: GLOSSARY OF TERMS USED WITHIN THIS DOCUMENT

**Aftercare:** This is the support or care that a person can expect to receive once discharged from inpatient care. Typically, a discharge plan will be developed by the multidisciplinary team and with the service user, which will make clear what care and support will be provided.

**Agonist:** In pharmacology, a substance that stimulates or mimics a receptor-mediated biological response by occupying cell receptors.

**Antagonist medication:** A chemical entity extrinsic to endogenously produced substances that occupies a receptor, produces no physiologic effect, and prevents endogenous and exogenous chemicals from producing an effect on that receptor.

**Anxiety:** This is the term used to describe experiences such as chronic fear, tension and panic attacks. Some people have an overwhelming feeling of dread that prevents them getting on with everyday life. Sleepless nights and recurring thoughts are common, as well as nausea, palpitations, dizziness and difficulty breathing. Anxiety is one of the most common mental health problems.

**Audit cycle:** The process of carrying out a clinical audit project follows a cycle of identifying a topic, setting standards, measuring current practice against these standards, agreeing to recommendations, and implementing change. This cycle is repeated to ensure change has occurred and improvement is maintained.

**Care Coordinator:** A care coordinator is the person responsible for making sure that a patient gets the care they need. Patients and carers should be able to contact their care coordinator (or on-call service) at any reasonable time. Once a patient has been assessed as needing care under the Care Programme Approach, they will be told who their care coordinator is. The care coordinator is likely to be community mental health nurse, social worker or occupational therapist.

**Care plan:** A care plan is a written plan that describes the care and support staff will give a service user. Service users should be fully involved in developing and agreeing to the care plan, signing it and keeping a copy.

**Carer:** The term carer is used throughout to refer to partners, family, friends and concerned others who are affected by someone else’s drug use.

**Clinical audit:** A process used to measure the quality of aspects of care and services and to improve that quality.

**Clinical governance:** A framework that ensures that organizations monitor and improve the quality of services provided and that they are accountable for the care they provide.

**Clinician:** The term clinician is used throughout the Clinical Guidelines to refer to the range of professionals working in treatment settings with people with substance use disorders. Clinicians increasingly covers other professions, including nurses, pharmacists, psychologists and drug workers.

**Clinical team:** A team of healthcare professionals from different disciplines (e.g. nursing, psychiatry, occupational therapy).

**Cognitive behavioural therapy (CBT):** This is an approach to treatment that involves working with people to help them change their emotions, thoughts and behaviour. A person’s personal beliefs are addressed in order to understand and change behaviour.
**Consent to treatment:** If you are an informal patient, you have the right to refuse any treatment. You have a right to receive full information about the treatment, its purpose and possible side effects. If consent is not obtained, the treatment cannot normally be administered.

**Consultant Psychiatrist:** A consultant psychiatrist is a trained mental health doctor with additional specialist training in psychiatry.

**Clinical Psychologist:** A clinical psychologist is a trained mental health professional specializing in psychology – normally with a post-graduate qualification in clinical psychology. Psychologists have skills in the assessment and treatment of mental illness and psychological problems. Unlike psychiatrists, they are not medical doctors; their skills include assessing cognitive functions (for example, speech and thought) and providing talking interventions.

**Diagnosis:** Identifying an illness or problem by its symptoms and signs.

**Dual diagnosis:** Dual diagnosis refers to two or more disorders affecting one person. For example, mental illness and learning disability. It is also used to indicate that a person who has been diagnosed with a mental health problem also misuses substances, such as illegal drugs, legal drugs or alcohol.

**Drug terminology**

**Drug:** The word drug is used to describe a psychoactive substance (other than alcohol) used illicitly or illegally, except in the term ‘controlled drug’ where it refers to a controlled substance.

**Evidence-based recommendations:** A decision about management based primarily on evidence from scientific literature.

**Family therapy:** This form of therapy involves all relevant members of a family, placing importance on the family as a pathway toward helping to treat the person.

**ICD-10 (International Classification of Disorders):** The ICD is a form of classifying mental health problems and assisting clinicians in diagnosing problems. The number 10 represents the 10th edition of the book.

**Korsakoff’s syndrome:** This is a problem that usually occurs in people who have had severe, long-term alcohol abuse problems. It is characterised by marked short-term memory loss.

**Multidisciplinary:** Denotes an approach to care that involves more than one discipline; typically this will mean that doctors, nurses, psychologists and occupational therapists are involved.

**Medicine:** Used to describe a substance made into a suitable formulation for use in treatment, except where the term ‘controlled drug’ is used to describe a substance defined by and controlled under the *Misuse of Drugs Act*. The term ‘drug’ may also be used when describing the properties of a chemical used as a medicine, or when used in a widely accepted compound term such as ‘non-steroidal anti-inflammatory drug’ or z-drug.

**Opiate vs. opioid:** Opioid is used in line with the WHO definition to refer to the whole group of natural, semi-synthetic and synthetic compounds that act on opioid receptors. However, opiate is also used at times for substances derived from the poppy plant and for the semi-synthetic drug diamorphine (heroin).

**Solution vs. mixture:** Methadone solution is used throughout as the MHRA-preferred term to describe methadone oral solution.

**Person who uses drugs (PWUD) or Person who injects drugs (PWID):** These terms are used throughout, except where an alternative aids clarity and readability or is specifically appropriate, in which cases ‘patient’ or ‘service user’ or other term are used.
**Protocol:** A locally agreed document that provides detailed procedures for the delivery of an intervention. Protocols should be based on evidence of what is effective.

**Psychosis or psychotic disorders:** These disorders involve distorted perceptions of reality and irrational behaviour, often accompanied by hallucinations and delusions.

**Randomized controlled trial (RCT):** A type of research or experiment used to compare the effectiveness of different treatments. Patients are randomly assigned to groups. The groups either receive the treatment being assessed or are a control group. The control group receives dummy (placebo) medication. RCTs offer the most reliable form of evidence for effectiveness.

**Recovery:** No single definition of recovery was used by the expert group. Recovery is "a process, which is different for each individual, which has key components of gaining voluntary, sustained control over substance use, whilst maximizing health and well-being and gaining social integration. It should be: an individual process or journey rather than a predetermined destination; built on hope, in order to sustain motivation and support expectations of an individually fulfilled life; about enabling people to gain a sense of control over their own problems, the services they receive, and their lives; helping people to find opportunities to participate in wider society; culturally appropriate."

**Risk assessment:** Identifying aspects of a service that could lead to injury to a patient or staff member and/or to financial loss for an individual.

**Service user:** This is someone who uses health services. Other common terms are patient or client.

**Substance use disorders (SUDs)/Drug and alcohol use disorders:** Are the preferred terms used throughout this document and refer to the use of both drugs and alcohol.

**Substance abuse:** This refers to the abuse or misuse of non-medical or recreational drugs and/or alcohol. As well as physical problems, some substance abuse can lead to psychological problems, such as depression, anxiety and, in some cases, psychosis.

**Talking treatment or talking therapies:** These are psychological treatments in which improvement in a person’s symptoms or well-being is achieved by talking with a therapist or counsellor rather than, or in addition to, taking medication.

**Dose titration:** Dose titration means to slowly increase the dose of a drug to an optimal level to meet patient need.

**Tolerance:** Refers the body’s capacity to endure a level of medication or a drug. Tolerance may increase over periods of time. It can also be used to refer to a person who uses drugs capacity to consume a level of either alcohol or illegal drugs due to repeated use or exposure.

**Treatment and recovery care plan/planning:** Different terms are in use to describe processes for, and the product of, agreeing with a service user a plan for what they wish to address in their treatment and recovery, and how. These are generally variations on and combinations of care plan, treatment plan and recovery plan. These guidelines use the all-encompassing term 'treatment and recovery care plan'.

**User involvement:** User involvement refers to a variety of ways in which people who use health services can be involved in the development, maintenance and improvement of services. This includes patient satisfaction questionnaires, focus groups, representation on committees, involvement in training and user-led presentations and projects.