



UNODC

United Nations Office on Drugs and Crime

Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in Southeast Asia

CBTX

Foreword

Drug use disorders are health conditions that can affect any individual, family and community. Yet misperceptions, fears of social and legal consequences, and discrimination all tend to keep people away from the services they need. On the other hand, if they get help, people suffering from drug use disorders can and do manage their condition, recover and lead happy, productive, and full lives.

UNODC promotes a health-oriented approach to drug dependence. Together with WHO it has launched a Joint Programme on drug dependence treatment and care which promotes and supports worldwide evidence-based policies, strategies and interventions that are based on a public health and human rights approach, in order to reduce drug use and the health and social burden it causes. The Joint Programme encourages investment in comprehensive and results-oriented programmes for drug dependence treatment and care, particularly community-based interventions.

The dominant response in Southeast Asia to drug use and dependence are compulsory centres for drug users, which are not consistent with a number of Principles of Drug Dependence as proposed by UNODC and WHO in 2009. Community-base treatment for drug use disorders, a cost-effective alternative, is not well understood in the region.

This Guidance Document outlines community-based treatment as an alternative model to compulsory centres, which results in less restriction of liberty, is more cost-effective, less stigmatizing and offers better prospects for the future of the individual and society. The Guidance Document is aimed at helping practitioners in the health, social work and law enforcement sectors implement community-based Treatment.



Jeremy Douglas
Regional Representative for
Southeast Asia

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Glossary of terms and abbreviations

Abstinence	Refraining from using drugs
Agonist	A substance that acts on receptor sites to produce certain responses, for example both heroin and methadone are agonists for opioid receptors.
AIDS	Acquired Immunodeficiency Syndrome, in which the immune system is weakened and unable to combat infectious diseases.
Alcoholics Anonymous	Mutual help or self-help group; twelve step method
Analgesic	A substance that reduces pain and may or may not have psychoactive properties. Opioids are analgesics.
Antagonist	A substance that counteracts the effects of another agent. Pharmacologically, an antagonist interacts with a receptor to inhibit the action of agents (agonists) that produce specific physiological or behavioural effects mediated by that receptor. For example, naloxone and naltrexone are both antagonists for opioid receptors.
Antidepressant	One of a group of psychoactive agents prescribed for the treatment of depressive disorders; also used for certain other conditions such as panic disorder. There are three main classes: tricyclic antidepressants (which are principally inhibitors of noradrenaline uptake); serotonin receptor agonists and uptake blockers; and the less commonly prescribed monoamine oxidase inhibitors.
Antisocial personality disorder	Previously known as ‘psychopathy’ or ‘sociopathy’, this disorder is characterised by a pattern of complete disregard for others. Deceit and manipulation are central features.
Anxiety disorders	Characterised by problematic anxiety that is so persistent, or so frequent and intense that it prevents the person from living in a way they would like. Panic attacks are a common symptoms of anxiety disorders.
Anxiolytics	Anti-anxiety drug. Benzodiazepines are examples of anxiolytics.
Benzodiazepine	A group of structurally related drugs used mainly as sedatives/ hypnotics, muscle relaxants, and anti-epileptics. Benzodiazepines were introduced as safer alternatives to barbiturates. They do not suppress REM sleep to the same extent as barbiturates, but have a significant potential for physical and psychological dependence and misuse.
Bipolar disorders	Also known as bipolar affective disorders or manic depression, these disorders are characterised by recurrent episodes of mania (or hypomania) and major depression. In between episodes the person is usually completely well.
Borderline Personality Disorder	Marked by persistent patterns of instability in relationships, mood, and self-image. Borderline Personality Disorder is also characterised by marked impulsivity, particularly in relation to behaviours that are self-damaging.
Cannabis	General term for the products of the plant <i>Cannabis sativa</i> . See also marijuana and hash.
Cocaine	An alkaloid obtained from coca leaves. Cocaine is a powerful central nervous system stimulant used to produce euphoria or wakefulness.
CRA or CRAFT	Community Reinforcement Approach or Community Reinforcement Approach with Family Therapy. (See “4.4.1 Types of counselling”)
Craving	A strong desire or urge to use drugs, most apparent during withdrawal and may persist long after cessation of drug use. Symptoms are both psychological and physiological. Cravings may be triggered by a number of cues, e.g., seeing a dealer, walking past a place where drug use occurred in the past.
Delusions	False beliefs that usually involve a misinterpretation of perceptions or experiences. For example, sufferers may feel that someone is out to get them, that they have special powers, or that passages from the newspaper have special meaning for them.
Demand reduction	A general term used to describe policies or programmes directed at reducing the consumer demand for psychoactive drugs. It is applied primarily to illicit drugs, particularly with reference to educational, treatment, and rehabilitation strategies, as opposed to law enforcement strategies that aim to interdict the production and distribution of drugs (supply reduction).

Depressant	Any agent that suppresses, inhibits, or decreases some aspects of central nervous system (CNS) activity. The main classes of CNS depressants are the sedatives/hypnotics, opioids, and neuroleptics. Examples of depressant drugs are alcohol, barbiturates, anaesthetics, benzodiazepines, opiates and their synthetic analogues.
Depressive disorders	Involve only the experiencing of major depressive episodes. Depressive disorders are distinct from feeling unhappy or sad (which is commonly referred to as 'depression') in that they involve more severe and persistent symptoms.
Diacetylmorphine, Diamorphine	Alternative generic names for heroin.
Diazepam	A common benzodiazepine
Diversion program	A program of treatment or re-education for individuals referred from criminal courts (criminal diversion) in lieu of prosecution or incarceration, which is usually held in abeyance pending successful completion of the diversion programme.
Dual diagnosis	A general term referring to comorbidity or the co-occurrence in the same individual of a psychoactive substance use disorder and another psychiatric disorder. Also known as comorbidity.
Gateway drug	An illicit or licit drug, use of which is regarded as opening the way to the use of another drug, usually one viewed as more problematic.
Halfway house	Often, a place of residence that acts as an intermediate stage between an inpatient or residential therapeutic program and fully independent living in the community. Halfway houses are used for drug users trying to maintain abstinence, people with mental health disorders and those leaving prison.
Hallucinations	False perceptions such as seeing, hearing, smelling, sensing or tasting things that others cannot.
Hallucinogen	A chemical agent that induces alterations in perception, thinking, and feeling. Examples include LSD, mescaline, and phencyclidine (PCP).
Harm reduction	Policies or programs that focus directly on reducing the harm resulting from the use of alcohol or drugs, for example clean needle programs.
Hash	Extracted resin of cannabis, also known as hashish or hash oil.
HIV	Human Immunodeficiency Virus, the infectious agent that causes AIDS.
Hypomania	Like mania, but less severe.
IDU	Injecting drug user or use.
Incidence	The rate at which conditions or illnesses occur, often expressed in terms of the number of cases per 10,000 people per year. For example, the incidence of HIV infection is the number of people contracting the virus in a year.
Inhalants	A group of psychoactive substances which are central nervous system depressants, rapidly changing from a liquid or semi-solid state to vapour when exposed to air. The most commonly used inhalants include petrol, lacquers and varnishes containing benzene, and adhesives, spray paint, glue and paint thinners containing toluene. Also called solvents or volatile substances, their appeal is linked to being inexpensive, readily available, easily concealed, and rapid intoxication with accompanying rapid resolution of intoxication.
Lapse	Sometimes called a slip, a lapse is an isolated occasion of drug use after a period of abstinence.
Maintenance	A stage of behaviour change in which a dependent drug user tries to remain abstinent or tries to maintain the behavioural change they have achieved.
Maintenance therapy	Prescription of medication on a long-term basis to support behavioural change. Opioid agonists (methadone, buprenorphine) and antagonists (naltrexone) can both be used in maintenance therapy.
Marijuana (marihuana)	Lower potency dried flowering heads and leaves of the cannabis plant.

Medication-Assisted Treatment (MAT)	Combination of pharmacological intervention with counseling and behavioral therapies. This provides the patient with a comprehensive approach in the treatment of substance misuse disorders.
Methadone	A synthetic opiate drug used in maintenance therapy for those dependent on opioids. It has a long half-life, and can be given orally once daily with supervision.
Mood disorders	The predominant feature of mood disorders is a disturbance of mood where emotions are experienced to the extreme. They involve having “episodes” of dysfunction which may be major depressive episodes, manic episodes, a mixture of both manic and depressive, or hypomanic.
Mutual-help group	A group in which participants support each other in recovering or maintaining recovery from alcohol or other drug dependence or problems, or from the effects of another’s dependence, without professional therapy or guidance. Prominent groups in the alcohol and other drug field include Alcoholics Anonymous, Narcotics Anonymous, and Al-Anon (for members of alcoholics’ families), which are among a wide range of twelve-step groups based on a non-denominational, spiritual approach. “Self-help group” is a more common term, but “mutual-help group” more exactly expresses the emphasis on mutual aid and support.
Naloxone	A short-acting opioid receptor blocking agent that is primarily used for the reversal of opioid overdose.
Narcotic	A chemical agent that induces stupor, coma, or insensibility to pain. The term usually refers to opiates or opioids, which are called narcotic analgesics. It is often used imprecisely to mean illicit drugs, irrespective of their pharmacology.
Narcotics Anonymous	See mutual-help group.
Needle-sharing	The use of syringes or other injecting instruments by more than one person, particularly as a method of administration of drugs. This confers the risk of transmission of viruses (such as human immunodeficiency virus and hepatitis B) and bacteria (e.g. <i>Staphylococcus aureus</i>). Many interventions such as methadone maintenance and needle/syringe exchanges are designed partly or wholly to eliminate needle-sharing.
Neuroadaptation	The process whereby the brain adapts to the presence of a drug.
Neuroleptic	One of a class of drugs used for the treatment of acute and chronic psychoses. Also known as major tranquillizers and antipsychotics.
Nicotine	The major psychoactive substance in tobacco, nicotine has both stimulant and relaxing effects.
Opiate	One of a group of alkaloids, including morphine and heroin, derived from the opium poppy (<i>Papaver somniferum</i>) with the ability to induce analgesia, euphoria, and, in higher doses, stupor, coma, and respiratory depression.
Opioids	All drugs with morphine-like activity, both natural opiates and synthetic drugs such as methadone.
Personality disorders	Characterised by destructive patterns of thinking, feeling, behaving and relating to other people across a wide range of social and personal situations. These maladaptive traits are stable and long-lasting. Antisocial personality disorder and borderline personality disorder are the most prevalent and tend to impact most upon treatment of drug abuse.
Polydrug use	The simultaneous or sequential non-medical use of more than one drug.
Prevalence	A measure of the extent of a particular condition or illness usually expressed in terms of the number of cases per 10,000 people in a given population. For example, the prevalence of HIV infection is the number of people in a population infected with the virus at a point in time.
Psychoactive drug or substance	A substance that, when ingested, affects mental processes. Not all psychoactive drugs produce dependence.

Psychotic disorders	People experiencing a psychotic episode lose touch with reality. Their ability to make sense of both the world around them and their internal world of feelings, thoughts and perceptions is severely altered. The most prominent psychotic symptoms are delusions and hallucinations.
Relapse	A return to uncontrolled drug use, or use at levels similar to those prior to a period of abstinence.
Sedative/hypnotic	Any of a group of central nervous system depressants with the capacity of relieving anxiety and inducing calmness and sleep. Benzodiazepines and alcohol are examples.
Self-help group	See mutual help group
Stimulant	Any agent that activates, enhances, or increases central nervous system activity. Examples are amphetamines, cocaine and caffeine.
Substitution treatment	See Medication-Assisted Treatment
Supply reduction	A general term used to refer to policies or programmes aiming to interdict the production and distribution of drugs, particularly law enforcement strategies for reducing the supply of illicit drugs.
Tolerance	A state in which continued use of a drug results in a decreased response to the drug. Increased doses are needed to achieve the same level of effect previously produced by a lower dose.
Tranquilliser	A calming agent, a general term for several classes of drugs used in the management of various mental disorders.
Twelve-step group	A mutual-help group organised around the 12-step program of Alcoholics Anonymous or Narcotics Anonymous.

1. Nature of substance use and dependence

People who use drugs are a heterogeneous population who may experience multiple and complex difficulties.

A model presented by Thorley¹ shows that problems may arise from a number of patterns of drug use and not just because someone is dependent on a drug. A common misconception is to think that if someone has a drug problem then they must be dependent. Thorley’s model explains that problems arise from intoxication, regular or excessive use and dependency.

Thorley’s model (Figure 1) has three parts:

- Problems from getting drunk or stoned (intoxication)
- Problems from using alcohol or drugs regularly (regular or excessive use)
- Problems from not being able to stop using alcohol or drugs (dependence).

The circles are drawn so they overlap, indicating that people can have problems in one or more areas.

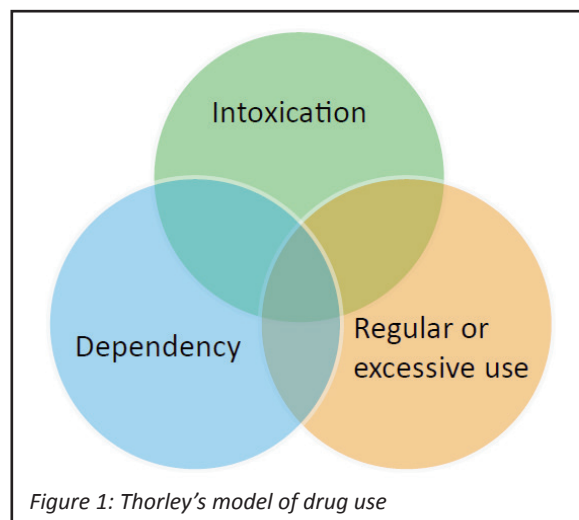


Figure 1: Thorley’s model of drug use

Problems from getting intoxicated usually come from the short-term effects of the drug. These problems people see most often, are the most disturbing and visible, and are more likely to be social in nature (see table below).

Health problem	Family, friends	Law
Hangover Feeling sick, vomiting Stomach pains and problems Head injuries from falls Other accidents and injuries Drowning Accidental overdose	Arguments Fighting Neglecting children Violence at home Sexual assault Child abuse	Being intoxicated Doing damage to things Drink driving Assaulting people Accidental killing Drug possession offences

Problems from regular or excessive use come from continued use over a period of time. This may not allow the person’s body to recover completely from the last time they used, so each time their health may get a little worse. Money problems may develop because of regular spending on the drug. Some problems of regular or excessive use are indicated in the table below.

Health problem	Family, friends	Law
Brain and nerve damage Mental health problems Heart disease, diabetes, cancer Infectious diseases Sleep and dental problems	Family problems Marriage problems Work problems Neglected children No food in the house	Drug possession offences Drink driving offences Not paying bills Sex work Drug dealing

Drug dependence develops after a period of regular use, with the time period varying according to the quantity, frequency and route of administration as well as factors of individual vulnerability and the context in which drug use occurs.

Many young people who have experimented with drug use do not become frequent users and many who become frequent users do not become dependent. Most heroin users report one to two years between their first use of heroin and their first period of sustained daily use (indicating the development of dependence).

¹ Thorley, A. Medical responses to problem drinking. *Medicine*, 3rd series (1980), 35:1816-1833.

Multiple factors including availability of drugs, family and peer influences, and the environmental context contribute to decisions to initially try drugs. Once use has occurred, further factors contribute to the likelihood of developing dependence, including:

- Environmental factors (cues, conditioning, external stressors)
- Drug-induced factors (molecular neurobiological changes resulting in altered behaviours)
- Genetic factors through traits such as response to drug use, personality, concurrent psychiatric disorders²

Approximately one in four (23%) people who use heroin will become dependent. This is the second highest rate of dependence after nicotine (32%) and substantially higher than the equivalent rates for alcohol (15%), cocaine (15%), amphetamine (11%) and cannabis (9%).

The way in which dependence develops is much the same for all drugs. Using daily or almost every day over a period of time leads to physical and psychological changes. Physically, the body adapts or 'gets used to' having a drug on a regular basis. Eventually the drug is needed to function 'normally' and more is needed to get the same effect. When this happens, stopping or cutting down is very difficult because a person will start 'hanging out' or withdrawing. The drug may then be taken to ease or stop withdrawal occurring.

Psychologically, a person's thoughts and emotions come to revolve around the drug. A person will 'crave' the drug (have strong urges to use), and feel compelled to use even though they know (or believe) it is causing them difficulties – perhaps financial or legal worries, relationship problems, work difficulties, physical health problems and psychological problems such as depression and anxiety.

Smoking or ingesting methamphetamine is a significant form of drug use in Southeast Asia. Amphetamine-type stimulants, particularly methamphetamine, are used to enhance the ability to work as well as in recreational or social situations. Work requiring stamina, long hours and hard work is closely linked to methamphetamine use for some people. Such work provides higher income, but the user enters a vicious circle of using methamphetamine in order to be able to do the work, but then having to work to get enough money to buy more drugs and so on. Alcohol consumption may also be linked to methamphetamine use, with alcohol being used to help relax and sleep and eat, but also as a substitute when methamphetamine is not available.

'Dependence' is widely accepted as describing a characteristic set of cognitive, behavioural and physiological signs. (See 5.1.4, Diagnostic guidelines for dependence.) As indicated by these criteria, drug dependence is not just heavy drug use, but a complex health condition that has social, psychological and biological dimensions, including changes in the brain – it is not a weakness of character or will.

The key elements of dependence are the loss of control over use, and continued use despite awareness of problems caused or exacerbated by the using behaviour. It is these aspects that make dependence particularly damaging to both the individual and the community. The high risk of harm to individual users and the community of dependent and problematic use make this population the target for treatment services.

Because of its nature as a chronic frequently relapsing health disorder, drug dependence requires long-term treatment and care. People who inject drugs comprise a substantial group of people infected with Human Immunodeficiency Virus (HIV). Drug dependence treatment and care should therefore include a continuum of care for people infected with HIV as well as harm reduction approaches to prevent further spread of HIV.

²Kreek MJ et al. (2005). Pharmacogenetics and human molecular genetics of opiate and cocaine addictions and their treatments. *Pharmacological reviews*, 57(1):1-26.

1.1 Principles for a substance abuse treatment system

The nine principles of drug dependence treatment as outlined by a UNODC-WHO 2008 discussion paper, provide guidance for gradually implementing treatment of quality to those in need.

Principle 1: Availability and Accessibility of Dependence Treatment

Treatment services need to be available, accessible, affordable and evidence-based to deliver quality care for all people in need of support.

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

Comprehensive assessments, diagnostic and treatment planning are the basis for individualized treatments that address the specific needs of each patient and that will also help to engage him/her into treatment.

Principle 3: Evidence-Informed Dependence Treatment

Evidence-based good practice and scientific knowledge on dependence should guide interventions.

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

Treatment interventions should comply with human rights obligations, be voluntary and provide the highest attainable standards of health and well-being.

Principle 5: Targeting Special Subgroups

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

Principle 6: Dependence Treatment and the Criminal Justice System

Dependence should be seen as a health care condition and dependent individuals should be treated in the health care system rather than the criminal justice system with community-based treatment offered as an alternative to incarceration where possible.

Principle 7: Community Involvement, Participation, and Patient Orientation

Community-based treatment responses to drug and alcohol abuse and dependence can promote community change, active involvement of local stakeholders and support for community funding models.

Principle 8: Clinical Governance of Dependence Treatment Services

It is important that treatment services have clearly defined policies, treatment protocols, programs, procedures, definition of professional roles and responsibilities, supervision and financial resources.

Principle 9: Treatment Systems: Policy Development, Strategic Planning and Co-ordination of Services

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

2. Context of treatment

2.1 National and international efforts to combat illicit drug use

Treating drug dependence as a medical condition does not imply that illicit drug use is condoned. Rather, the existence of illicit drug use is acknowledged, and in the context of good public health, the objective is to take appropriate measures to limit the harm to people who are affected by drug use and dependence, their families and the rest of the community through community-based care.

The community-based approach is undertaken in the context of an ongoing strategic approach to combat illicit drug use encompassing efforts to engage the country as a whole in responding to illicit drug use. In general such a strategic approach combines supply reduction, demand reduction and law enforcement, with the community-based approach being an element of demand reduction.

It is also relevant to note that enhancement of the economic and social wellbeing of communities, particularly those in areas where cultivation of opium poppies is possible, or has occurred, is an important element in reducing the supply of illicit drugs.

As the illicit drug trade does not respect borders, it is also important for countries in the region to cooperate on measures to control the supply of drugs.

2.2 National health systems

This section considers the usual structure of national health systems. Section 3 presents in more detail the role of the different components of a national health system to the delivery of community-based treatment and care services for drug users.

The general structure of national health systems is a hierarchy with increasing specialisation. As the degree of skills, and specialisation of services increases with each level, the service delivery model is one of stepped care, with a key issue being the determination of when it is appropriate or necessary to refer a person to the next level of care.

Health interventions need to reach people either by being provided at their homes, schools, and workplaces, or by encouraging them to visit health facilities. Programmes based in communities can reduce the costs and barriers that impede people's access to services, while general primary care can act as an interface between community health programs and individual clinical care, whether ambulatory or inpatient. Hospitals are needed to reinforce community and primary care services when specialised equipment or skills are required for particular interventions.

2.2.1 Community level services

Community-based resources provide a channel for reaching families with information and resources. They also mobilise additional resources, such as volunteers' time, local knowledge, and community confidence and trust.

Community-level programs can include a range of interventions but generally focus on services related to safe motherhood, nutrition, and simple prevention and treatments.

Community-based health clinics provide basic services, supported by outreach workers, often with no specific training or qualifications.

2.2.2 Primary care

The basic notion of primary care is a range of health care services that act as an interface between families and community programs on the one hand and hospitals and national health policies on the other. A well-functioning general primary care system is integral to the success of a health system overall because it provides the bulk of services close to the population and acts as the bridge between local care and care at the next levels, such as hospitals.

2.2.3 Hospitals and specialised clinics

Hospitals and specialised health clinics provide services that are more sophisticated, technically demanding, and specialised than those available at a primary care facility.

The range of services hospitals offer includes diagnostics, treatment, care, counselling, and rehabilitation. Hospitals may also provide health information, training, and administrative and logistical support to primary and community health care programs. When a hospital's service area coincides with a local government administrative unit, it may be responsible for other public health functions throughout the catchments area.

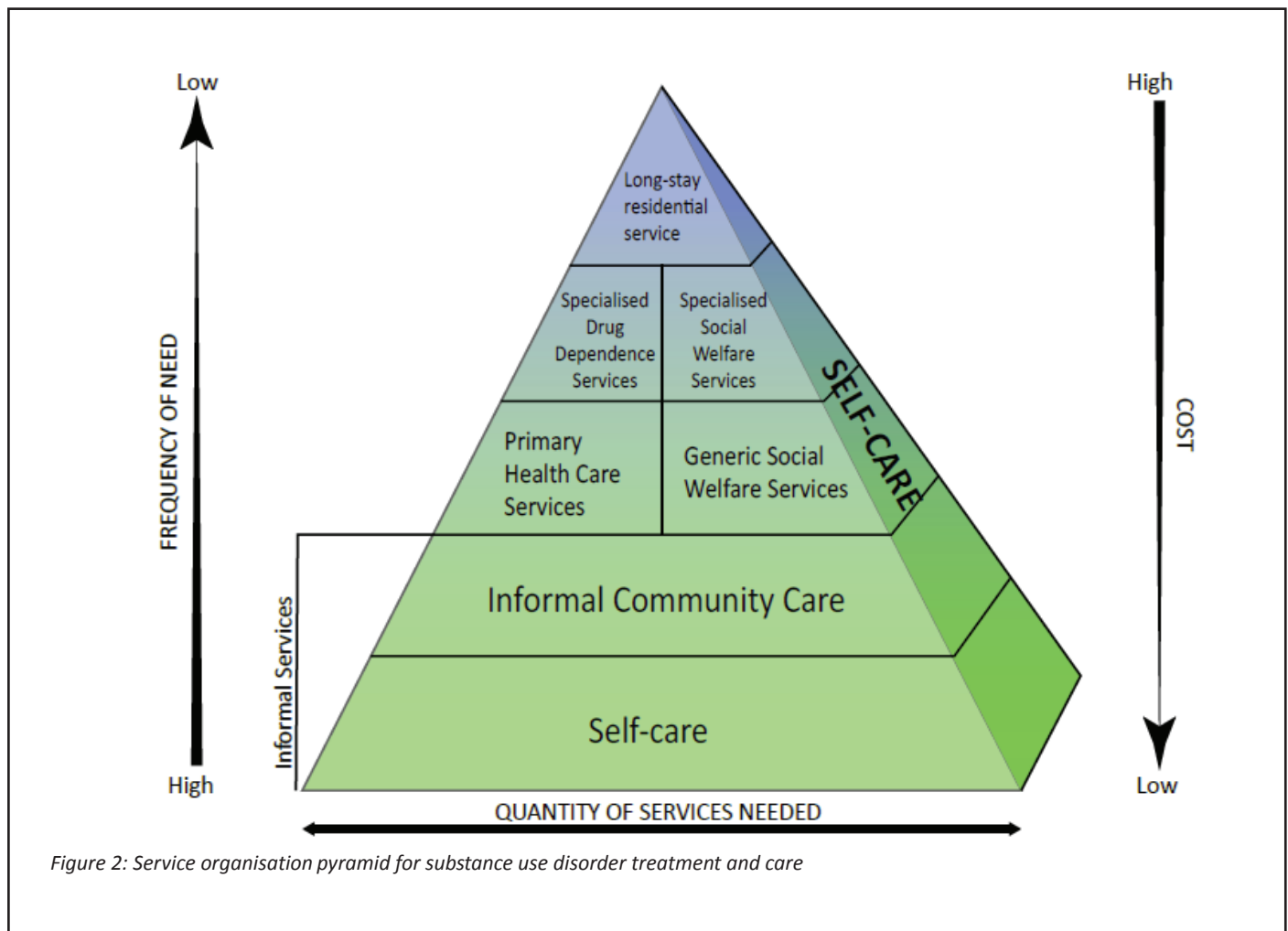
The strength of a hospital is that it concentrates skills and resources in one place for conditions that are either uncommon or difficult to treat. It is also a repository of knowledge and diagnostic tools for assessing whether referral to an even more specialised facility is indicated.

The next level of care is the specialised hospital, which provides complex clinical care to patients referred from the community, primary, or hospital levels. Referrals explicitly link the different levels of health care in both directions. Community, primary, or hospital facilities direct patients to a specialised hospital for care. The specialised hospital, in turn, provides support and information to assist the other levels and refers patients back to them when appropriate.

3. Community-based treatment approach

3.1 Philosophy of the community-based approach

The core goal of the community-based treatment model is to ensure a holistic approach to treatment and care of drug users with the intensity of essential care varied according to the nature and complexity of the problems experienced by the individual. As such the approach is broadly based on the World Health Organization Pyramid of Mental Health Services (Figure 2).



Key principles of community-based treatment are:

- Continuum of care from outreach, basic support and harm reduction to social reintegration, with no “wrong door” for entry into the system
- Delivery of services in the community – as close as possible to where drug users live
- Minimal disruption of social links and employment
- Integrated into existing health and social services
- Involve and build on community resources, including families
- Participation of people who are affected by drug use and dependence, families and the community-at-large in service planning and delivery
- Comprehensive approach, taking into account different needs (health, family, education, employment, housing)
- Close collaboration between civil society, law enforcement and the health sector
- Provision of evidence-based interventions
- Informed and voluntary participation in treatment
- Respect for human rights and dignity, including confidentiality
- Acceptance that relapse is part of the treatment process and will not stop an individual from re-accessing treatment services

There are many benefits from community-based interventions, both for people who are affected by drug use and dependence and for the community. Essential elements of the community-based approach are the forging of close linkages and collaboration between service providers in the community, the health sector and social welfare support for rehabilitation and reintegration. The process usually starts and is sustained within the community where the drug user and his/her family lives and is implemented with the assistance of all community organisations and a substantial contribution from the non-government sector.

Active patient involvement aims to promote ownership and responsibility, change in individual behaviour, and improvement of the quality and utilisation of health services.

There is increasing recognition that the process of service development needs to be accountable to and shaped by the wide range of community interests. Community and service users play an important role in helping shape an approach that ensures appropriate accountability and responsibility of all those involved in the delivery of services.

Community-oriented interventions can increase community support for people with drug problems and promote supportive public opinions and health policy. Community information and empowerment can also help reduce discrimination and social marginalisation. Reducing the stigma of drug use is a factor that is likely to substantially improve accessibility to treatment and reintegration into society.

Mainstreaming drug dependence treatment in health and social care interventions not only enables the treatment of a larger number of patients, it also promotes a paradigm change within society to acknowledge drug dependence as a multi-factorial disorder.

Treatment provided in the community is less invasive than other treatments such as residential or inpatient treatment, and less disruptive to family, working and social life, thereby fostering independence of the client or patient. It has the added advantage of facilitating use of a range of treatment and rehabilitation services, which in the community are more accessible and affordable. Crucially, a community-based approach, by not sending drug users away and out of sight, helps the community to understand the complexities of drug problems and thereby helps reduce stigma and discrimination against drug users.

It is expected that the implementation of community-based drug treatment will enable people with drug-related problems to have improved access to a range of quality services from education, information and drug counselling, to assistance in stopping or reducing drug use and avoiding the harmful health and social consequences of drug use, especially HIV, hepatitis and sexually transmitted infections. People who are affected by drug use and dependence will be offered help to improve the overall quality of their life and wellbeing through social support for rehabilitation and reintegration into the community.

3.2 Service delivery model

The model provides for comprehensive care for people who are affected by drug use and dependence and includes services in and by the community, primary health services and expert medical and psychiatric diagnosis and services in district or referral hospitals or specialised clinics. Clients are referred to whichever services are appropriate, based on screening of drug and alcohol problems, and referred back to the community for support and aftercare. This approach ensures community participation and linkages to ongoing drug use prevention and harm reduction services in the community.

People who are affected by drug use and dependence may enter the treatment system at any point. For example they may:

- First be seen in the community and stay in the community being helped by community health or social workers
- Go directly to a health centre, or drug treatment clinic
- Go directly to a hospital
- Be referred from one to the other

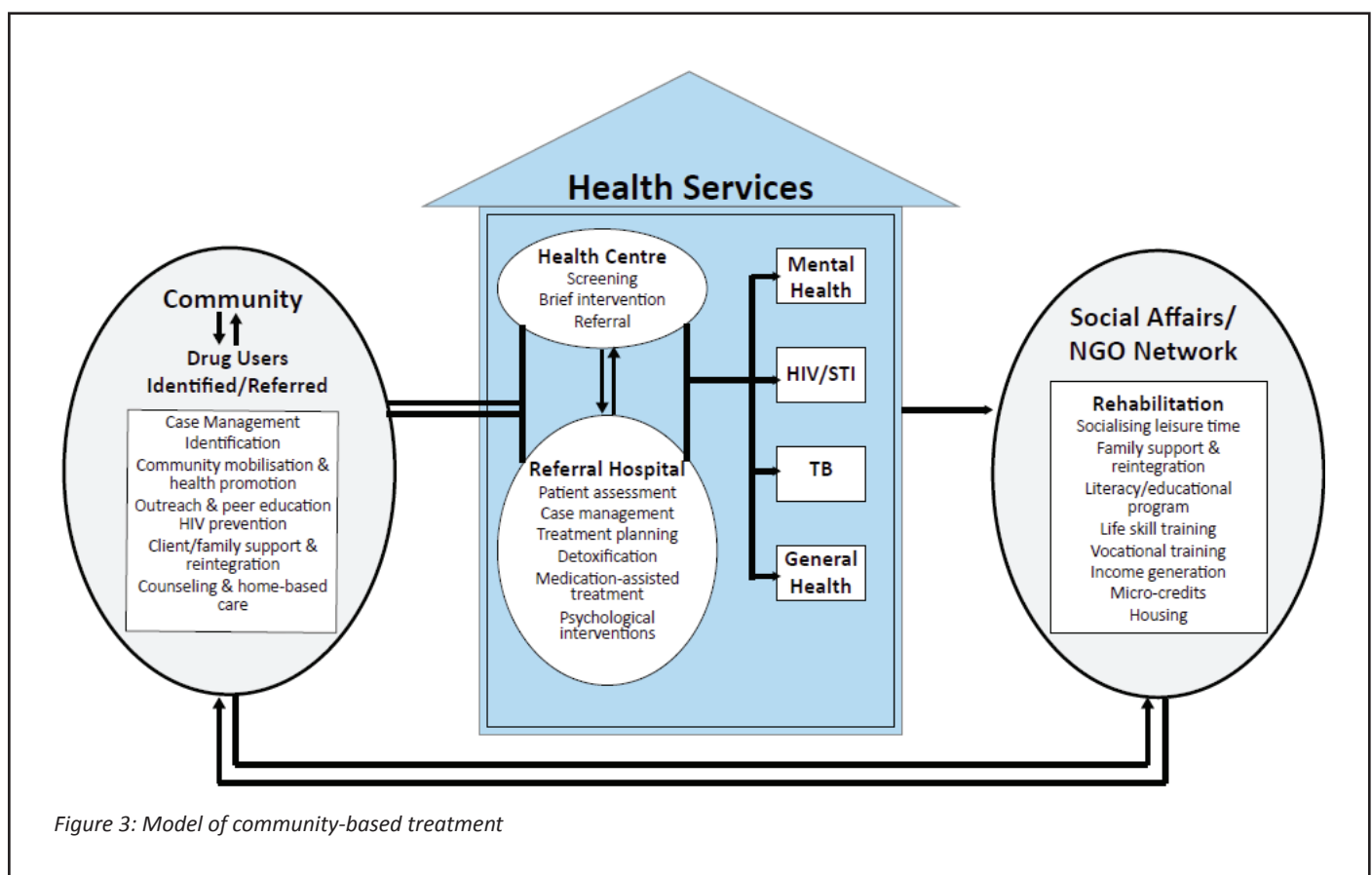
There should be linkages between drug dependence treatment services and hospital services, such as emergency rooms, infectious diseases and internal medicine departments, as well as specialised social services such as housing, vocational, mental health training and employment. Integrating psychiatric and drug dependence treatment increases retention of patients with comorbid psychiatric disorders and reduces mortality.

Implementing partner non-government organisations (NGOs) can play a significant role in the provision of services for patients with drug dependence in coordination with the public health system. They can be particularly helpful in the process of reaching out, scaling up treatment, providing support in the community and facilitation of rehabilitation and reintegration.

Where feasible, services should be offered as “one-stop-shop”. Alternatively linkages with existing services should be established and referral ensured through case management.

Services should be designed to serve the needs of specific population subgroups, such as women (including pregnant women), children and adolescents, and commercial sex workers.

Engagement with law enforcement authorities at national and local levels through agreements between law enforcement and community services can ensure an enabling environment and a facilitative/supportive role for law enforcement agencies in the delivery of a continuum of care to drug users.

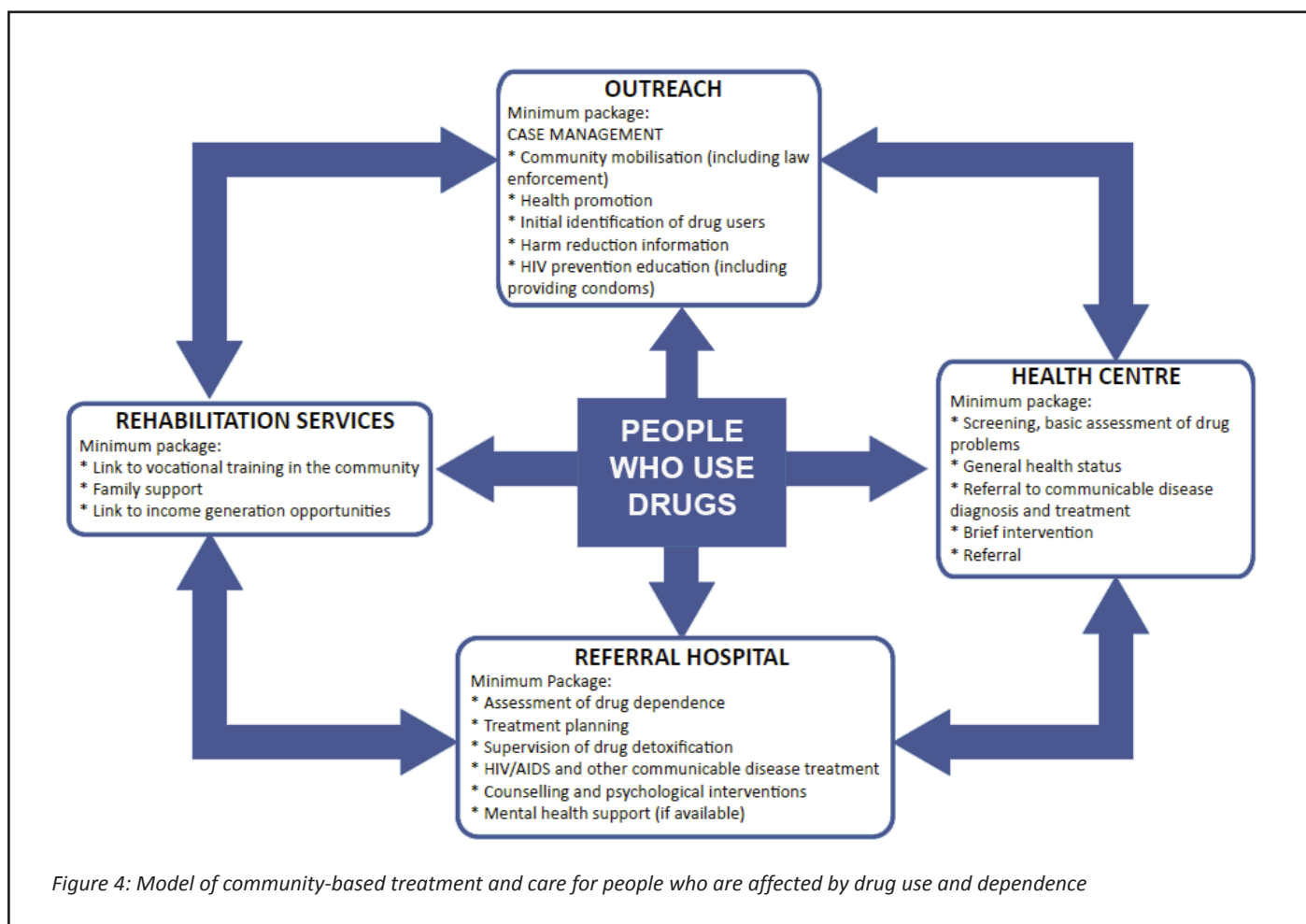


There are three major components to the model (Figure 3):

- Community organisations including NGOs help identify drug users, conduct basic screening of drug problems and refer to primary health services when required. Community organizations also focus on preventive education and health promotion support and on the delivery of basic support, reintegration and rehabilitation services
- Primary health services are provided in the health centres and specialist health services in hospitals
- The social welfare agencies and NGOs offer education, vocational and skills training, income generation opportunities, micro-credits, etc.

The role of the community is at the core of the model. The journeys of the people who are affected by drug use and dependence through the treatment and rehabilitation system begin and end in the community. Although there is no one single “best” way of entering the treatment system, drug users often are identified in the community by a variety of stakeholders including family members, NGO peer and outreach workers, law enforcement personnel and others. The provision of drug and HIV information, a preliminary screening of drug and alcohol problems and risk behaviours usually are undertaken in the community. Upon identification drug users may be either helped in the village or community or, if willing, may be referred to a health drug treatment clinic or hospital.

The model reflects the complexity of identification, diagnosis and treatment interventions for people who are affected by drug use and dependence in the community. It is clear that there is no one identifiable single entry point into the treatment and intervention system. Drug users may, if they so wish, go directly to the health centre or hospital or specialised clinic, or request assistance from government agencies or NGOs. Consequently, the model may be best described in a circular form around the individual client/patient rather than linearly (Figure 4).



The combination of services provides a continuum of care from informal community care and community outreach services, to drug withdrawal, counselling, aftercare, rehabilitation and reintegration.

The model provides the basis for close collaboration between NGOs, health and social support services at the village or community level, and provides a focal point for regular liaison between local law enforcement agencies and the community. Such a mechanism includes the raising of awareness among law enforcement officials of their role in facilitating access to health and social services for people with drug-related problems as an alternative to punitive sanctions.

3.3 Components and roles of community-based approach

Flow diagrams providing referral guides for each of the components are included in this section as an additional explanation of the roles of each component of a community-based approach.

3.3.1 Community (including outreach)

The major tasks for all community organisations are 'awareness raising', public education and health promotion, highlighting the complexity of drug use behaviours and consequences. Community-based workers help identify drug users, conduct preliminary screening interviews and basic needs assessment of the user and his/her family and together devise an 'action plan.' The initial interview and plan determine whether the people who are affected by drug use and disorder can be helped, in the first instance, in their villages or whether they need to be referred for more expert advice to the local health or drug treatment clinics or to a hospital. Community members and NGO-trained peer outreach workers assist by offering basic counselling and support to people who are affected by drug use and disorder and their families if uncomplicated home-based withdrawal is indicated. They also support people

who are affected by drug use and disorder and their families in their recovery and reintegration and rehabilitation during and following treatment at the health or drug treatment clinic or hospital.

Key individuals and organisations operating in the community can be mobilised to identify, engage, inform and assist drug users and their families to deal with drug problems. The role of community organisations is key to the process. There are many resources in most communities, including civil and religious groups, health services and political establishments.

Village health support groups are mechanisms to increase community ownership and involvement in health issues in the village. Volunteers include parents, students, teachers and youth and are offered training by NGOs. Health support groups work to mobilise community participation in the health care system.

Drop-in centres are places that drug users can feel safe to visit, where their various health and other needs can be met. Drop-in centres are less stigmatising and more attractive to people who are affected by drug use and disorder. They provide a range of services such as peer support, needle and syringe programs, referral and other health, nutritional, social and recreational activities. A small health team, comprising doctors, nurses, health workers, peer educators or outreach workers can effectively address drug-related health problems in drop-in centres.

3.3.2 Community health centres

Health centres are the closest public health facility to the population. They provide basic health care, including the treatment minor injuries and diseases such as malaria, diarrhoea, sexually transmitted diseases, TB, and leprosy.

The geographical proximity of community health centres removes an important barrier to access for people who are affected by drug use and dependence. For drop-in centres which do not have a medical officer on staff, or where the local situation makes it appropriate, the use of a local general practice clinic may be useful, in terms of client referral and access to medical advice.

It is assumed that community members, including community health workers, outreach and peer workers, family members and police, will refer people who are believed to have a substance use problem to health centres. Some will come of their own accord once they hear that help is available.

People who are affected by drug use and dependence and their families can benefit from the help of trained health centre staff. If treatment can be offered in the health centre, patients will not have to leave their villages and be sent far from home for treatment. The health centre offers a good opportunity for brief counselling, which is appropriate for people who do not have severe problems.

Community participation is obtained through health centre management committees. The health centres refer cases to hospitals or specialized clinics if necessary.

The health centre management committee is designed to represent community interests and consists of a number of community volunteers, several health centre staff and representatives from the local authorities.

Community health centres provide screening for substance use problems and associated health conditions, and provide basic primary health services. Drug users presenting with complex problems of psychiatric comorbidity, polydrug use or serious medical problems are referred to hospitals. The health centre offers basic education and brief counselling on risks of drug-related problems, working in tandem with community organisations, outreach workers and families. It is expected that community health staff will be able to offer help and support to a large number of drug users who are not drug dependent but who require services to prevent an escalation and worsening of drug-related problems and ameliorate the adverse consequences of existing drug use.

Health centres liaise with NGOs in the community, and refer patients back to community organisations who provide follow-up aftercare and facilitate access to rehabilitation and reintegration services when needed.

Key roles and responsibilities of health centres:

- Screening for substance misuse using standardised instruments (see “5.1 Screening questionnaires suitable for use in community setting”)
- Provide primary health, physical and psychiatric examination
- Provide treatment of basic health problems and symptomatic treatment for health consequences of substance use

- Provide access to voluntary counselling and testing, medications for HIV, tuberculosis and sexually transmitted infections
- Provide brief counselling
- Refer back to community or to hospital/ specialized clinics as appropriate

It is feasible to establish on-site primary health care services for people who are affected by drug use and dependence within a drug treatment clinic, especially if an outpatient program of medication-assisted treatment exists. Such services may be attractive to drug treatment clinic clients and it is highly likely that the majority of them will voluntarily use them.

3.3.3 Hospitals and specialized drug treatment clinics

Hospitals provide complementary services including treatment of complicated cases, and medical, surgical and obstetrical emergency cases, surgery, maternal and child health, X-ray, ultrasound and laboratory services, and rehabilitation services. Hospitals are not equal in their service provision, with some offering less extensive services. Only some are able to diagnose and treat drug use disorders and potential comorbidities. Drug treatment clinics are included in this section as they generally operate at the district or provincial level, with a focus on drug treatment rather than general public health services. However, drug treatment clinics may also operate at the community level. Hospitals provide a higher level of medical care than that of the health centres. Patients referred to the hospitals undergo a comprehensive assessment and diagnosis of substance use and dependence, a mental health examination leading to diagnosis and treatment – if indicated – of psychiatric comorbidities (including psychosis, depression and suicidal ideation, anxiety disorders, etc). In addition to drug use problems the hospital medical staff treats all medical problems including coinfection with HIV or hepatitis C, tuberculosis or sexually transmitted infections. Hospitals also provide medicated detoxification if required, either on an inpatient or outpatient basis. Psychosocial counselling is the core approach for those dependent on amphetamine- type stimulants while counselling with pharmacotherapy are the key services for those dependent on opioids.

Treatment planning with the patient will form the basis for further interventions and rehabilitation. The hospitals liaise with treatment and care partners at all levels. They refer patients back to community services as soon as practicable and work together with community-based organisations and patients to develop realistic rehabilitation and reintegration plans. The hospital follows up patients to determine the efficacy of their interventions.

The key responsibilities of hospitals or specialised clinics are:

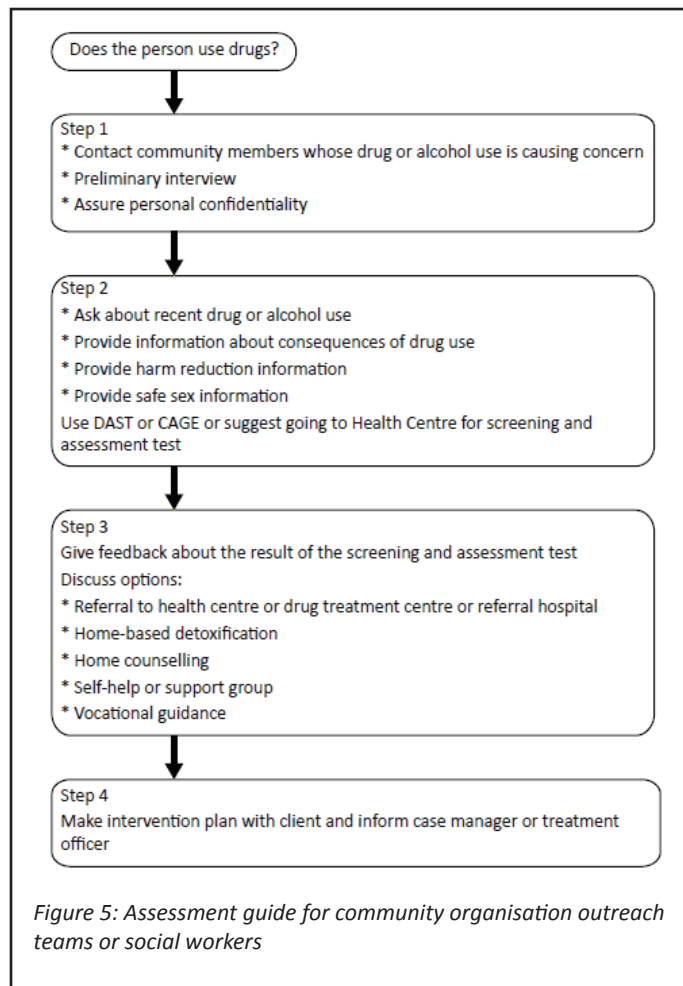


Figure 5: Assessment guide for community organisation outreach teams or social workers

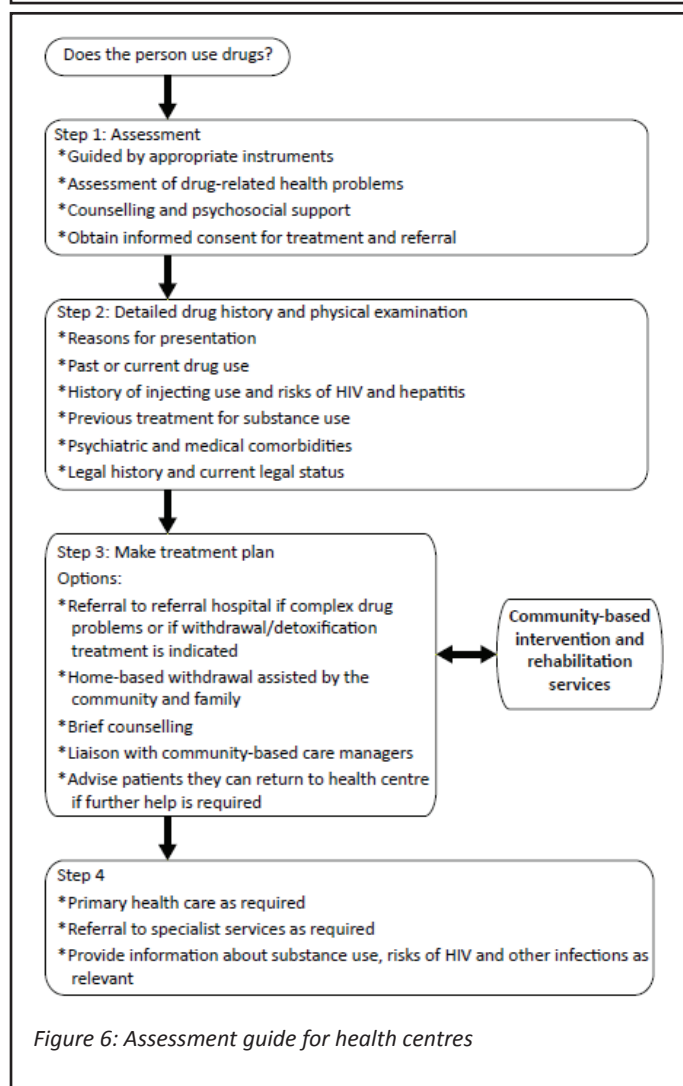


Figure 6: Assessment guide for health centres

- Assessment and diagnosis of drug and alcohol problems using appropriate instruments (see “5.1 Screening questionnaires suitable for use in community setting”)
- Assessment of physical health (with special attention to drug use comorbidity)
- Medicated withdrawal
- Psychosocial counselling
- Treatment planning and consultation with case managers in the community
- Referral to social welfare services
- Referral back to the community
- Referral to mutual support groups

Drug users often present with a multiplicity of problems, which require a multi-sectoral approach. Essential elements of the community-based approach are the forging of close linkages and collaboration between different service providers in the community and the health sector and with ancillary health and welfare support and rehabilitation programs.

Aspects to be considered in a treatment plan in the context of hospital or specialized clinic, agreed with the patient and family if appropriate, include:

- Determine what are the major problems confronting the patient
- Focus treatment on the most pressing issues (not necessarily drug problems)
- Determine whether the patient needs pharmacologically assisted withdrawal – if yes, should it be in the hospital or at home?
- How will supervision of withdrawal be undertaken?
- Is the patient suitable for medication-assisted treatment (if dependent on opioids)?
- What happens after withdrawal? Counselling? Relapse prevention? Referral to rehabilitation?
- Counselling approaches will depend on the availability of counsellors (behavioural approaches, motivational interviewing, relapse prevention)
- Agree on the review and monitoring of the treatment plan

3.3.4 Non-government organisations (NGOs) and social support services

NGOs have a key responsibility to ensure a continuum of care and to provide ongoing support to client and family and are the focal points for client management and coordination of care in a community-based approach.

Social welfare and NGOs provide a large number of services in the community. In the community-based treatment approach they provide case management for clients. NGOs also provide drug and HIV prevention education in the community including harm reduction.

Key activities of social welfare and NGOs:

- Provide education to the community about the effects of drugs, especially the links between drug use and HIV infection, sexual health and condom use and facilitate referral to voluntary counselling and testing
- Provide sensitivity training on drug use disorders to law enforcement, community leaders, local authorities, teachers, parents, traffic police and religious leaders
- Collaborate with stakeholders in the community (including law enforcement) in conducting preliminary screening for drug and alcohol use for people for whom there is community concern
- Collaborate with other organisations working with people who are affected by drug use and dependence and HIV and with organisations providing rehabilitation training
- Assist in referral to medical treatment in health centres or hospitals or clinics as appropriate
- Provide harm reduction information to drug users, particularly on sexual risks, condom use and clean injecting practices, through outreach, peer education, drop-in centres and support groups
- Provide psychosocial counselling to people affected by drug use and dependence and their families
- Provide rehabilitation services such as life skills and vocational training
- Support mutual-help and support groups for people affected by drug use and dependence
- Provide home visits and home-based care when required and help support non-pharmacological withdrawal and relapse prevention when indicated

3.3.5 Law enforcement

Police contribute to the effectiveness of a community-based approach by considering options other than arrest or direct referral to residential centres for drug users, and assist the drug user in receiving help in the community.

Police participate in the community-based approach by collaborating with other community-based organisations in the identification and preliminary screening of drug users and in discussion with drug users (and their families if appropriate) of options for treatment.

There are fundamental differences between drug dependence treatment and law enforcement procedures. In the treatment context, drug dependence is considered a complex health problem combining social, mental and physical aspects. In the context of law enforcement, illicit drug use is regarded as criminal behaviour.

A positive paradigm of community-based care can occur when police recognise the value of a health approach to drug use and dependence. Police attitude towards drug dependence treatment will change with greater understanding of the nature of drug dependence. Once drug dependence is recognised as a chronic health disorder having negative health and social impact with many contributing factors, the required response will also be understood as a long term health intervention.

A multi-sectoral approach involving law enforcement, health and social sectors will produce the most effective response in terms of reducing drug use in the community. Promoting treatment for drug dependence as an alternative to punishment will provide support for an effective approach with a continuum of care. The strengthening of partnership at all levels, particularly between government and agencies that directly or indirectly target people who are affected by drug use and dependence, including health, public security, social security, justice and drug control, is critical.

As the agency in the community charged with upholding the law of the land and ensuring public safety, the police have a critical part in supporting a community-based approach by participating in the program and contributing to associated strategic planning and activities. It is important to engage the police at national, provincial, district and community level, alerting them to the advantages of the community-based treatment approach.

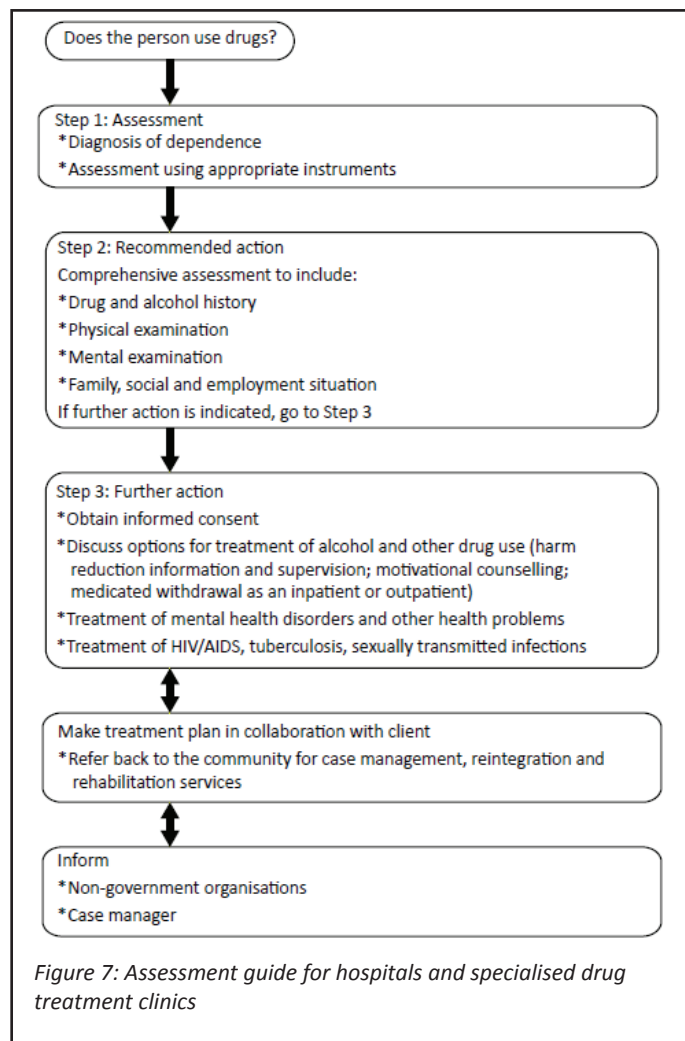
Dealing with community concerns about drug use

The primary role of police is to enforce the law; however there may be alternatives to the criminal justice system that can assist people affected by drug use and dependence to access help and in so doing help reduce drug problems and serious health consequences, as well as drug-related crime. Thus this approach is also more likely to promote integration and employment.

Few people who use drugs, once dependent, will stop drug use because they are concerned about police/ law enforcement. This is because 'dependence' means a compulsion to continue to use, as well as unpleasant symptoms once drug use is discontinued. Hence there is a need to assist drug users to identify realistic options, since punishment and coercion does not work.

Police can act as a useful resource for schools in drug education programs and take part in community education about drugs and/or HIV risks. Police can provide a supportive environment for health center drug services, hospitals and specialized clinics, drop-in centres, and needle and syringe programmes by not targeting the vicinity of these programs to arrest users.

In any situation police have to consider their actions and responses and what impact those actions may have on the whole community.



Ideally, the police and health and community-based non-government workers work together to ensure the reduction of harms from drug use. Police can do this by avoiding activities that further marginalise drug users, and avoiding a climate of fear that leads to problematic and chaotic drug use. This way, police promotes and supports agencies that deal with people affected by drug use and dependence on an ongoing basis. Police can take every opportunity to promote the role of harm reduction and explain why police are taking that approach; an approach that will provide a much more helpful and positive message for the community and will show good leadership.

A community-based approach allows for careful screening and assessment of the nature and severity of drug problems and allows the police to use a range of strategies to deal with people affected by drug use and dependence, approaches which be more effective than punishment or compulsory centres for drug users or to residential centres for drug users. These alternative approaches have the potential to free up a lot of police time previously taken up with dealing with minor drug offenders, time that can be used to tackle more harmful crimes in the community, such as drug trafficking, robberies and assaults.

It is important that police are fully aware of community-based approaches to drug use problems because their role in helping to reduce drug-related harm in the community is critical.

Police can provide leadership and guidance in the development of programmes that aim to reduce drug-related harm to individuals and communities and can use their discretion in dealings with drug users. When a person who is affected by drug use and dependence is apprehended, police should consider:

- How should the good of the community be assured?
- Does the offence committed by the person who is affected by drug use and dependence constitute a serious danger to the rest of the community?
- Are there alternatives to arrest and taking the person to court, or to sending them to the residential centres for drug users?
- Police are well placed to encourage entry into drug treatment programs because:
 - » Police have a presence 24 hours a day, seven days a week
 - » Police have frequent contact with all members of the community including people who are affected by drug use and dependence
 - » Police often have contact with users at times of crisis when motivation for treatment is high, such as after overdose, public dispute or family violence, driving under the influence of alcohol, etc.

It is recommended that police consider referring people suspected of using drugs or alcohol excessively to NGO staff, peer educators and outreach workers, self-help groups and whenever possible to a designated community case manager and/or the health centre for screening and assessment.

Police should avoid arrests at the scene of a drug overdose as such action can deter people from calling for medical help without delay because of the fear of prosecution.

4. Guidelines for interventions

This section provides guidance on recommended interventions for the treatment of people who are affected by drug use and dependence. The recommended therapeutic interventions and tools are not specific to any particular component of a community-based approach, but guidance is also provided on the sorts of interventions that should be provided in more specialised, rather than community-level, settings (see 5. for recommended tools).

4.1 Screening

People who are affected by drug use and dependence are often reluctant to enter treatment; they may lack insight into the negative consequences of their use of drugs, and they may be in a state of denial about their level of use. Screening helps identify the major problems (drug use as well as psychosocial and medical problems). Early identification of drug problems generally leads to better treatment outcomes.

Screening is a useful assessment procedure to identify individuals with hazardous or harmful drug use, or drug dependence, as well as associated risk behaviours (viral transmission via needle sharing and/or unprotected sexual activity, potential violent behaviour, suicide risk). Basic health care (e.g., treatment for common ailments, wound care) can be delivered by trained local workers, community health workers or auxiliary nurses. They can be effective in identifying people who are affected by drug use and dependence allowing early diagnosis and intervention in disease and infection, referral to other agencies and provision of follow-up care.

There are standardised tools to assess drug use and its severity in an individual that help to consider the degree of help required (see “5.1 Screening questionnaires suitable for use in community setting”). The ASSIST questionnaire is one of the tools recommended for screening for hazardous or harmful drug use. Once an initial assessment has been completed using the ASSIST, the scores indicate the level of problems and whether referral to health center or specialized care is indicated. If the patient scores 27 or higher with the ASSIST, the patient should be referred to further expert assessment, treatment or care. However, if the patient scores 26 or less, a health centre, together with patient outreach should devise a counselling and treatment plan.

Primary health care staff as well as health and counselling staff in social services, at schools, and in the criminal justice system need to be aware of the benefits of screening and early identification of drug use related problems and should be trained to administer screening tools and associated intervention packages.

The results of screening should be discussed with the client in a non-judgmental, supportive manner. The purpose of screening should be to begin an open discussion about drug use.

The identification of drug use through screening also provides opportunities for the delivery of brief interventions (see “4.4.4 Duration and general structure of counselling sessions”)

Key principles for self conducting screening interventions:

- Find an approach that is comfortable for you – choose a screening tool that can be used with a wide range of patients
- Be non-judgmental – experience has shown that patients are generally not offended by questions about alcohol and drug use if they are asked in a non-judgmental, non-moralistic, non-threatening manner, and if the health implications and benefits of reduction and abstinence are stressed
- Know how to respond – prepare yourself for patients’ questions about why you are asking; become familiar with the risks of drug use and the benefits of stopping
- Be positive – emphasise that benefits will begin as soon as drug use is reduced or stopped, and that the earlier they are able to stop, the better. It is never too late

4.2 Assessment and treatment planning

Establishing a therapeutic relationship

Good assessment is essential to the continuing care of the patient. Not only can it enable the patient to become engaged in treatment but it can begin a process of change even before a full assessment is complete. The primary purpose of assessment is to carry out a functional analysis and determine the best type of response. However, the

initial assessment is also a time when patient and clinician establish a therapeutic relationship. Hence the content and manner of assessment are both important.

For the prospective patient, the assessment interview is often a time of great vulnerability and expectation. The decision to seek treatment is frequently made at a time of crisis. It is important for drug treatment staff to demonstrate an accepting, non-judgmental approach, being neither authoritarian nor overly intrusive. The assessment interview is also a time for setting the ground rules.

Patients are often hesitant or reluctant to disclose their drug use or problems. Drug dependents report discomfort, shame, fear, distrust, hopelessness, and the desire to continue using drugs as reasons they do not openly discuss their dependence with treatment staff.

Drug treatment staff should approach patients who suffer from drug use disorders in an honest, respectful way, just as they would approach patients with any other medical illness or problem.

It is important for drug treatment staff to employ common sense, courtesy, and an appropriate level of neutrality in establishing a relationship with patients. It is easy to present the impression of being excessively distant, remote and authoritarian in order to protect oneself from the demands and manipulations of the patient. At the other extreme, it is also easy for the prescriber to become overly sympathetic to the patient and too accepting of the patient's own account of their circumstances. In this situation drug treatment staff may come to see themselves as advocates and supporters of their patients to the extent of becoming enmeshed in what is happening to them.

It is more beneficial for patients in the long-term if drug treatment staff preserve an appropriate neutrality: being concerned and caring but also recognising when patients are making excessive demands and not rescuing them from their often self-induced crises.

The therapeutic relationship should be based upon mutual understanding between staff and patient of:

- Their respective views as to the cause and nature of the patient's problems
- Each party's expectations of treatment – what staff expect of the patient, the patient of staff and the patient of treatment
- How the patient's goals might best be met

The more overt and collaborative the approach to treatment and the more responsibility for treatment is shared, the more effective the treatment is likely to be. Most patients are willing and able to provide reliable, factual information regarding their drug use. Questions should be asked in a direct and straightforward manner, using simple language and avoiding street terms.

Assessment

Assessment and diagnosis are core requirements for treatment initiation. Assessment is an ongoing process, and does not stop at the first interview.

Diagnostic criteria commonly used in the mental health field are the references to reach diagnosis of a drug use disorder. Diagnosis of comorbid psychiatric disorders is ideally made and followed-up by a psychiatrist, but with adequate training, other health care professionals can successfully identify and manage drug use disorders and associated psychiatric comorbidity.

Good care planning aims to deliver services that are client-centred rather than centred on the service provider.³ Patients affected by drug use disorders often have multiple treatment needs across a range of personal, social and economic areas that cannot be addressed when taking into consideration only their addictive symptoms in a standardised way. As for any other health care problems, diagnostic and comprehensive assessment processes are the basis for a personalised and effective approach to treatment planning and engaging the client into treatment. The effectiveness of treatment can be expected to be greater if treatment is responsive to an individual's stage of change and personal circumstance. Care plans can facilitate access to an integrated selection of services and may prevent people from dropping out of treatment. Assessment is the first stage of care planning.

Treatment plans should be agreed by the clinician and patient and should be continually updated and revised

³ Drug abuse treatment and rehabilitation: A practical planning and implementation guide. United National Office on Drugs and Crime, Vienna, 2003.

throughout treatment. Procedures and timing should also be agreed for review of the plan. Steps in the treatment planning process are:

- Collect client data and information
- Conduct assessment
- Identify problems
- Prioritise problems
- Identify solutions, interventions and steps to be taken interventions
- Referral as appropriate

The assessment of drug dependence and severity should be made with appropriate instruments (see “5.1.4-5.1.8 Screening questionnaires suitable for use in community setting”). A comprehensive assessment takes into account the stage and severity of the disease, somatic and mental health status, individual temperament and personality traits, vocational and employment status, family and social integration, and legal situation. It further considers environmental and developmental factors, including childhood and adolescent history, family history and relationships, social and cultural circumstances, and previous treatment attendance. An adequate assessment process creates the environment for the development of a therapeutic alliance to engage the person into treatment.

4.2.1 History taking

See 5.2.1 for drug dependence interview form

Reasons for presentation

It is clear that motivated clients are more likely to adhere to and complete the treatment that is offered to them. Clients who are resolved to improving their health are also often more successful. This is in contrast to clients who have been forced into treatment by family or community.

It is therefore important to understand

- In crisis (health, economic or legal?)
- Brought in by a concerned parent, relative, spouse, employer, friend or outreach worker
- Want help for their drug use and motivated to change their behaviour
- Usual source of drugs not available
- Referred from another medical practitioner
- Pregnant? (if female)

Past and current drug use

The aim of the drug use history is to elicit as accurately as possible something about past and current drug-taking behaviour. This is best determined by taking a careful history, documenting the extent and duration of drug use, and the extent to which it has influenced the patient’s life.

This includes:

- The age of starting drug use (including alcohol and nicotine)
- Types and quantities of drugs taken (including concomitant alcohol misuse)
- Frequency of use including routes of administration
- Experience of overdose
- Periods of abstinence
- What triggers a relapse?

History of injecting and risk of HIV and hepatitis

- Past history
- Present usage and why patient changed to injecting?
- Supply of needles and syringes
- Sharing habits (lending and borrowing injection equipment)
- Does the patient know how to inject safely?
- How does the patient clean equipment?
- How does the patient dispose of the used equipment/works?
- Has the patient thought about or tried any other method of use?
- Knowledge of HIV, hepatitis B and C issues and transmission
- Use of condoms

Previous treatment for substance use

Information on previous treatment can help determine the client's resolve to seek treatment and the likely adherence to different treatment programs and regimes. If the client has tried other treatment methods, this may indicate that they are serious about treatment. Their response to previous treatment can help in selecting the type of treatment for the current episode.

Ask about:

- Types of treatment (detoxification, methadone, unsupervised withdrawal) and reasons for failure and relapse and interruption of treatment
- Number of attempts at medication-assisted treatment
- Number of time on treatment
- Perceived benefits from treatment
- Maximum dose of medication-assisted treatment
- End of treatment and reasons for terminating treatment

Psychiatric and medical comorbidities

In general, at assessment or in the first weeks of treatment, staff should ensure that physical health and psychological functioning have been assessed, either by themselves or by referral. Specific screening for HIV, hepatitis B and C and for psychiatric illness is recommended. Some of these issues may be dealt with at the assessment interview, while others may be more appropriately attended to once the patient has been stabilised in treatment.

Possible issues include:

- Any psychiatric consultations?
- Any overdoses (accidental or deliberate)?
- Complications of drug use – abscesses, thromboses, viral illnesses, chest problems
- Hepatitis B, C status, if known
- HIV status, if known
- History and/or diagnostics for sexually transmitted infections
- Last menstrual period (in female clients)
- Operations, accidents and head injury
- Any current medication?

Social and personal history

The aim of assessing social and personal history is to determine if the client has suitable social support that will enable them to adhere to treatment. Strong family support may decrease drop out. On the other hand should the client live with a partner who is also dependent on drugs, this may be disruptive to their treatment attempt.

- Family situation
- Employment situation
- Housing and financial situation including social relationship debts

Legal history and current legal status

- Any current and previous charges and custodial history?
- Juvenile justice experience

4.2.2 Physical examination and investigations

A physical examination is an important component of assessment. For example, the presence of needle track marks, and signs of intoxication or withdrawal are helpful in establishing drug dependence and its complications.

In assessing general health, look for evidence of medical problems (e.g., jaundice, ascites, encephalopathy as signs of liver disease).

Consider common comorbid medical conditions – look for evidence of chronic diseases that require treatment such as diabetes and hypertension.

- General – anaemia, nutritional status, dentition and overall hygiene
- Skin – needle marks, tattoos, skin abscesses and open wounds, cellulitis related to injecting
- Drug-related – assessing the medical complications associated with use of opioids, amphetamines and other drugs
- Chronic obstructive pulmonary disease secondary to cigarette smoking
- Evidence of tuberculosis
- Cirrhosis, neuropathies or cardiomyopathy secondary to alcohol dependence

After voluntary confidential counselling consider tests for HIV, hepatitis B and C. Liver function tests are recommended at the commencement of treatment to establish a baseline. Periodic monitoring of liver function is also recommended. Abnormalities or medical problems detected by laboratory evaluation should be addressed as they would for patients who are not addicted.

Urinary drug testing can be helpful in clarifying or confirming an unclear drug use history. As with any patient, the clinician is alerted to a spectrum of possibilities, and works with the patient using the information collection from the toxicology screen.

4.2.3 Treatment options

After comprehensive assessment, the physician should:

- Establish the diagnosis or diagnoses and determine appropriate treatment options for the patient
- Make initial treatment recommendations, provide information to the patient and obtain informed consent
- Formulate an initial treatment plan
- Plan for engagement in psychosocial treatment if necessary
- Ensure that there are no absolute contraindications to the recommended treatments
- Explain and discuss treatment options
 - » Detoxification with supportive medications
 - » Withdrawal using methadone
 - » Medication-assisted treatment
- Provide counselling together with advice about relapse prevention
- Warn the patient about the possible risk of heroin overdose after detoxification or when reducing methadone after achievement of abstinence
- Final decision is made jointly by the physician and patient

4.3 Case management

The main purpose of case management is to link clients to the range of services that suit their individual needs. Case managers work with the client, other members of the treatment team, and other services or organisations, to select the mix of interventions and support. The mix of interventions and services is selected based on research evidence, how appropriate a method is to the client's individual situation, how acceptable it is to the client, whether trained staff is available, and cultural appropriateness.

Drug use can be very complex and interlinked with many other problems, including social exclusion. Case management helps to identify the broad range of social, psychological and health services that a person who is affected by drug use and dependence may need during treatment and rehabilitation, as well as in support of integration and cessation of treatment.

Interventions at a social level include assistance with basic needs as well as basic healthcare, friendship, community support and promotion of well-being.

Social support is a crucial aspect of the continuum of care. Initial emergency support such as food, and temporary housing for those in need will be essential to attract people who are affected by drug use and dependence to services. Rehabilitation and reintegration are key to sustained recovery from drug use problems. The community-based approach involves social welfare institutions working together with NGOs, development partners and health services in the community to build and/or identify vocational and work opportunities, micro credits and income generation schemes to support the rehabilitation and reintegration of drug users.

Social services are initiatives and interventions aimed at the needs and problems of vulnerable groups. They include rehabilitation services, housing support services, foster care, food services, or daily care, and other forms of support

made by social workers and others to meet essential needs. Developing sports and recreational events and learning skills help to provide social alternatives to substance use.

Where substances such as amphetamines are being used to aid work performance, it is difficult to ask people to stop working in order to attend drug treatment activities unless they find alternative sources of income. During the initial phase of treatment, some type of incentive may help to engage clients.

From the perspective of drug dependence treatment, social services also promote community and social integration for drug users in order to prevent, limit and help them to overcome the harmful effects of drug use. Such services may include:

- Promoting health care and linking drug using clients with community resources
- Creating and providing counselling and psychotherapy services for people who are affected by drug use and dependence
- Promoting cohesive family relationships with a view to making the family a safe base for people who are affected by drug use and dependence to rely on
- Assisting drug users to access information and create better opportunities and choices for solving their problems
- Assisting people who are affected by drug use and dependence to access community activities, and social services, help them to become equal and able to contribute or integrate with their families, communities and society
- Create favourable conditions for recovered drug users to get a job and meet their essential needs, live independently and participate more actively in economic and community activities

4.3.1 Treatment (care) plans

All structured treatments should be delivered according to a written, individual treatment plan for each client. Planning should be a collaborative process and involve an assessment with the client, not of the client. Plans should take into account the views and motivations of the client and their personal and social supports and problems.

The aims of care planning are to:

- Develop, manage and review documented care plans
- Ensure that drug users have access to a comprehensive range of services across the local health, welfare and drug treatment services
- Ensure the coordination of care across all agencies involved with the client
- Ensure that there is continuity of care and that clients are followed throughout their contact with the treatment system
- Maximise client retention within the treatment system and minimise the risk of clients losing contact with the treatment and care services
- Re-engage clients who have dropped out of the treatment system
- Avoid duplication of assessment and interventions

A treatment plan should:

- Describe the client and their personal, social, economic and legal situation
- Show sensitivity and awareness of the client's culture, ethnic background and religious affiliation as well as their gender and sexuality
- Describe the client's current problems (as known)
- Specify authorised sharing of information (what information will be sought and/or given to other professionals/agencies and under what circumstances)
- Describe the specified interventions that are planned
- Set out the goals of treatment and progress 'milestones' that can be achieved
- Describe how the care plan will be reviewed and regularly updated over time

Treatment agreements need to be flexible and realistic. It is important that clients do not take on goals they are unlikely to reach as their failure to reach them may destabilise their progress in treatment.

Goals in treatment need to be short-term. This may be achieved by breaking down larger problems into smaller tasks for action or change. This makes the management and resolution of large problems more feasible and gives clients a sense of achievement and greater control. The smaller tasks or goals should be desirable, able to be evaluated, positive, specific in time frame, achievable and measurable.

Goals could include:

- Reduction in drug use or abstinence
- Improved physical health
- Improved psychological health
- Improved social adjustment and functioning; and
- Reduction in criminal behavior
- The treatment plan further specifies for each client the issue that will be improved and steps the client and the service provider will take to achieve the goal

Realistic treatment agreements can provide the treatment process with a sense of structure and purpose beyond the daily routine.

4.3.2 Reviewing treatment progress

Reviews of treatment progress benefit both treatment staff and client by highlighting areas of progress, or challenges (including relapse) indicating the need for adjustment of the treatment plan.

Because people often leave treatment prematurely, and premature departure is associated with high rates of relapse to drug use, programs need strategies to engage and keep clients in treatment. These strategies should be part of the treatment review process.

Monitoring the use of opioids and other drugs is of value in evaluating the overall effectiveness of a particular program and its individual treatment providers. Monitoring may also be useful in determining how well clients are progressing in treatment and whether changes in treatment should be made for clients with specific problems.

Current monitoring options that are used widely include urine testing, client self reporting and clinical observation. The validity and reliability of these techniques can be improved when used in combination.

Self reporting can be a reliable guide to drug use in settings where no negative consequences result from disclosure. Self-reporting is conducive to facilitating an atmosphere of trust and goodwill between staff and clients. However, caution should be exercised when making clinical decisions based solely on self-reported drug use.

Urine testing should only be undertaken with good reason, such as in the initial clinical assessment of individual clients or as part of program evaluation. Urine testing can also be useful when clients are unstable and when there is some uncertainty about their drug use. Test results should be used, in collaboration with the client, to review and improve the individual's progress in treatment.

Urine testing is an objective measure of drug use, however, when undertaking urine testing, steps should be taken to ensure that urine substitution has not occurred, such as checking the temperature of the urine sample.

Urine testing will only detect recent drug use. The actual timeframe varies depending on the drug being measured and will also depend on the threshold level set by the testing laboratory. False positives and false negatives do occur.

Clinical observation is also an important part of monitoring treatment progress. Useful indicators include signs of drug use, frequency of contacts and missed appointments.

4.4 Counselling

Overcoming drug dependence entails substantial social and lifestyle adjustments. The provision of psychological and supportive interventions to encourage behavioural and emotional change is important to the overall treatment process. Psychological interventions offer formal structured counselling approaches with assessment, clearly defined treatment plans and goals and regular reviews. Informal approaches may involve advice and information, drop-in support and informal counselling.⁴

Psychological and social support interventions change drug using behaviour and address the various emotional issues, practical needs (housing, employment, financial management) and social interaction (family issues, building networks unrelated to drug use) for recovering people who are affected by drug use and dependence. Psychological

⁴ *Drug abuse treatment and rehabilitation: A practical planning and implementation guide*. United National Office on Drugs and Crime, Vienna, 2003.

treatment is also an important part of medication-assisted treatment for supporting compliance with the prescribed treatment and minimising illicit drug use.

Psychological interventions help clients to identify and address the reasons for drug use, the negative consequences of their drug use, and the benefits associated with stopping drug use. Identification and development of skills to prevent relapse are also a focus of psychological interventions, as are self-confidence, positive thinking, and motivation for effective self-treatment.

A counsellor plays an important role in the client's change process. The role of the counsellor is to provide guidance and suggestions for clients to help set goals and develop a treatment plan. In drug dependence treatment, a counsellor should also help clients to develop problem solving and refusal skills, to identify risk situations and ways to deal with the risks.

4.4.1 Responding to stage of change

Counsellors will find it helpful to assess where the client is in terms of the stages of change (see figure 11). The 'stages of change' model was developed to describe the processes involved in people trying to stop tobacco smoking, and is a useful model in understanding other forms of behaviour change. The model proposes that individuals pass through a number of stages during the process of behaviour change. Counselling is most likely to be effective if the approach used reflects the stage of behavioural change for individual clients.

Motivation to change is not a 'fixed' state in a person, but rather is subject to many forces including the intervention of health workers. The health worker can assist clients to move from one stage to the next and to learn from unsuccessful attempts to control their drug use.

Not all people who are affected by drug use and dependence want to stop using drugs. In the pre-contemplation stage, people who are affected by drug use and disorder will not have allowed any concerns they may have about their drug use to influence their actions. They will often not immediately recognise problems they are having as resulting from their drug use.

During **pre-contemplation** the user perceives the benefits of drug use as outweighing the disadvantages, and the disadvantages of change outweigh the advantages. Family, friends, health and social workers may be concerned about some consequences of the person's drug use, but the person who uses drug may accept this as collateral damage. If pre-contemplators come for help, it is usually because of pressure by others. Motivational interviewing is an appropriate technique to help users in the precontemplation stage to explore the advantages and disadvantages of their current patterns of drug use, thereby helping them move to the contemplation stage. Explore the meaning of events that brought the client to treatment, or the results of previous treatment, eliciting the client's perceptions of the problem and offering factual information about the risks of substance use, providing personalised feedback about assessment findings, exploring the pros and cons of substance use, and examining discrepancies between the perceptions of the client and others of the problem behaviour. Harm reduction interventions (e.g., provision of condoms or clean injecting equipment) are recommended in this stage.

In the **contemplation** stage, the patient have realised that their drug use is doing harm and are weighing up the benefits and the costs of continuing to use. The balance of costs and benefits begins to shift, although there is still ambivalence about change. Contemplators may struggle with weighing up the costs of their substance use against the benefits. They may also evaluate the benefits they perceive as related to their substance use against the amount of effort, time, energy and the loss it will cost them to change their use. Serious consideration of problems but persistent ambivalence about change is the key element in contemplation. Motivational interviewing is again an appropriate technique for exploring the client's personal values in relation to change. Emphasise the client's free choice, responsibility and self-efficacy for change, and elicit self-motivational statements of intent and commitment from the client.

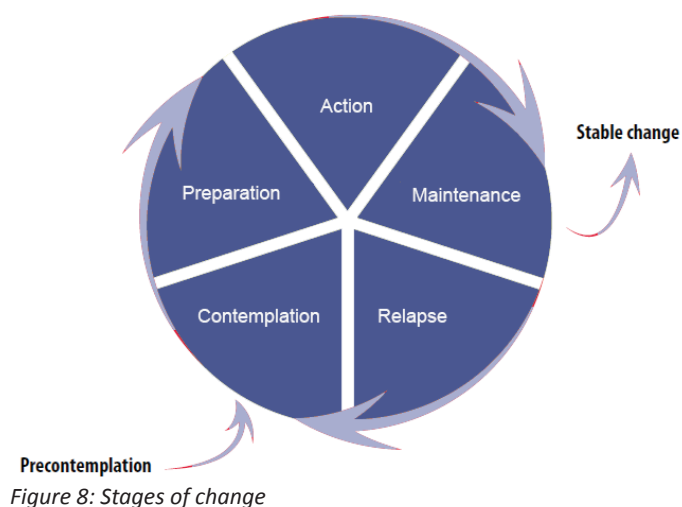


Figure 8: Stages of change

In the **preparation** stage the balance has shifted. The patient is preparing to take action and has confidence in their capacity to change. Change is seen as worthwhile. They begin to look at the costs of their use more critically. The negative consequences of drug use are now seen as outweighing the benefits. They may already have made some small changes, such as delaying the time of their first cigarette in the morning. A client in this stage needs encouragement, assistance in setting realistic goals and developing a plan of action. A menu of potential strategies can be presented and discussed. Help the client to consider barriers to change and ways to overcome those barriers; explore treatment expectancies and the client's role; elicit from the client what has worked in the past for the client or others known to the client; and assist the client to enlist social support. Goal setting, identifying internal and external supports and resources and identifying strategies to support change can help.

In the **action** stage the person is taking steps to change. They are implementing strategies to change their drug use pattern. They usually spend the least time in this stage as they are waiting to enter treatment, relapsing and returning to thinking about stopping, or on the way to maintenance. Help clients in this stage to solve problems, set goals; give them feedback and support to implement their change plan; and prepare to maintain the gains. Support their engagement in treatment and reinforce the importance of remaining in recovery, but support a realistic view of change through small steps. Help clients to find new reinforcers of positive change, including assessment of the strength of family and social support available to the client. It is helpful to review the initial reasons that led to the decision to change to help them maintain their motivation for change.

In the **maintenance** stage patients have succeeded in stopping their harmful drug use and are concentrating on continuing that progress. Changes in behaviour maintained for six months or more are usually associated with substantial improvements in the quality of life. Without such changes, the effort to change may not seem worth it and relapse is more likely. Quality of life includes factors such as employment, the quality of relationships, financial security, housing and spiritual support. The focus in this stage is on building resilience, self-monitoring, identifying high risk situations and appropriate coping skills. Affirm the client's resolve and self-efficacy, help them practice and use new coping strategies, and develop a "rescue or safety" plan if the client resumes substance use. Review long-term goals with the client. It is helpful to encourage them to articulate the positive reasons for maintaining change to reinforce their decisions, and the provision of relapse prevention approaches is appropriate.

Relapse occurs when patients have not managed to maintain abstinence for one of any number of reasons. It could be a reasoned choice about the benefits of returning to drug use or it could be a slip related to a variety of emotional or social triggers. Relapse may take the user into any of the other stages of behaviour.

The stages of change model highlights the relapsing-remitting nature of addiction. Relapse should not be seen as a treatment failure, but as a common characteristic of therapy. Most users will work through this cycle several times in their drug-using careers; some will never escape it. Help the client understand that relapse is a part of the normal change process, encourage them to share information and learn from a relapse to develop a new change plan.

4.4.2 Types of counselling

Cognitive-behavioural approaches

Cognitive behavioural therapy (CBT) examines the interplay between thoughts, behaviour and environment.

The cognitive-behavioural approach to drug use incorporates many treatment interventions. CBT works under the assumption that behaviours are guided by thoughts and emotions (feelings), that human behaviours are mainly established through a process of learning.

CBT assumes that substance dependence is a learned, maladaptive behaviour rather than being caused by an underlying pathology. Under this assumption, therapy for substance use disorders takes the form of an educational-learning process in which the counsellor becomes a coach and the client has an active learning role throughout the process. CBT aims to guide clients to learn that although we cannot control all aspects of our lives, we can control the way we perceive and deal with things that happen around us.

Interventions typically focus on enhancing client motivation, providing new knowledge about drug use and its consequences, and challenging problematic beliefs about drug use and more general beliefs and cognitions. During CBT, clients learn to recognise "destructive" behaviours and change them to more constructive behaviours. The client should be instructed and encouraged to begin some new alternative activities. Many clients have poor or non-existent repertoires of drug-free activities. Efforts to "shape and reinforce" attempts to try new behaviours or return to previous non-drug-related behaviours are an important part of CBT.

A useful technique in CBT is functional analysis. This technique helps develop understanding of how drug use entered and is connected with other aspects of a client's life. Those details are critical to creating a useful treatment plan. Using functional analysis techniques, the counsellor helps the client to recognise thoughts, emotions, circumstances and consequences surrounding their drug use. Functional analysis is also called ABC analysis, that is analysis of Antecedent emotions and circumstances surrounding a Behaviour, as well as its Consequences. The technique helps the client to be aware of risks that could cause them to relapse. Functional analysis also allows the client to explore more deeply why they used drugs for the first time, as well as identify situations where they might be tempted to use drugs, or where the client may find it difficult to cope.

Functional analysis for drug use is conducted through the five Ws:

- When does the client usually use drugs?
- Where?
- Why?
- With or from Whom
- What happens after drug use?

(See “5.2.14 Functional analysis or high-risk situation record” for an example of a tool.)

CBT is a very active form of counselling. A good CBT counsellor is a teacher, a coach, a “guide” to recovery, a source of reinforcement and support, and a source of corrective information. Effective CBT requires an empathetic counsellor who can truly understand the difficult challenges of addiction recovery.

The CBT counsellor has to strike a balance between being a good listener and asking good questions in order to understand the client when teaching new information and skills, providing direction and creating expectations, reinforcing small steps of progress and providing support and hope in cases of relapse. The CBT counsellor also has to balance the need of the client to discuss issues in his or her life that are important and the need of the counsellor to teach new material and review homework. The counsellor has to be flexible to discuss crises as they arise, but not allow every session to be a “crisis management” session.

Motivational Interviewing

Motivational interviewing (MI) is a method to work with ambivalence and help patients explore their reasons to change drug use. The basic elements of motivational interviewing include:

- Express empathy
- Develop discrepancy (help the clients see the discrepancy between their drug use and their goals, between what they are doing and what they want to do, without the client feeling pressured or coerced)
- Avoid argumentation – roll with resistance (confronting the client on a position strengthens their resistance; instead of trying to stop something happen, shift to use of reflective thinking to try to encourage an alternative view)
- Support self-efficacy (give the client the confidence that they are likely to succeed, but be realistic and keep goals within reach)

The main aim of MI is to enhance the motivation of the client to change. Clients come to drug treatment for different reasons. Some come voluntarily seeking treatment, some are referred by family or friends but are themselves not yet ready for treatment. Some come to the program voluntarily but do not believe in the treatment outcomes, or do not know how to change their behaviours. With these cases counsellors can use motivational interviewing sessions to encourage clients to think about their drug use and motivate them to change.

Motivational interviewing differs from strategies that are intended to impose change through extrinsic means, e.g., by legal sanctions, punishment, social pressure, financial gain. Motivational interviewing focuses on intrinsic motivation for change, even with those who initially come for treatment as a direct result of extrinsic pressure.

To successfully conduct a motivational interviewing session, the counsellor should avoid some unhelpful assumptions that may negatively impact application of the approach and will reduce the likelihood that the client will change the behaviour. These assumptions that are to be avoided are:

- The patient ought to change behaviour
- The patient wants to change behaviour
- Health is the patient's primary motivator (health is often not important to people; it is better to identify what is important to them, not what is important to you)

- The intervention has failed if the patient doesn't choose to change (as the counsellor you are helping them, but they are the ones who have to do the work)
- Patients are either motivated to change or not (motivation for change is not like turning on a light switch; there are degrees of motivation – the role of the counsellor is to determine how motivated they are and through that assist them to change)
- Now is the right time to choose to change (sometimes people are not ready right now, it might take more time so that insisting they change now is unhelpful)
- A tough approach is the best approach (it will only harden their resistance to change)
- I'm the expert – the patient must follow my advice (you should learn from each other)

The skills of motivational interviewing are used to encourage clients to talk and to explore the ambivalence about their substance use. Successful use of these skills results in the counselor being able to elicit “change talk” in which the client presents the arguments for making a particular change. When clients are making “self-motivational statements” (also termed “change talk”) they are moving in the direction of being more motivated to change. This is the goal of motivational interviewing.

People are more persuaded by what they hear themselves say than by what other people tell them. When motivational interviewing is done well, it is not the counsellor but the client who explicitly states the concerns and intentions to change.

Community reinforcement and contingency management

These are behavioural approaches directed at modifying behaviours that are underpinned by conditioned learning.

Contingency management (CM) rewards or punishes specific types of behaviours using a structured, transparent approach that increases learning of desired behaviours. Most programmes focus on positive behaviours, with reinforcement for the desired behaviour. The elements of a contingency management program are:

- Clear definitions of the desirable behaviour (e.g., abstinence from illicit opioids)
- Regular monitoring for the presence or absence of the desired behaviour (e.g., urine tests)
- Specified rewards for the desired behaviour (e.g., money, vouchers, takeaway doses of substitution medication, or lottery tickets); and
- Positive personal feedback from staff for the desired behaviour

Contingency management can be administered by staff with relatively little training.

The Community Reinforcement Approach (CRA) is more broadly based in using social, recreational, familial and vocational reinforcers to aid clients in the recovery process. CRA integrates several treatment components, including building motivation to quit, helping cessation of drug use, analysing drug use pattern, increasing positive reinforcement, learning new coping behaviours, and involving significant others in the recovery process.

Elements of CRA⁵ include motivational induction, monitoring pharmacotherapy, functional analysis, skills training, job finding, marital counselling, and social-recreational counselling. CRA has been effectively combined with contingency management as an adjunct to long term treatment with methadone; CRA has also been integrated with family therapy into an approach called the Community Reinforcement Approach and Family Training (CRAFT).

Social Behaviour and Network Therapy (SBNT)

This approach was developed in the United Kingdom, originally for treatment of alcohol dependence, but more recently it has been adapted for people who are affected by drug use and dependence. The basic principle of the approach is to encourage a change of social network, from one that is supportive of drug use to one that is supportive of abstinence.

Access to welfare supports, together with encouragement from friends, partners, children, parents and other significant individuals is commonly involved in the pathway out of drug use disorders.

⁵ See also <http://pubs.niaaa.nih.gov/publications/arh23-2/116-121.pdf>

Relapse prevention

Relapse prevention involves avoiding a return to drug use and building a healthier self by becoming involved with activities that do not include drug use. Relapse prevention typically employs both CBT and motivational interviewing techniques.

The conceptual model of relapse prevention views relapse as a natural part of the process of change: lapses and relapses are viewed as opportunities for clients to understand their behaviour and develop new skills to deal with high-risk situations.

Interventions comprise skills to recognise cues and risk factors for drug use, and the development of strategies to resist drug use. A range of counselling approaches are used with the aim of helping clients:

- Recognise the situations in which they are most likely to use drugs ('triggers' and craving)
- Avoid these situations when appropriate
- Cope more effectively with the range of problems and problematic behaviours associated with drug use

Factors that are triggers for drug craving can be classified as external or internal. External triggers or surrounding circumstances to drug use can be people (drug dealers, drug-using friends), places (bars, parties, drug dealers' houses, area of town where drugs are used), things (drugs, drug paraphernalia, money, alcohol, movies with drug use), time periods (paydays, holidays, periods of idle time, after work, periods of stress) or specific events that happened before or after using drugs (e.g., marriage troubles, family or sexual relationship problems). Internal triggers can be emotions, such as anxiety, anger, frustration, sexual arousal, excitement, boredom, fatigue, or happiness. Triggers for drug craving are highly idiosyncratic, and identification of cues should continue throughout treatment (see "5.2.15 External trigger questionnaire", "5.2.16 Internal trigger questionnaire").

Triggers can cause the client to think about drug use, leading to cravings and finally to drug use. Using the list of external and internal triggers, the counsellor assists the client to identify high-risk situations that may be associated with external or internal triggers that are highly associated with drug use (see "5.2.17 External trigger chart," "5.2.18 Internal trigger chart"). Other situations that have never been associated with drug use are referred to as low-risk situations. After identifying high- and low-risk situations, the counsellor teaches the client to decrease the time in high-risk situations, and increase the time in low-risk situations.

Coping with craving is central to relapse prevention. Craving is part of dependence on all substances. While sometimes presented as a simple phenomenon, craving is complex and multifaceted.

To some people craving means an urge to use drugs; to others it is a longing for something they miss, and still others desire the feeling they had when they were using drugs, without actually taking the drug.

Craving is a natural result of not having drugs after a long period of exposure. It is most intense when drug use is first stopped, especially when drugs are readily available. People usually don't crave drugs when they know for certain that drugs are not available. Craving is always temporary and often comes in waves.

In addition to advising the client to decrease their exposure to high-risk situations, relapse prevention also provides the skills to enable behavioural change and strategies to regain control over the urge to use drugs.

The three main approaches to managing craving are "delay," "distract" and "decide":

- Engaging in non-drug-related activities, such as walking, going to the movies, going to mutual help meetings, things that are low-risk situations and serve as a distraction from cravings
- Talking about craving – talking with another person can help to focus on the physiological and emotional sensations of the craving instead of thinking about drug use. Self-talk and self-instruction may also help
- "Surf" the craving – focus on the physiological and emotions sensations and use relaxation techniques to control and modify the craving or wait until it is over, like a wave going past

These strategies may not stop craving completely, but with practice they will reduce the frequency and intensity of craving and make it less disturbing and frustrating when it occurs.

One of the most common relapse situations is when a client is offered drugs by a friend or dealer. Frequently, their ineffective manner of dealing with this situation can result in use of drugs. Many of the people who are affected by drug use and dependence social networks have become so narrow that they associate with few people who do not

use drugs, and cutting off contact may mean social isolation. Some people will have become involved in distribution, and extricating themselves from the distribution network is difficult.

Counsellors should explore with clients strategies for reducing contact with dealers or friends using drugs.

Basic drug refusal skills are:

- Respond rapidly, not hesitating
- Have good eye contact
- Respond with a clear and firm “no” that does not leave the door open to persuasion or future offers
- Make the conversation brief
- Leave the situation

Counsellors should review the basic refusal skills with clients, practice them through role-playing, identify and discuss problems with assertive refusals.

Techniques to stop thoughts about drug use are also relevant. These should be presented to the client who should choose the technique that works best for them:

- Visualisation: Imagine a scene in which you deny the power of thoughts of use. For example, picture a switch or a lever in your mind. Imagine yourself moving it from “On” to “Off” to stop the using thought. Have another picture ready to think about in place of those thoughts
- Snapping: Wear a rubber-band loosely on your wrist. Each time you become aware of thoughts of using, snap the rubber-band and say, “No!” to the thoughts as you make yourself think about another subject. Have a subject ready that is meaningful and interesting to you.
- Relaxation: Feelings of hollowness, heaviness and cramping in the stomach are cravings. These often can be relieved by breathing in deeply and breathing out slowly (do this three times). You should be able to feel the tightness leaving your body. Repeat this whenever the feeling returns
- Call someone: Talking to another person provides an outlet for your feelings and allows you to hear your thinking process. Have phone numbers of supportive, available people with you always so you can use them when you need them

Lapses and relapses should be framed as mistakes that the client can learn from, and not indications of failure.

The period immediately following treatment represents a time of high risk for relapse, and as such appropriate support is important at this time. This may be provided by aftercare, which comprises a broad range of community-based service supports designed to maintain the benefits that have been achieved when a structured treatment has been completed. The provision of aftercare offers the opportunity to reinforce treatment interventions and may reduce the number, length and severity of relapse.

Aftercare may involve a continuation of individual or group counselling and other supports, but usually at a lower intensity and often by other agencies. Self-help or mutual support groups, such as Narcotics Anonymous, are an important provider of aftercare. Clearly, a supportive family and community environment will also be conducive to helping in the recovery of people who have received drug abuse treatment.

4.4.3 Setting for counselling

Psychological interventions may be offered on a one-on-one or group basis. It is important to offer a range of treatment services to clients and some may prefer to participate in a group model for psychological interventions. Whilst group work may not be the best fit for all clients, for some it may present an opportunity to reduce isolation. Choice is an important determinant of the perceived value of group counselling for service users.

The need to talk in front of other people (particularly about drug use) is a potential barrier to participating in group work but some users find it an important first step in addressing problems underlying their drug dependence. Little value is generally placed on group participation by those who had had participation imposed on or required of them (such as by a court).

The purpose of individual counselling in drug dependence treatment is to help clients identify their drug problems and establish goals of treatment, treatment modality, treatment plan, scheduling sessions, frequency and length of treatment, potential involvement of others, and termination of treatment.

The approach to a particular counselling session depends on the type of counselling. While all clients will have scheduled sessions with their counsellor, there will be some cases where an individual counselling session is initiated by the client to address a particular issue. The role of the counsellor changes when counselling is client-initiated or counsellor-initiated and the approach to the counselling session will be different.

4.4.4 Duration and general structure of counselling sessions

Brief interventions

Brief interventions are structured therapy of a limited number of sessions, usually one to four, sometimes requiring no more than five minutes, and sometimes up to two hours in total. Such interventions can provide information about drug use, particularly through approaches to reduce the risks of drug use, both to the individual and the general community. Brief interventions also aim to increase awareness of the negative aspects of drug use and reasons for ceasing use, and to motivate users to take action to modify their drug using behaviour, and to encourage them to engage in treatment. As such brief interventions often use motivational interviewing techniques.

Brief interventions on their own can promote behavioural change, or can act as the first stage of more intense treatment. Brief interventions are applicable to individuals from a wide range of cultures and backgrounds and they can be used in a variety of settings, both opportunistic and within specialised substance abuse treatment.

Brief interventions are appropriate to be used in conjunction with screening, for example after completion of the ASSIST questionnaire. Explain the findings of the ASSIST questionnaire (or other screening tool) and ask the patient to reflect on what was revealed in the test:

- Provide information and education about drug use and associated harms
- What are the major problems at the moment?
- Engage the person in a discussion about their substance use. Ask them to identify the perceived benefits of drug use (e.g., helps the person to work) as well as the potential harms
- With the client/patient, try to evaluate the positive and negative effects of substances – by challenging overstated claims of benefits and bringing up some of the negative aspects which are perhaps understated
- Avoid getting into an argument with the client/patient and try to help the person to understand the real impact of the substance in the person's life
- Encourage the person to decide for themselves if they want to change their pattern of substance use, particularly after a balanced discussion of the pros and cons of the current pattern of use
- If the person is not ready to stop or reduce substance use, ask the person to come back to discuss further, perhaps with a family member or a friend

Structured treatment

Structured treatment would be expected to comprise three or more sessions (each 45-60 minutes long) of individual counselling in addition to group sessions. These sessions would in general:

1. Orient the client to the treatment program including:
 - Help clients understand what is expected of them during treatment
 - Determine immediate treatment goals and develop a change plan
 - Help clients make a treatment schedule
 - Enlist the help of family members in supporting the client's recovery
2. Assess progress, support successes, and provide resources to keep recovery strong:
 - If the client's recovery is on track, review relapse prevention skills, give positive reinforcement for successes, and identify areas of possible improvement – a recovery checklist (see "5.2.10 Recovery checklist") may help with this
 - If the client has been struggling with recovery or is experiencing a personal crisis, address these issues, allowing time for the client to talk about what is going on and, when appropriate, develop a plan to help the client maintain or get back to recovery – a relapse analysis chart (see "5.2.11 Relapse analysis chart") may be helpful
3. Help the client to develop a plan for continuing treatment by:
 - Evaluating their progress in recovery – the treatment evaluation tool (see "5.2.12 Treatment evaluation form") may be useful
 - Setting continuing treatment goals (see "5.2.13 Continuing treatment plan")
 - Developing a clear understanding of how to maintain recovery, with short- and long-term recovery goals and a realistic plan for accomplishing those goals

Additional sessions may be required when the client experiences a crisis, such as relapse, to support the client's engagement in treatment and for relapse prevention depending on the detail of the treatment program and the specific needs of the client.

Whenever possible, the counsellor should involve the client's family or other significant and supportive persons in the individual sessions (which are then conjoint sessions). In conjoint sessions, generally the counsellor sees the client alone for the first half of the session and then invites family members to join the client for the second half. This arrangement should be communicated to the client and family members before they arrive for the session so that they can actively manage their time. The counsellor should try to accommodate the client by scheduling individual sessions at convenient times.

Plenty of time should be allowed for questions during each session to enable clients and their families to feel they are participating in the process, to describe urgent issues and to discuss emotionally charged topics.

Attributes of an effective counsellor

1. Creative and imaginative – a good counsellor will be able to identify linkages between the client's thoughts, feelings and behaviours which the client may not have recognised.
2. Practical – it is important for the counsellor to be flexible and give practical guidance on ways that the client can move towards achieving their goals. Many clients have difficulties with abstract thinking so providing simple, clear messages will assist the client in maintaining their resolve not to use drugs.
3. Respectful to clients – an honest and mutually respectful relationship encourages shared communication and reinforces the client's confidence in the counsellor and the program. Always being on time in counselling sessions is an indicator of respect for clients.
4. Empathetic – an effective counsellor should express empathy toward the client. This means not imposing your views or concerns on the client, but rather understanding their views and concerns. Empathy is the ability to understand and share the feelings of others. Empathy is the art of exposing the client's world, and conveying an understanding of the client's world so that the client can understand about him or herself more fully and act accordingly. Empathy is going with clients into their world of emotions and feelings, without being sucked into these feelings or emotions.
5. Action-oriented – an approach that is centred on the best way to achieve identified goals.
6. Having a professional knowledge base – an effective counsellor should be equipped with a good knowledge base. This means acquiring and mastering basic counselling skills and techniques, as well as having a fundamental knowledge about drugs, drug addiction, and drug addiction treatment. A good counsellor should also be equipped with knowledge in security and safety in conducting a counselling session.
7. Maintenance of ethical behaviour at all times – the counsellor should maintain ethical behaviour in all relationships with clients. This requires the counsellor to always maintain a professional relationship and avoid dual relationships with clients (for instance, being both a counsellor and a business partner of the client). Sexual or other personal relationships with clients are unacceptable.

4.4.5 Attributes of an effective counsellor

Voluntary

Counsellors, in discussion with clients, help clients to identify solutions to their problems but they have no right to force clients to do anything. Voluntary participation in counselling is important to help the client become more open and comfortable, to help the counselling service become known as user-friendly, and to establish and maintain clients' trust in the counsellor. This in turn will result in the good will of the service spreading among people who are affected by drug use and dependence in the community or region, which is particularly important with hidden drug users.

Confidential

This is crucial in working with people using drugs. Assurance of confidentiality makes clients feel comfortable and trust their counsellor when disclosing personal information necessary for treatment. Counsellors should explain the limits of confidentiality to their clients at the beginning of treatment. The principles of confidentiality require that counsellors should always respect and protect the client's right of privacy. Counsellors should maintain the principle of confidentiality except when doing so would result in obvious danger to the client or others. In these cases, the

decision to breach confidentiality should only be considered after discussion with a supervisor or manager that the action is appropriate. Personal information about clients may also be disclosed by legal obligation.

Examples of situations where personal information may be disclosed:

- The client provides informed consent to the disclosure – for example, if a client asks counsellors to inform and discuss his or her problems with family members, friends or other persons. Consent should also be sought to the release of information as part of a referral of a client to another service
- For the client's benefit – i.e., disclosure of information for the purpose of treatment. Information not relevant to treatment should not be disclosed, and client information should not be communicated outside of the treatment team
- Where there is a clear danger to the client or others – e.g., when a client reports suicidal thoughts, or where children may be at risk
- For the benefit of the community – for example, when the client shows signs of having acquired infectious diseases that can be rapidly spread into the community. Such cases should be reported to local health authorities
- Upon a court order or request from competent bodies as prescribed by law

Reliable

Counsellors should present themselves as reliable to their clients. A counsellor who is reliable is a person that clients find sincere. They are punctual, predictable and caring. The client feels they are being listened to and cared for by the counsellor. Accurate information, clear explanations and appropriate referrals will increase the perception that a counsellor is reliable. A reliable counselor also keeps clients' personal information confidential.

Non-judgemental

Being non-judgemental means staying neutral, not reacting to the client's issues. This lets counsellors keep in control and remain open to change. Counsellors can only counsel when they learn from clients' experience – use the client's information to guide the discussion. Good understanding of clients' perception of norms is important – it helps you position their belief system within a framework of possible options.

Respectful

Respect means that counsellors treat every client the same, regardless of their age, gender, looks, social position, or financial status. Starting a counselling session on time is a way for a counsellor to express respect for their client and it makes the client feel that the session is an important part of the counsellor's day. Mutual respect ensures effective communication and counsellor-client interactions. When mutual respect is established clients will become more cooperative and open and comfortable about sharing their "real problems," which enables counsellors to work with them to identify sound solutions.

Safe

Safety is important for both counsellors and clients. Safety means assuring the security of the clients' information, the clinic property and the broader physical environment.

Linked with other services

Participation in drug addiction counselling brings stability to many clients. This stability allows them to deal with a variety of related issues that may be beyond the skills and expertise of the drug addiction counselling service. In particular, problems such as housing, employment, health-related issues such as HIV, and legal problems are more likely to be managed in an effective way when the person is in drug addiction counselling. Linkage to these other services to enable the client to move into them is an important component of effective drug addiction counselling (see "4.3 Case management").

4.4.6 Basic counselling skills

The process of communication between the client and the counsellor is a continuous two-way sequence of events. This ensures that the counsellor listens (receives the message), processes (considers the message in combination with previous knowledge and experience), responds (delivers a response to the original message) and teaches clients skills and techniques to deal with their problems. There are four types of counselling skills that a counsellor should attain:

- Active listening
- Processing
- Responding
- Teaching

This section considers the components of these areas of skill in turn.

Active listening

Active listening is the central skill and act of counselling. Active listening in the counselling situation is the capacity to hear what the client is saying verbally and nonverbally, understand it, and communicate understanding and empathy to their client. Active listening makes clients feel cared for, and considered, and it encourages them to continue to share information.

Active listening with an encouraging expression (or reward listening) helps to establish and maintain rapport between the counsellor and the client, helps the client to disclose, to express feelings, and create a mutual knowledge base for both the client and the counsellor.

Respect and acceptance are essential in the practice of reward listening. Counsellors need to communicate sincerity in their manner, their body language, and their face without saying it in words. It is not sufficient to say things like “I really care” or “You can trust me.”

Active listening comprises four components: attending, paraphrasing, reflection of feeling, and summarising.

(a) Attending

Attending refers to a concern by the counsellor with all aspects of the client’s forms of communication. It includes listening to the verbal content, observing nonverbal cues, and then communicating back to the client that she or he is paying attention. The skill of attending is the foundation upon which all other skills are built.

Attending demonstrates that you listen to the verbal content of the conversation and also attend to the non-verbal cues. You can communicate back with words like “um-hm” or “yes” or by repeating the keywords. It helps the client to feel relaxed and comfortable and express their ideas freely. Nodding your head is showing: “yes, I understand and I am listening to you.” Appropriate eye contact with facial expressions, maintaining a relaxed posture and leaning forward occasionally, are other ways to express attending. A careful, attentive counsellor does not interrupt the client unnecessarily when the client is speaking, as this will make the client feel that the counsellor is not interested.

Look at the client carefully – you will see many non-verbal cues that will tell you whether the words they are speaking reflects what they are feeling in their head and their hearts.

Most of counselling is listening. Attending is listening and looking, and not necessarily speaking. Appropriate attending helps counsellors to have better understanding about the clients, notice any physical issues, and in the meantime helps the client feel relaxed and comfortable, trust the counsellor, express their ideas and feelings freely in their own way, and take a more active role in the sessions.

(b) Paraphrasing

Paraphrasing is when the counsellor restates the content of the client’s previous statement based on the counsellor’s understanding and words. The purpose of paraphrasing is to communicate to the client that you understand what he or she is saying. Paraphrasing can be a very useful skill for the counsellor to summarise complicated information in a way that the counsellor and client can both use to think about what to do next.

It encourages the client to think about an issue that you identify as important because you play the words back. It makes them think about what they’ve just said. It will have a much bigger impact than if they just say it to themselves because it highlights the issue.

(c) Reflection of feelings

Reflection of feelings or reflective listening is when the counsellor expresses the client’s feelings, either stated or implied. The counsellor tries to perceive the emotional state of the client and respond in a way that demonstrates an understanding of the client’s emotional state.

A good counsellor should have empathy with the client. Empathy involves sharing understanding of the client's point of view. Reflective listening can assist this process. Listening to their words but also identifying their emotions can be helpful to link what the client feels to their experiences. For example, you may say "you feel upset because your parents do not trust you." You can also bring to the surface feelings that are hidden. It teaches the client that their feelings are related to their behaviours.

Sometimes people can say things that are complicated and not easy to understand. In those situations reflective listening can be very helpful. You can say something like "What I've heard you saying is....., is that right?" or "Let me summarise what you have just said to make sure that I understand it correctly."

Reflection of feelings is a useful counselling skill as it helps the counsellor check whether or not they accurately understand what the client is feeling. The skill also helps the client to realise that the counsellor does understand, to increase awareness of their feelings, and learn that feelings and behaviour are connected.

(d) Summarising

Summarising indicates that the counsellor is attending and highlighting the main points discussed in the counselling session. Summarising is an important way for the counsellor to gather together what has already been said, make sure that the client has been understood correctly, and prepare the client to move on. Summarising is putting together a group of reflections.

Summarising helps counsellors to ensure continuity of direction of the session. It provides order to large sections of information because sometimes the information the client gives covers many different topics and points of view but not necessarily in a logical order. You can help to structure this information into a logical order through summarising, then you can link that summary to the next open-ended question to refocus the client on the issues you want to discuss.

Summarising helps to clarify the purpose and meaning of the discussion. Counsellors can also prompt for more information and provide an opportunity for the clients to hear their own thinking. Summarising can highlight ambivalence by linking the negatives and the positives of drug use in one statement. For instance, you could say, "On the one hand this... and on the other hand, that."

For clients, summarising creates opportunities for them to clarify the meaning and realise whether the counsellor understands what they are saying or not, and obtain a sense of movement and progress of the discussion. Periodic summaries will help link together what has been discussed, show the client that you have been listening, and help to point out issues on which the client is ambivalent.

A summary at the end of the session will help to pull together clearly and succinctly what has transpired during the session. In order to summarise at the end of a counselling session, consider: What were the main things to come out of the session? What will the client do in the future? What have you agreed to do? This sort of summary puts things together so that clients can leave with a clear plan. Taking note of main points of discussion may help the counsellor to give a more concrete summary. Summarising can also help the counsellor terminate the session in a logical way, or to focus on one issue while acknowledging the existence of other concerns.

It is important to differentiate between summarising and paraphrasing. Both these skills help to express that the counsellor is understanding exactly what has been said by the client, but while paraphrasing mainly focuses on one idea or sentence, summarising helps to put together all the information discussed in a period of time during the counselling session, or even during the whole session.

Processing

Processing is the act of the counsellor thinking about his or her observations about the client and what the client has communicated. Processing takes place within the counsellor, between listening to the client and responding to the client. This involves the counsellor's ability to mentally catalogue data or observations about the client's beliefs, knowledge, attitudes and expectations, and then categorise factors influencing the client's judgment and performance.

Responding

Responding is the act of communicating information to the client that includes providing feedback and emotional support, addressing issues of concern, and teaching skills. Responding involves empathy, probing, interpreting and silence.

(a) Empathy

Empathy is the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experiences of another. Empathy is not an ability or tendency to identify with a client's experiences, rather it is a learnable skill for understanding the client's meaning through the use of reflective listening, whether or not the counsellor has had similar experiences.

(b) Probing

Probing is a counsellor's use of a question or statement to ask for more information, clarification about a point that the counsellor thinks is important.

The direction of counselling is influenced by probing skills and hence is invariably the counsellor's views. Whenever you ask a question, you will be asking about what you want to know, and not necessarily what the client wants to tell you. As such, your questions "lead" or direct clients. However, probing has an important part to play in counselling. It focuses the client's attention. You will need information from clients and at times may want to influence the direction of the exploration. In general, probes are interventions that increase the counsellor's control over both process and content. For this reason, probing should be used sparingly and with care, particularly in the early stages of counselling. The probing skills are: questioning, making statements, and making proposals.

There are two types of questions: closed questions and open-ended questions. Closed questions limit the client to a short answer, such as "yes" or "no." Examples of closed questions are "where were you born?", "do you have a job?", "are you married?" In contrast, open-ended questions allow the client to answer in a multiple of different ways – the client cannot simply say "yes" or "no," and you cannot predict the answer and its dimensions. Open-ended questions encourage the client to provide detailed information. There are two magic words in questioning: "what" and "how." Examples of open-ended questions are "How did you feel when you first used cannabis?" or "What made you quit school?"

Closed and open-ended questions are both useful in working with clients. Closed questions can be ideal for counsellors to obtain a specific or factual piece of information, and are also useful when the counsellor thinks that the client cannot respond to any more probing questions. However too many closed questions at the beginning of a session can prevent the discussion from flowing as they tend to shut people off and it can feel like an interrogation. Open-ended questions, in contrast, tend to explore detailed information or clarify clients' answers. They are ideal for probing ideas, opinions and feelings. Open-ended questions can be useful at the beginning of an interview as they provide the client with opportunities to raise or expand concerns or issues. A word to avoid when the client's feelings are strong is "what" – this kind of question requires thinking, and when feelings are high, most people are not in a state to think. In general, it is best if the counsellor can flexibly combine both closed and open-ended questions to probe for information from the client.

Making statements is a gentler form of probing. For example, instead of asking a client "what did she do to upset you?" you might say "I'm not sure what she did to upset you." Statements tend to be less intrusive and controlling than questions. Probing is also about saying "please tell me more about that."

(c) Interpreting

Interpreting is the counsellor's explanation of the client's issues after observing the client's behaviour, listening to the client, and considering other sources of information.

By using this skill, the counsellor offers the client a new frame of reference from which to view their situation. It also helps to provide the counsellor with a possible, plausible linkage between the client's thoughts, feelings and actions and possible consequences. It helps the client to realise that there is more than one way to look at situations, problems and solutions. When using interpreting skills, it is wise to put them as suggestions rather than statements or facts or beliefs. You can do this by commencing your interpretation with something like "it sounds like you are saying...". This may help the client feel more comfortable, that the counsellor is not being judgemental.

Interpreting is a very important skill and has three components: (a) determining and restating basic messages, (b) adding the counsellor's ideas for a new frame of reference and (c) checking out these ideas with clients. Taking the role of a counsellor you are interpreting the information and testing a feeling and reflecting it back to your clients. So it is giving them a chance to understand the implication of what they are saying.

Sometimes it is also helpful to understand whether you have attached the right emotion to the things they tell you because sometimes a client's emotions get very confused. Two emotions that clients often get confused are anger and sadness which are both strong emotions. The confusion arises because we are interpreting how we would react in their situation and attribute our emotions to them.

Sometimes people don't see the linkage between their behaviours and consequences. Interpreting can make the consequences more obvious to them. It involves discussing the short-term and long-term consequences of the behaviour. For example: "From what you have said, I understand that you realise that smoking is causing you to cough and it may have long-term consequences for your health. In fact it may mean that you have a serious lung condition. Have you ever thought about it in that way?"

(d) Silence

This is one of the most interesting skills to be used in counselling and one that is probably the most challenging for most counsellors. Silence allows clients to examine information and think about what they heard or felt. Silence gives clients time to reflect, to be aware of, and to grab their emotions. Silence also demonstrates that communication does not need to be in words.

In a normal conversation, after 30 seconds, you will feel pressure to say something, anything, to fill the silence, but counselling is not just a conversation. Counselling has a purpose. There will come a time in the session when the client has said something that is very important and very difficult and you can see that they are uncertain about taking the next step. So they will not say anything. But while you are thinking those thoughts, the client at the same time is thinking about what they have just said. It is really starting to sink in. What they have said will have more impact because of the silence.

When combined with attending skills, silence can serve to encourage the client to continue sharing. The silence can lead them to the next step. The client will be the one to recommence the session. The client will be the one who thinks about the connection rather than the counsellor. They might have greater insight into what they've just said because often people don't think carefully about their words unless there is time to think.

Silence is the skill to use for big deep moments, when the clients have had an insight or said something that is very emotional. The silence prevents them from moving onto more comfortable areas of discussion which will distract them from confronting issues.

Silence is not something to use for small things. If silence is used on a trivial issue, the client may be confused about your intention. They may think you have stopped listening to them or that the counselling session is finished because there is no logical linkage to the next step.

Teaching

Teaching is the counsellor's transfer of skills to the client through a series of techniques and counselling strategies. "Teaching clients new skills" requires counsellors to master a series of micro-skills, including: (a) use repetition, (b) practice (c) giving a clear rationale, (d) monitoring and encouraging, (e) use of assignments, (f) exploring resistance, (g) praising approximations, and (h) developing a plan.

(a) Use repetition

Repetition entails counsellors restating information and clients practicing skills as needed for clients to master the necessary knowledge and skills to control their drug use. In many instances, drug users have very defined routines around acquiring, preparing, using, and recovering from drug use. Therefore, it is very difficult for them to change these patterns, especially when they encounter withdrawal symptoms. In addition, after using drugs for a long time, there is a negative impact on their capacity for attention, remembering and other cognitive skills making it difficult for them to understand, remember, and use new skills and techniques to cope with their drug use. For that reason repetition of sessions or parts of sessions may be necessary for patients who do not easily understand the concepts or the rationale of the treatment.

(b) Encourage practice

From social learning perspectives, drug use is a behaviour that clients learned from society. To change this behaviour, clients need to be taught alternative, healthy behaviours, such as skills for coping with craving, refusal skills, or thought stopping skills (see “Relapse prevention.”) Mastering a new skill requires time and practice. The learning process often requires making mistakes and being able to learn from them. It is critical that clients have the opportunity to try new approaches. Practice is the central part of teaching and learning a new skill. The learning process often requires making mistakes, making changes based on those mistakes, and then trying again over and over until the skills are mastered.

It is important that counsellors offer their clients plenty of opportunities for practice, both within sessions and outside of them. In-session practice helps clients to grasp basic elements of the assignment, raise their opinion and thoughts about the assignment, and receive feedback and guidance from the counsellor. Practice outside the counselling session helps clients to rehearse the new skills in real-life situations, identify obstacles and barriers for using the skills, and then discuss these issues with their counsellor in the next session to find solutions to overcome the obstacles and barriers. However, practice is only useful if the client sees its value and actually tries the exercise. Compliance with assignments outside of counselling sessions is a challenge for many clients.

(c) Give a clear rationale

Counsellors should not expect a client to practice a skill or do a homework assignment without understanding why it might be helpful. Counsellors should constantly stress how important it is for clients to practice new skills outside of the counselling session and explain the reasons for it. Many people drop out and do not practice their homework because they do not understand the importance of the suggested assignments and practicing them.

(d) Monitoring and encouraging

Monitoring is following up by obtaining information on the client’s attempts to practice the assignments and checking on task completion. It also entails discussing the client’s experience with the tasks so that problems can be addressed in session. Encouraging means reinforcing further progress by providing constructive feedback that motivates the client to continue practising new skills outside of sessions.

Monitoring the client’s practice of homework assignments is very important. It helps to improve the client’s compliance with the treatment plan, and improves the effectiveness of the assignments. Checking the completion of homework is a way to emphasise the importance of practicing coping skills outside the counselling sessions. It also offers opportunities for counselors to discuss with the client any obstacles or difficulties encountered during practice. In general, clients who do homework tend to have counsellors who value homework, spend a lot of time talking about homework, and expect their clients to actually do the homework.

The early part of each session should include at least five minutes for reviewing a practice exercise in detail. It should not be limited to asking clients whether they did the exercise. If clients expect the counsellor to discuss the practice exercise, they are more likely to attempt it than clients whose counsellor does not follow through.

(e) Use of assignments

The information provided by clients through the practice exercises and homework can be used as a basis for constructive feedback and motivation.

The work that clients do in a practice exercise and their thoughts about the task convey a wealth of information about clients, their coping styles and resources, and their strengths and weaknesses. Such information is valuable to the counsellor and should be used during sessions. Rather than simply checking homework, the counsellor should explore with clients what they learned about themselves in doing the task. This, along with the counsellor’s own observations, will help guide the topic selection and pacing of future sessions.

(f) Explore resistance

Some clients do practice exercises in the waiting room, at the last minute before a session, while others do not even think about their exercises. Failure to implement coping skills outside of sessions may have a variety of meanings: clients may feel hopeless and therefore do not think it is worth trying to change their behaviour; they may expect change to occur through their willpower alone, without making specific changes in particular problem areas; because

their life is chaotic and crisis-ridden, they may be too disorganised to carry out the task, and so on. By exploring the specific nature of their difficulty, counsellors can help clients work through these issues.

(g) Praise approximation

Most clients do not immediately become fully abstinent upon treatment entry and many are not fully compliant with practice exercises. Counsellors should try to shape clients' behaviour by praising even small attempts at working on assignments, highlighting anything the client reveals as helpful or interesting in carrying out the assignment, reiterating the importance of practice, and developing a plan for completion of the next session's homework assignment.

(h) Develop a plan

A plan for change enhances your client's self-efficacy and provides an opportunity for them to consider potential obstacles and the likely outcomes of each change strategy. To help the clients develop a change plan, the counsellor should offer a menu of change options (for instance, to stop using drugs, to reduce drug use, or to stop drinking, etc.) working with them to develop a behaviour contract or a change plan worksheet, and helping them to reduce or eliminate barriers to action.

4.4.7 Things to avoid in drug dependence counselling

Counselling is an interaction, with cooperation and mutual respect between counsellor and client, to help the client confidently face problems and enhance their capacity to solve their own problems. Effective counselling should be client-centred and responsive to the client's needs, help the client create resources and self-confidence to solve their problems. To achieve this there are things that counsellors should avoid.

1. Moralizing

Remember the goal of your work is to help clients with problems solve those problems. Never moralise their experience or behaviours.

2. Ordering

You are a counsellor, not their supervisor or employer. You have no right to order. What you can do for clients is provide suggestion and guidance, not orders.

3. Threatening

Try to avoid attitude or language that make the client feel that they are threatened. Your role is to provide a supportive environment that encourages the client to share their problem so that you can help.

4. Arguing

The clients may not take your advice and they may use words that hurt you. Try to understand their worries and do not argue with them. Stay calm and help them understand that they have the right to make their own decisions, and you respect that

5. Disagreeing

It is not your role to rate what is wrong and what is right – that may lead to disagreement. Learn from them so you can teach them new skills and give advice.

6. Over-interpreting

Your role is to try to understand your client and to bring together their words into a package that is easier to understand, but do not over-interpret what they are telling you – this is likely to lead to misunderstanding

7. Sympathising

A good counsellor should have empathy with his or her clients, but a professional counsellor also knows how to avoid sympathising, never takes sides or involves his or her emotions in directing the counselling session. A professional counsellor should understand clearly the difference between empathy and sympathy. Sympathy is the ability to feel and experience the emotion of others.

Sympathy places emphasis on sharing of grief and loss, while empathy does not emphasise any specific emotion. Sympathy can include agreeing with some aspects of others' beliefs and emotion, while empathy focuses on understanding the belief and emotion but does not express agreement or disagreement with these. An empathic

person grasps the inner world of others, while the sympathetic person captures only the aspects that he or she agrees with.

A counsellor, in order to help their client, besides being able to understand and feel the client's emotion, must maintain a certain objectivity, not to sympathise, "to cry with and to laugh with" the client. A counsellor should empathise but not sympathise with the client.

8. Judging

You help your client identify their problems and what puts them at risk. It is different from judging. Judging will cause mis-trust and denials of problems and lead the session in the wrong direction. You should listen without judgment, criticism or blame, and try to gain a better understanding of the client from his or her viewpoint.

What to remember and what to do	What NOT to do
Show respect to clients. Remember that clients are people, not "just" drug users.	Do not criticise or blame clients.
Talk to them in a private place – ensuring that what you are told is confidential.	Do not discuss private matters with clients where other people can hear the conversation.
Keep the information that you get confidential.	Do not share names or other information about clients unless they have given you permission to do so.
Approach the topic of drug use gradually – for example, before you begin to talk about drug issues, engage in small talk (How are you? How did you get here today?)	Do not immediately give advice and tell the client what to do. Instead give information.
Give your full attention to the person you are meeting with (make eye contact, avoid interruptions, turn off your phone).	Do not allow yourself to be distracted by phone calls, people knocking at the door.
Listen more than you speak.	Do not talk too much or threaten clients unless they do what they are told (e.g., with informing police or family).
Speak in a normal voice and try to indicate that you are listening and understand the problems.	Do not use sarcasm or a mocking tone of voice.
Ask questions that need more than a yes or no answer.	Do not ask questions for which there are no good answers (eg. Why are you behaving this way? Why are you hurting your family?).
If patients express emotions (fear, sadness, anger, shame, embarrassment), allow them to do so without any negative reactions from you, or giving false reassurance.	Do not say "don't cry" or "don't worry" or "try not to think about it" or "don't be afraid" or "everything's going to be OK" – those statements make patients feel like you are not able to tolerate their emotions. Do not promise things that you cannot guarantee.
Before you ask each new question, acknowledge the answer they gave to your last question.	Do not ignore what patients have already told you.
Take your time and speak slowly. Make the client feel that you have all the time to listen. Rushing makes patients feel unimportant.	Do not make jokes or try to distract them from their difficulties – it will make them think that you do not take them or their problem seriously.

4.5 Medical and pharmacotherapy

4.5.1 First aid for people affected by drug use and dependence

Skin and soft tissue injuries are common in injecting drug users, although serious complications are rare. When complications do occur, they can be severe and result in lengthy hospitalisation, chronic illness and death.

In general, assessment should determine:

- Wounds or infections requiring minor attention, such as antibiotics, compresses or topical treatments
- Wounds requiring incision and drainage
- Wounds or infections needing referral to a hospital

Bruising at the injection site can be treated with various topical creams. Application of ice may also be useful.

Redness or swelling around the injection site may occur as a result of missing the vein and injecting into soft tissue. It usually resolves without treatment within a few days. Application of warm compresses may be useful.

Scarring (track marks) is caused by repeated injections into the same site. Topical creams may soften scars and reduce track marks. Rotating injecting sites and using a new needle for each injection will also reduce scarring.

Skin ulcers, either as a complication of venous stasis or from injecting itself, usually respond to local wound care and topical antibiotics:

- Use a mixture of methylated spirits and betadine (iodine) to keep the wound dry
- If pus is present, washing with antiseptic (eusol, betadine or similar) may be useful
- If large, dressings which encourage tissue growth and reduce infection should be used

Collapsed veins occur when repeated local infections produce scarring of the vein. It can also result from use of a barbed needle which tears the vein, damages valves in the vein and can produce a large amount of scarring. Using a new needle for each injecting and rotating injecting sites can help prevent collapsed veins. Using a sterile swab to clean the skin before injecting also helps reduce vein collapse by reducing the amount of bacteria on the skin that may cause localised infections.

Abscesses usually begin to develop three to ten days after injection and slowly increase in size and discomfort over the following week. They appear as a reddish, painful swelling which may feel hot to the touch. They then develop into a hard, pus-filled core.

Treatment of abscesses:

- Incision and drainage – irrigating the wound with sterile saline may be necessary for large wounds
- Antiseptic dressing (eusol, betadine or similar) to cavity for 1-2 days or until granulation is achieved
- Following drainage, dress with bulky gauze to absorb wound secretions
- Daily dressing with betadine solution as follow-up wound care
- Commence short course of antibiotic therapy
- If analgesia is required, use paracetamol or diclofenac
- Patients should be educated about using a clean alcohol swab, or soap and water, to clean the injection site each time they inject. Rotating injecting sites may help to reduce the possibility of abscesses

4.5.2 Responding to overdose^{6,7}

Although an overdose is more likely to occur through injecting, it can occur through smoking opium. Any client using opioids should receive education on overdose causes and prevention. Overdose as a cause of death is preventable in the majority of cases because it usually:

- Happens to experienced users
- Happens over 1-2 hours, not instantly
- Is frequently witnessed by other users or by other persons present who can take life-saving action
- Can be treated (reversed) effectively with naloxone (Narcan).

⁶ UNODC/WHO, 2013. Opioid overdose: preventing and reducing opioid overdose mortality

⁷ New York State Department of Health, 2006. Opioid Overdose Prevention Guidelines for Training Responders

There are many myths around what to do at an overdose management. Many of these waste valuable time when the victim may not be breathing. In essence, calling for assistance and breathing for the person significantly improves their chances of surviving, even if the people present do not know correct mouth to mouth procedures.

Naloxone is a short-acting opioid antagonist that binds very tightly to opioid receptors, replacing other opioids that may be there and blocking other opioids from binding. It has a long clinical history of successful use for the treatment of opioid overdose. Specifically, naloxone is used in opioid overdoses to counteract life-threatening depression of the respiratory system and the central nervous system, allowing an overdose victim to breathe normally. The medication has no effect if opioids are absent and naloxone has no potential for abuse. In addition to reversing respiratory depression, naloxone may induce withdrawal symptoms in the dependent user under the influence of opioids, which, although unpleasant, are short-lived. Naloxone is on the WHO Model List of Essential Medicines and should be available in all health-care facilities that may be called upon to respond to opioid overdose.

Signs of Overdose

Overdose is more likely to occur 1-2 hours after using an opioid rather than just after injecting or snorting. After individuals use opioids/heroin, they should check in regularly with each other to make sure they are responsive and not slipping into an overdose.

Signs of an overdose are:

- Pinpoint pupils
- Slowed or shallow breathing
- Bluish lips and nail beds resulting from lack of oxygen
- Unconsciousness, not responsive to stimulation: Immediate action should be taken

7 Steps for responding to an opioid overdose

1. Stimulation

- Yell the user's name
- Shake the person
- Do a sternal rub. The sternal rub is a very good technique to awaken someone from a heavy nod. To do a sternal rub, make a fist and then rub the sternum (also known as the breastbone) with your knuckles in center of the person's chest, and apply pressure while rubbing. If the person does not respond after 15-30 seconds of doing a sternal rub, it is likely that the person is overdosing and requires immediate attention

2. Call for Help

- Call for Emergency Medical Services
- If leaving the person alone, place them in the Recovery Position: Put the person on his/her side. This will help to keep the airway clear and prevent the person from choking on vomit

3. Check Breathing and Respond

- If the person is not breathing, the responder should start by giving a few rescue breaths and then administer naloxone
- If the person is breathing but unresponsive, then the responder should administer naloxone first

4. Administer Naloxone

- Inject 1cc of naloxone into a large muscle such as the upper arm or thigh. Naloxone is fast-acting, and adequate respiration will typically resume within 3-7 minutes of intramuscular administration of naloxone and the effects will then last for 30-90 minutes, which, in most cases is sufficient to prevent death
- If no response in 3-5 minutes, inject an additional 1cc of naloxone with a new needle. If emergency services have not yet been called, it is urgent to do so now
- Dispose of the used syringe carefully in a puncture-proof container

5. If Person is Not Breathing (or no naloxone is available), Perform Rescue Breathing

- Tip the head back with one hand under the neck. Use the other hand to hold the nose closed
- Make a seal over the mouth with your mouth (using a mask if it is available) and give two quick breaths; then one every five seconds
- Continue rescue breathing until the person breathes on his/her own

6. Evaluation and Support

- Stay with the overdose survivor and provide reassurance that the drug withdrawal symptoms will decrease in about one hour. Tell them that more drugs (opioids) should not be used now and keep them active/awake
- Inform the medical emergency services of what happened and how much naloxone was given
- Encourage the survivor to go to the hospital for observation for at least one hour

7. Discussion of ongoing drug or pain treatment after the effects of the naloxone have worn off. Provide education on the factors increasing the risk of overdose and on recognition of overdose symptoms, as well as on the need for respiratory support and medical assistance in cases of overdose. Negative health outcomes associated with non-fatal overdose, such as respiratory infections, may develop later. Advise the person to seek a basic health screening in the days following an overdose

4.5.3 Detoxification

Chronic drug use is associated with physiological changes that comprise physical dependence. Users who are dependent must undergo detoxification if they are to become abstinent.

Withdrawal occurs when the drug of dependence is eliminated from the body, and any physical adaptation that has occurred as a consequence of dependent drug use is reversed. The nature and severity of withdrawal depends on an individual's drug use history and the pharmacology of drugs used.

Detoxification entails the provision of interventions to ensure that the withdrawal process is completed with safety and minimal discomfort. Many of the people who are affected by drug use and dependence cease use without assistance from detoxification services; others may be supported by family members or other services. Interventions may entail largely a supportive environment, the use of medications to counter the symptoms of withdrawal, or medications specific to the drug of dependence.

Detoxification can be managed in a variety of clinical and community settings depending on the individual's needs and circumstances, health risks and severity of withdrawal.

Because detoxification addresses only the physical adaptation, and not the social dimension of dependence, detoxification is not in itself a treatment for dependence. Rather, detoxification is a stepping stone treatment.

Rates of relapse following detoxification tend to be high. However, detoxification also provides a limited opportunity for interventions which may encourage people affected by drug dependence to move towards the next stage of change and at least a period of respite from the risks associated with regular drug use as well as promoting engagement in further treatment.

Management of opioid withdrawal

Detoxification procedures include prescribing medications together with psychosocial support. Opioid withdrawal treatment without methadone or other treatment options may be preferable for patients with a short history of opioid use.

'Cold turkey' withdrawal (i.e., the abrupt cessation of chronic drug use without medication) is best reserved for people with lower levels of dependence in a setting with appropriate care and support and the capacity to intervene if the level of discomfort becomes unacceptable to the patient. Control of vomiting and diarrhoea is particularly important to prevent dehydration which can have serious consequences if left untreated. The Clinical Opiate Withdrawal Scale (see "5.2.2 Clinical Opiate Withdrawal Scale [COWS]") can be useful for confirming the presence and severity of withdrawal.

Alleviation of the discomfort of opioid withdrawal can be achieved by using medications directed at the specific symptoms of withdrawal. Appropriate medications include benzodiazepines for sleep disturbance and anxiety, anti-emetics, anti-diarrheals, muscle relaxants and non-opioid analgesics.

The group of drugs known as alpha2-adrenergic agonists (e.g., clonidine, lofexidine, guanfacine) may also be used to reduce the elevated blood pressure, increased heart rate and other adrenergic features of opioid withdrawal.

Opioid withdrawal can also be aided with reducing doses of opioid agonists, such as tincture of opium, methadone (see 5.2.4 and 5.2.5 for the methadone prescription tools) or buprenorphine (if available). This approach should be considered for patients with:

- History of previous unsuccessful withdrawal efforts without methadone
- No use of any other drugs
- Urgent need to stabilise due to medical or psychiatric condition
- Preference for this withdrawal treatment

The aim of dosing with opioid agonists in this context is to provide symptomatic relief during withdrawal from opioids. The opioid agonist should be commenced at a dose that is sufficient to diminish withdrawal symptoms, although it may not completely abolish symptoms. The dose is then reduced over a period of time, usually 21 days with methadone but as little as five days with buprenorphine.

Detoxification can be either in home or community detoxification unit or hospital, or via close supervision as an outpatient. With outpatient detoxification, supervised daily dosing is recommended, with any additional medication (e.g., benzodiazepines) for symptomatic relief also provided during daily attendance at the dispensary.

Short-term use of methadone, buprenorphine or tincture of opium to assist withdrawal is most likely to be successful if there is:

- Strong patient motivation to become drug free
- Good social support for the patient
- A short history of opiate use
- No use of any other drug
- A patient request for this treatment option

Inpatient detoxification may be considered when:

- Over the past six months, criteria for substance dependence (with physiological dependence) are met and current, objectively verified use is confirmed
- The client is currently tolerant to one or more substance classes such that an abrupt cessation of use will lead to the onset of withdrawal symptoms
- The client expresses a clear preference to withdraw from substance use in an inpatient programme, or is willing to receive that type of treatment
- Previous treatment or detoxification experience and/or the client's drug use involvement, or personal resources suggest that completion of detoxification is unlikely in a community setting
- Withdrawal symptoms of a severe and/or complex nature are likely to follow cessation of the main substance(s) used, or the client's social environment contains one or more people (for example, a partner or friends/acquaintances) who are currently using drugs and who are likely to hinder the client's resolve or ability to participate in an outpatient program and present an immediate risk of relapse

Arrange to review the patient even after completion of withdrawal treatment, to assess their progress and discuss relapse prevention.

Management of amphetamine withdrawal

Mental state symptoms such as paranoia, delusions or perceptual disturbances are common among people affected by stimulant use and dependence. Signs and symptoms can fluctuate with time. A formal mental state examination should be undertaken of all drug patients who have a history of stimulant use.

Withdrawal typically occurs in three phases. The *crash phase* commences as stimulants wear off, and can last for several days. Key features include fatigue, flat affect, and increased sleep and reduced cravings. The *withdrawal phase* typically commences 2-4 days after last amphetamine use and 1-2 days after last cocaine use. Features are predominantly psychological, with fluctuating mood and energy levels, cravings, disturbed sleep, and poor concentration. Withdrawal features gradually subside during the *extinction phase*, which lasts from weeks to months.

Phase	Time since last stimulant use	Common signs and symptoms
'Crash'	Commences 12-24 hours after last amphetamine use, subsides by day 2-4	Exhaustion, fatigue, agitation and irritability, depression, muscle aches. Sleep disturbances (typically increased sleep, but insomnia or restless sleep may occur)
Withdrawal	Commences 2-4 days after last use, peaks in severity over 7-10 days, and then subsides over 2-4 weeks	Strong craving; fluctuating mood and energy levels, alternating between irritability, restlessness, anxiety and agitation; fatigue, lacking energy
'Extinction'	Weeks to months	Gradual resumption of normal mood with episodic fluctuations in mood and energy levels, alternating between irritability, restlessness, anxiety, agitation, fatigue, lacking energy. Episodic cravings, disturbed sleep.

There is considerable variation in the severity of withdrawal when stopping regular stimulant use. The following factors may affect the severity of withdrawal:

- Intensity of use
- Type of stimulant used
- Dose and frequency of use
- Mode of administration (injecting is often associated with greater amounts of use, higher severity of dependence and perhaps more severe withdrawal)
- Other drug use
- Current health problem/illness
- Client expectations
- Environmental and psychosocial support

Withdrawal from stimulant drugs is not medically dangerous, and no specific treatment has been shown to be effective. The usual objectives in treating stimulant withdrawal are to assist the patient to interrupt a period or pattern of compulsive use, to identify and manage comorbid conditions and to initiate relapse prevention treatment. Withdrawal is best managed in a quiet, low-stimulating environment that permits observation of the patient.

The following measures are recommended:

- Monitor regularly, including monitoring of mental state (note that moods may fluctuate from low mood and flat affect, to restlessness and agitation)
- Ensure that those withdrawing drink at least 2-3 litres of water per day
- Provide multivitamin supplements containing B and C vitamins
- Give symptomatic medication for aches and pains, anxiety

See "4.6.3 Psychotic disorders" for information on the management of psychosis.

The long-term extinction phase of stimulant withdrawal requires integration between withdrawal services and post-withdrawal treatment.

It is important to provide the patients with post-withdrawal support especially as the symptoms may become most difficult a few weeks after stopping drug use.

4.5.4 Medication-assisted (maintenance) treatment

Medication-assisted treatment involves the prescription of a drug with similar properties to the drug of dependence, but with a lower degree of risk. The value of medication-assisted treatment lies in the opportunity it provides for dependent drug users to reduce their exposure to risk behaviours and stabilise in health and social functioning before dealing with the physical dimension of dependence.

The main forms of medication-assisted treatment are prescribed methadone or buprenorphine for opioid dependence and nicotine replacement therapy (patches, gum, inhalers) for tobacco smoking. Psychosocial support is usually an integral part of medication-assisted treatment – psychosocial support in the treatment of drug

dependence refers to the many ways in which professional and non-professional members of society can support the psychological health and the social environment of the drug user, to help improve both the quality and duration of life. Assistance can range from the simple (e.g., provision of food and shelter) to the complex (e.g., structured psychotherapy).

Worldwide, methadone syrup for oral intake is the pharmacological agent that is most commonly used for medication-assisted treatment of opioid dependence. Buprenorphine, administered as a tablet or film placed under the tongue, is increasingly being used. Slow release oral preparations of morphine are also emerging as alternatives. While there are some differences in the pharmacological properties of these medications, the principles of medication-assisted treatment are similar. This document focuses on methadone as it is the preparation most likely to be used in Southeast Asia.

Supervised daily supply of an adequate dose of methadone in a structured program has been demonstrated to:

- Reduce the mortality rate to one-third that for opioid users not in treatment
- Markedly decrease opiate use and criminal activity
- Increase legitimate annual earnings
- Decrease obstetrical and foetal complications for pregnant women

Medication-assisted treatment using methadone or buprenorphine has demonstrated effectiveness in the prevention of infectious diseases, especially HIV/AIDS but is also beneficial in promoting compliance with treatment regimes for HIV infections and tuberculosis and is associated with better outcomes from treatment of these conditions.

Criteria to determine the suitability of medication-assisted treatment	Contraindications to medication-assisted treatment
Age above 18 years	Very young drug users (for patients aged 16 years or younger, obtain written permission from a parent or legal guardian)
Dependent opioid users	Drug users with acute psychosis or being treated with MAO inhibitors
Drug users injecting opioids (heroin and/or synthetic)	Polydrug (including alcohol) users for whom opioids are not the primary drug of dependence; short history of opiate use
Persons willing for oral medication-assisted treatment (provide informed consent for treatment)	Heavy alcohol use; acute alcoholism, head injury with raised intracranial pressure; patients with clinically significant liver impairment

Admissions for substitution treatment should be restricted to persons who are dependent on opioid drugs, as indicated in the following criteria:

- In the past year, diagnostic criteria for opioid dependence (with physiological dependence) are met
- The client expresses a preference a community stabilization/maintenance program
- The client is currently tolerant to opioids and abrupt cessation of use will lead to the onset of withdrawal
- There are reasonable grounds to assume that the client will be able to attend treatment and comply with the rules and regulations operating in the prescribing program, or, due to the nature of the client's substance dependence, he/she is not able to make an immediate commitment to abstinence and requires a period of stabilisation/ maintenance and monitoring based on appropriate substitution and other adjunctive medication pending further assessment of treatment goals

Medication-assisted treatment is generally not appropriate for:

- People aged less than 18 years
- Those unable to give informed consent (e.g., due to a major psychiatric illness)
- Those with significant concomitant medical conditions that may be exacerbated by opioids or that increase the risk of overdose (e.g., severe respiratory or hepatic insufficiency)
- High risk polydrug use, particularly the use of drugs (alcohol, benzodiazepines) likely to cause sedation and increase the risk of overdose

Medication-assisted treatment may be delivered in a variety of settings, including drug treatment services or outpatient clinics, community-based health centres, hospital clinics, mental health centres and correctional facilities.

Practitioners from different disciplines and backgrounds may be involved in delivering medication-assisted treatment – medicine, nursing, social work, pharmacy and mental health, among others. Their roles will vary depending on factors such as qualifications, program setting, available resources and geographic location.

Intake procedures

Information given to patients prior to methadone treatment should include:

- The dynamics of stabilisation (starting slow with methadone and going slow)
- The hazards of polydrug use, particularly in the first week of treatment
- The effects and side effects of methadone
- Program guidelines and conditions
- Expected behaviour from the patient
- Risks and symptoms of an overdose

It is good practice to ensure that the patient can provide proof of identity and to attach current photographs to prescribing and dosing sites. This helps to reduce the risk of dosing errors.

Induction phase

Factors determining the initial dose of methadone include:

- The degree of neuroadaptation to opioids
- Concurrent medical conditions, including impaired hepatic function
- The time since the patient's last drug use
- The patient's state of withdrawal or intoxication
- Interactions with other prescribed medications
- The perceived likelihood of the patient's misuse of alcohol, prescription or illicit drugs.

Initial doses of methadone are usually in the range 15-30mg, once daily in the morning, with the dose varied as indicated in the table below.

Initial methadone dose	Condition of patient
15-20mg	Severe medical conditions Low or uncertain levels of neuroadaptation High risk polydrug use
20-25mg	Moderate level neuroadaptation or some risks
25-30mg	High level neuroadaptation Patient well known to doctor and no risk factors Prior methadone treatment with frequent review

Any methadone or combined drug toxicity should be reviewed when peak blood levels occur (usually 2-4 hours after dosing).

The signs and symptoms of methadone toxicity include slurred speech, unsteady gait, poor balance, drowsiness, retarded movement, stupor and snoring. Pin point pupils and respiratory depression may be observed. Mixed poisoning is usual. This is a serious medical emergency and the patient should be reviewed urgently. Poisoning may proceed to:

- Coma (unarousable, atypical snoring, flaccid, cyanosed)
- Respiratory depression and hypoxia
- Death

A split dose approach (i.e., an initial low dose, 10-20mg, with review at the time of the second dose) is effective when there is some uncertainty about the appropriate starting dose.

WARNING:

- There is a high risk of potentially fatal drug overdose involving methadone and other CNS depressant drugs
- The initial prescription should be for three days only to ensure the patient will return for review after the fourth dose

Stabilisation phase

After 3-5 days, the dose can be increased by 5-10mg at intervals of 2-3 days, with a maximum increase of 20mg in any one week, until stabilisation is achieved.

- Rapid dose increase may result in toxicity
- Admit the patient to a drug treatment clinic for up to two weeks for close observation if there is a risk of methadone toxicity, for example due to drug interactions

Maintenance phase

A maintenance dose of at least 60mg/day is recommended (range 60-120mg/day). The dose should be individualised to the patient's needs, but along with treatment of other medical conditions, methadone dose is an important determinant of outcome.

There should be regular contact between the prescribing doctor and the patient throughout methadone treatment, including at least:

- Twice during the first week
- Weekly for the first month
- Fortnightly during the 2nd and 3rd months
- Monthly for the next three months then
- Every three months

Termination of treatment

A decision to terminate treatment is the responsibility of the prescriber. Most treatment terminations will be requested by patients, but involuntary termination may occur due to unacceptable behaviour. Abrupt withdrawal should be avoided if termination of treatment is necessary.

Patients terminating treatment should be advised of other treatment options, the likely loss of tolerance, and the risk of overdose.

The dispenser may wish to cease dosing a particular patient because they have failed to comply with agreements established at the beginning of treatment. Problems may include poor compliance with agreed payment schedules. In most circumstances an attempt should be made to resolve the problem with the patient, and the prescriber should be notified. Possible responses to problems include referring the patient to another dispensing site, or asking the prescriber to do so.

If negotiation fails, the patient should be informed of the intention to cease dosing, preferably with a period sufficient to enable transfer to an alternative dosing point.

The decision to withdraw and the rate of withdrawal should be determined by agreement between the patient and the prescriber (in consultation with the dispenser and counsellor). Premature withdrawal should be discouraged and the patient warned of the high risk of relapse. Withdrawal should be closely monitored, and if the patient experiences difficulties, dose reduction should be stopped or doses increased until the patient is again stable.

*Dispensing arrangements**Client records*

The prescribing doctor should provide written dosing instructions for each patient, to be held at the dispensary. The dosing card should be used at the drug treatment clinic to review the patient's attendance, and changed doses should be written directly on the card by the prescriber (see 5.2.6 for a model of patient methadone dispensing record).

The doctor should contact the dispensing site that has been agreed for the patient to attend to arrange for daily supervised dosing and forward to the dispensing site:

- The prescription for methadone
- A recent photograph of the patient endorsed by the prescribing doctor
- Written commencement/transfer form specifying the date of administration of first dose, the name of the dispensing site at which the patient is to be dosed, and the duration of the transfer (if relevant)

The prescription should include the original written authorisation from the prescriber, including the current prescription dose and with the duration of treatment not more than six months.

A book for each patient should be used to record the date and time of each dose, with signatures by both patient and dispensers to confirm dosing. The use of a separate record for each patient ensures confidentiality and provides a complete dosing record.

Preparation of doses

Keep methadone bottles in a secure location and put away to a locked cabinet. Methadone should not be refrigerated. The shelf life of methadone solution is 12 months.

Each dose of methadone syrup should be diluted with water. For accurate measurement, use a syringe or displacement pump.

Prepare the dose only when the patient is in attendance.

Some dispensaries create consistent strength working solution (e.g., 5mg per ml). Containers of any solutions should be clearly labelled to indicate concentration to prevent accidental over- or under- dosing.

Administration of doses

A discreet location for administration of medication to patients is desirable.

Directly supervise dosing and engage the patient in conversation to ensure the dose is actually consumed.

Provide disposable containers to maintain an appropriate standard of hygiene. Observe for any signs of methadone or other toxicity.

Unsupervised (take-away) dosing

Risks associated with unsupervised dosing are:

- Hoarding and deliberate overdose of self or others
- Use in dangerous combination with other drugs
- Self-administration by injection
- Diversion of methadone for illicit use
- Trafficking to provide funds for heroin purchase
- Accidental overdose (e.g., by children)
- Sharing of dose with drug-using friend.

Unsupervised (take-away) doses should only be considered when:

- The client demonstrates clinical stability as indicated by
 - » A stable methadone dose
 - » Stable housing, support system, activities and regular attendance at clinic appointments
- The client has been in treatment for three months or more
- The client is able to safely store medication
 - » Clients with unstable living arrangements, such as those living on the street or in places without storage facilities may not be suitable for unsupervised dosing
 - » To ensure that children at home don't have access to medication

Only the prescriber may authorise take-away doses, in writing, with details of authorisation to be clearly recorded in the patient's book. Take-away doses should only be authorised for patients consistently attending the dispensary and has been stable for three months.

Under exceptional circumstances (e.g., illness restricting mobility, travel to meet employment responsibilities, or court appearances) prescribers may authorise take-away doses for up to three consecutive days but no more than once a month.

The dispenser should be contacted by the prescriber to confirm that recent behaviour and dose collection have been stable, and that there is no concern of misuse, before authorising take-away doses.

To deter injection or consumption by another person (especially a child), dilute each take-away dose with water to a volume of 200ml, and supply it in a container with a child-resistant closure. The following labels should be affixed to the container:

- This bottle contains a single daily dose of methadone to be taken on (date) by (patient's name)
- Dispensary details and date of supply
- Warning: This medication may cause drowsiness and may increase the effects of alcohol. If affected do not drive a motor vehicle or operate machinery. Keep out of reach of children. May cause death or serious injury if taken by another person.

Possible intoxication

The dose must not be administered if the patient appears to be intoxicated due to use of alcohol, prescription drugs or illicit drugs.

Common signs of intoxication or toxicity include:

- Slurred speech
- Unsteady gait
- Drowsiness or drooping eyelids
- Pupil constriction
- Shallow breathing

If intoxication is suspected, advice should be sought from the prescriber or drug treatment centre. Professional judgment must be exercised about the appropriateness of dosing based on observation of the patient to ensure safety.

Possible approaches to intoxication include:

- Instructing the patient to return later in the day (mild intoxication)
- Instructing the patient to consult the prescriber (moderate intoxication)
- Instructing the patient to attend to a hospital (severe intoxication)

During the initial stabilisation period, the blood levels of methadone take some days to reach a steady state as the drug is distributed to the body tissues. There is significantly greater risk of toxicity due to lack of recognition of the long half-life of methadone and the possibility of concurrent polydrug use. Assessment of intoxication is particularly important during stabilisation.

The maximum daily dose for new patients should not exceed 40mg. Further, it should be increased only gradually.

The prescriber should have advised the patient about the risks of polydrug use and other related risks (e.g., impairment of their ability to drive).

Patients with special needs

Some patients will be admitted to hospital, taken into police custody or temporarily transferred to another dosing point. After a patient's discharge from hospital there may be differences in the medication regimen, and possibly a change of prescriber. Whatever the reason, appropriate relevant information (previous dosing point with amount of the last dose and when it was consumed) should be provided to the prescriber and dispensing point.

If a patient on medication-assisted treatment is being held in remand or sentenced to a short prison term, the patient's usual prescriber should be permitted to continue methadone while the patient is in police custody.

Police may arrange for the delivery of the prescription to an appropriate dispensing site, to verify the prescription, check the timing of the last dose with the previous dispensary.

Patients with TB or who are HIV positive may be prioritised and referred to a specialist drug treatment centre, respiratory or infectious disease unit, or advice sought from these specialists.

Hepatitis B vaccination should be offered if the patient is not immune.

Advise hepatitis C carriers about the risk of blood to blood transmission and its prevention.

Managing missed doses

Irregular attendance for dosing is indicative of ongoing illicit drug use or a patient's need for counselling or review.

A single missed dose may not be significant, but the prescriber must be informed and advised when a patient attends irregularly for methadone doses.

Patients who fail to attend dosing for three consecutive days should not receive methadone at the dispensary without consultation with the prescriber.

Dosing should be recommenced based on the following principles:

- If the regular dose was greater than 40mg, reduce the dose by half if they miss more than three days (or 5mg/missed day if their narcotic tolerance is high)
- If they miss more than five days, start treatment again as per commencement guidelines
- If the dose was 40mg or less, reduce the recommencing dose by approximately 5-10mg
- Review the patient the following day and adjust the dose accordingly

Managing vomited doses

Methadone is almost fully absorbed within 20-30 minutes of ingestion. If the patient is reviewed within four to six hours after consumption of their dose, plasma levels will be at their peak. If there is good evidence of opioid withdrawal, administration of a supplementary dose may be recommended (half the usual dose).

If absorption is doubtful because of vomiting, review the patient the next day.

Transfer of methadone treatment

When transferring a patient, either temporarily or permanently, to another region:

- The prescribing doctor arranges a transfer of dosing points
- Clear, written instruction is provided to both dispensaries about the timing of the last dose at the transferring dispensary and the first dose at the receiving dispensary
- Good communication between transferring and receiving prescribers and dispensing sites is vital to avoid double dosing of the patient

Dual dosing on the same day by different dispensing sites may cause severe methadone toxicity. Transfers are also associated with the possibility of missed doses resulting in reduced tolerance for opioids, causing a risk of potentially dangerous opioid toxicity.

Before dosing a transferred patient:

- Ensure you hold a current prescription and certified photograph of the patient
- Contact the client's prescriber to confirm the dose and determine whether the client is to be reviewed before administration of a dose
- You may also require a new prescription or other written confirmation
- A single missed dose may not be significant but you must advise the prescriber
- Contact the previous dosing point to confirm the dose and verify precisely when the last dose was given
- It is recommended that you ask for written confirmation of this information

4.5.5 Medications to support relapse prevention

Medications may be used to support relapse prevention. For example, relapse prevention treatment for opioid dependence may be supported with naltrexone, which blocks the effects of opioid drugs. By preventing euphoric effects, naltrexone helps to extinguish drug-seeking behaviour and craving. The limited evidence available suggests that, in dependent opioid users who have withdrawn from opioids, those who take naltrexone are less likely to use heroin or engage in criminal activity than those who do not take naltrexone. Clinical experiences with naltrexone vary considerably between countries, with some countries finding very poor rates of retention in treatment. It is possible that cultural and social differences could result in a varying efficacy and acceptability of naltrexone treatment. Clinical experience suggests that naltrexone may be more effective in patients who are motivated to abstain from opioid use, for example, people at risk of losing their employment, or people who have come before the courts and risk incarceration. Naltrexone also may be more effective when family members are involved in the treatment or directly

observe the patient taking naltrexone. Naltrexone can also be used for relapse prevention treatment of alcohol dependence. However, experience with this medication in Southeast Asia is currently limited.

4.6 Treatment of psychiatric comorbidities

This section is aimed at staff of community-level services and drug treatment clinics without specialist psychiatric staff. The information provided is intended to help in the identification and management of mental health disorders in people affected by drug use and dependence and the identification of people in need of referral to specialist services.

Psychiatric comorbidity and other psychological problems are very common among people with drug use disorders (regardless of HIV status). Common psychiatric disorders among people who use drugs include:

- Major depression
- Bipolar disorder
- Anxiety disorders
- Schizophrenia
- Personality disorders

Injecting drug use and polydrug use may be contributing factors determining the intensity of symptoms. Suicidal thoughts or high risk behaviours may also be associated with injecting drug use. In addition people who use drugs may experience substance use-related disorders including withdrawal syndromes, substance use-related mood disorders (e.g., depression), and substance-induced psychosis. Sleep disorder, whether secondary to mood disorder or drug use, can also complicate treatment. Drug users should be informed that sleeping patterns will be irregular for some months after cessation of drug use.

4.6.1 Depression

The most prevalent psychiatric disorders in those who use substances are depressive disorders. Depression can be both a cause and a consequence of substance use.

Patients with depressive symptoms may be at increased risk for transmission of HIV infection due to an increased likelihood of engaging in high-risk behaviours. HIV-infected drug users with depression are less likely to adhere to anti-retroviral or other treatments (e.g., TB treatment). Treatment of depression increases adherence to drug dependence treatment.

Risk factors for depression	Clinical features	Physical symptoms
<ul style="list-style-type: none"> • History of prior mood disorder • History of anxiety disorder • Prior suicide attempt • Family history of depression or suicide • Inadequate social support • Non-disclosure of HIV status • Recent loss (occupation, family) • Multiple losses • Advancing illness • Treatment failure • Hepatitis C treatment with interferon 	<ul style="list-style-type: none"> • Depressed mood • Lack of interest in pleasurable activities and social withdrawal • Psychological symptoms <ul style="list-style-type: none"> » Crying spells » Low self-esteem » Pessimism » Helplessness » Hopelessness » Worthlessness » Suicidal ideas and/or intent 	<ul style="list-style-type: none"> • Non-specific and generalised aches and pains • Sleep disturbances • Reduced energy levels • Reduced motor activity • Loss of appetite • Constipation • Loss of libido

Assessment for suicidal risk is crucial when dealing with a patient with depressive symptoms:

- Assess and document suicidal thoughts and intentions:
 - » Have you ever thought of harming yourself?
 - » Have you had these thoughts recently?
 - » Have you made a plan to end your life?
 - » Do you think you would ever act on these thoughts?
- Closely monitor patients who give answers indicating that they have an intention to harm themselves and refer to psychiatric services

Effective management of depression should include co-management of the substance use disorder:

- Medication (e.g., fluoxetine, amitriptyline) is the mainstay of treatment for major depression
- Drugs used to treat depression are not dependence-inducing (addictive)
- Drugs take some time to produce a clinical response (up to 3 weeks), but symptoms such as sleep disorder improve within 2-3 days
- Side effects usually diminish in 7-10 days
- Drugs need to be continued for a minimum of six months. The doctor should be consulted before stopping the drugs
- Patient adherence to medication regimens is critical – those who take correct and adequate doses of antidepressants have the best chance of improving
- A general rule is to start with low doses of any medication, titrating up to a full dose slowly, in order to minimise early side effects that may act as obstacles to adherence
- Refer cases with severe depression to a psychiatrist

Patients often require substantial education about the nature of depression, as well as encouragement and therapeutic optimism that the treatment will work. Reducing the stigma associated with depression and its treatment is important in the treatment process. This includes working with family members. In addition to pharmacotherapy, cognitive-behavioural therapy (CBT) may be helpful.

4.6.2 Anxiety

Anxiety is very commonly associated with substance-use disorders, particularly during withdrawal from opiates and intoxication with amphetamines and other stimulants. It can also occur as an independent condition.

Clinical features of anxiety	Physical symptoms
<ul style="list-style-type: none"> • Excessive anxiety and worry • Psychological symptoms <ul style="list-style-type: none"> » Feeling nervous » Fear for no reason, excessive fear in familiar situations » Inability to relax 	<ul style="list-style-type: none"> • Restlessness • Getting easily fatigued • Difficulty in concentrating or mind going blank • Irritability • Tense muscles • Sleep disturbance • Episodic panic attacks (palpitations, tremors, excessive sweating, frequent urination, dry mouth, difficulty in breathing and feeling dizzy)

Treatment options for anxiety include:

- Relaxation techniques
- Supportive psychotherapy
- Short-term treatment with longer-acting anti-anxiety drugs such as clonazepam along with psychological therapies (clonazepam is preferred to shorter-acting benzodiazepines)

4.6.3 Psychotic disorders

Psychosis is characterised by delusions (false beliefs in the face of evidence against them) and hallucinations (the experience of sights and sounds such as voices that are not actually present).

Drug-induced psychosis is commonly associated with amphetamine intoxication, particularly in chronic amphetamine users.

Clinical features of drug-induced psychosis include:

- Bizarre and uncooperative behaviour
- Irrelevant, often nonsensical speech
- Agitation and violence
- Auditory hallucinations or internal dialogue

The aim of medication is the safe containment and management of the patient and to achieve a state of ‘rouseable’ drowsiness to facilitate restorative sleep.

Because of their safety profile and efficacy, benzodiazepines should be the initial choice of medication for the treatment of amphetamine psychosis. Antipsychotic drugs should only be administered if benzodiazepines are ineffective and should only be used for their sedative effect. Antipsychotic medications should be discontinued as soon as possible once sedative effects are adequate.

Oral medication should be offered early, particularly if there are signs of psychosis. Doses should be titrated to scores on the Level of Agitation Scale (LOA) (see “5.2.3 Level of Agitation Scale”). Initially use Lorazepam (2-4mg) and repeat one hour later if necessary. If the patient is highly agitated (LOA>4) and refuses oral medication, consider administering intramuscular midazolam, repeat the dose if no response after 10 minutes. If control is not achieved with lorazepam or midazolam, administer olanzapine orally, or by intramuscular injection if oral medication is refused. These medications may need to be repeated. If the patient remains agitated despite medication, physical restraint may be required, but should only be used as a last resort. In this case appropriate close supervision is necessary.

If an antipsychotic is used, its use should be reviewed within three days as routine ongoing administration of antipsychotics is usually unnecessary with amphetamine-induced psychosis. If symptoms are severe or do not resolve within three days, consultation with a psychiatrist is appropriate.

The management of chronic psychosis in people affected by drug use and dependence is complex and requires experienced psychiatric care.

4.7 Sustained recovery management⁸

A sustained recovery management approach is aimed at helping people affected by drug use and dependence achieve meaningful, productive, and sustainable livelihoods in their communities.

Faith-based frameworks of recovery usually advocate the resolution of substance use problems through the support of religious experience and rituals, and by being rooted in a community of shared belief (White and Whithers, 2005). They are primarily aimed at a reconstruction of personal identity, values, and interpersonal relationships. Non-religious frameworks of recovery, such as Women for Sobriety and Secular Organizations for Sobriety, tend to promote and facilitate reintegration into the community, through employment, education, and community life. They stress the importance of strength of character, self-reliance, assertive problem solving, and lifestyle balance. All of them share the placement of one’s past, present, and future relationship with alcohol and drugs within the larger context of one’s personal identity, self-esteem, and destiny (White and Nicolaus, 2005). They help to reintegrate the recovering person into the community through participation in shared cultural practice. The criteria would be for any of these frameworks (whether personal, cultural, or religious) to integrate and be open towards evidence-based drug dependence treatment and rehabilitation practices, while considering the client’s needs, recovery capital, and personal strengths.

Steps towards Building Recovery Capital

Domain 1: Physical and Mental Health Supports

Physical and mental health supports are important elements of drug rehabilitation and social reintegration processes. Beneficiaries are not only persons in the process of recovery, but also their families, their immediate environments, and the community at large. They are:

⁸ UNODC 2008, Drug dependence treatment: sustained recovery management. Good practice.

- Integrating primary health care and substance dependence treatment
- Addressing physical and mental health needs together with substance dependence as part of a sustained health care model
- Putting in place a system to facilitate referrals for further assessments and treatment services
- Ensuring that sustained recovery management of both substance dependence treatment and primary/mental care services are carried out by an interdisciplinary team of professionals, involving paraprofessionals (peer-groups), as far as possible, to ensure cross-disciplinary support, cost-effectiveness, and a continuum of care throughout the process of treatment, recovery, and social integration
- Making available follow-up services to treatment within the community, through networking with primary health care institutions, government agencies, NGOs and peer-group supports
- Ensuring that adequate assessment and screening tools are easy and quick to administer by staff members with varied levels of clinical training, (see Appendix II for WHO's Quality of Life Assessment tool, and the Treatnet Addiction Severity Index) and are able to identify both substance dependence and other co-occurring diseases
- Offering psychosocially assisted pharmacological treatment of opioid dependence and co-occurring psychiatric disorders
- Having in place specialized programmes for women who are most vulnerable when drug dependence is coupled with interpersonal violence such as child abuse, rape, and battering.

The prevention of negative health (and social) consequences of drug use through the following services—as part of a comprehensive package of drug dependence treatment and rehabilitation—are also ways to help people with drug related problems to stabilize their life (UNODC discussion paper: “Reducing the adverse health and social consequences of drug abuse: A comprehensive approach” (2008), available at: <http://www.unodc.org/unodc/en/frontpage/reducing-the-harm-of-drugs.html>)

- Offering non-discriminatory services to drug dependent persons aimed at protecting them from the adverse health and social consequences of drug dependence
- Providing reliable information and counselling on the physical and psycho-social risks of drug abuse (overdose, infectious diseases, cardiovascular, metabolic and psychiatric disorders, and impaired driving)
- Offering low-threshold pharmacological interventions (e.g., opioid-agonists and antagonist drugs), for immediate health protection and stabilization
- Providing vaccination programmes against Hepatitis to drug dependent persons
- Offering medication and emergency kits for managing overdoses
- Offering services for the prevention and management of sexually transmitted diseases, particularly to those involved in the sex trade
- Establishing voluntary HIV counselling and testing, and antiretroviral treatment for HIV-infected drug users
- Making available measures to prevent the acute consequences of stimulants use so as to contribute to the prevention of related emergencies
- Equipping street-workers and peer outreach workers units so that they are adequately trained to contact drug dependent persons in need of assistance
- Setting up needle/syringe exchange programmes for injecting drug users, where appropriate, under sound medical practice.

Domain 2: Family, Social supports, and Leisure Activities

Family involvement, social supports, and leisure activities have been shown to contribute to better outcomes in the treatment and rehabilitation process. The following actions show how families can play a key role in the treatment and rehabilitation process for drug dependent persons:

- Include the family throughout the treatment, rehabilitation and social reintegration process
- Offer training and educational programmes to family members and significant others that educate them about: the adverse effects of substance dependence; early detection; the basic components and process of the treatment plan; and the key steps of the client's recovery goals to help prevent relapse and improve treatment outcomes
- Provide family-based therapy that includes information on building communication skills, parenting skills, couples support, recognizing and preventing child abuse, and other supports to help restore family structure, vitality, trust, and build an environment that is conducive to recovery processes.
- Set up family-focused post-treatment monitoring and follow-up aimed at identifying and addressing obstacles to long-term recovery and preventing relapse
- Make available gender-specific and relational models to help women and men learn appropriate strategies for positive relationships with partners and social networks that could encourage relapse and thus hamper their recovery

- Link clients to significant others or relevant support networks that provide companionship, communication, and affection where lacking, necessary, and appropriate. (e.g., significant others can be extended family members, friends, neighbours, community members, or housemates in communitarian lodgings such as halfway houses)

Leisure activities can help develop skills and knowledge that lead to healthy ways of living, a functional family, and positive social relations. Participating in cultural and recreational activities such as sports, handicraft workshops, and group excursions is an important aspect of the process of treatment, rehabilitation and social reintegration of drug dependent persons. These activities can contribute to a comprehensive education offer for persons in recovery.

Actions to promote this outcome include the following:

- Make an initial assessment and identification of clients' preferences, skills, and needs that can help develop a leisure time plan during rehabilitation
- Establish and develop group activities to support the development of social skills that can ease the rehabilitation process
- Have skilled personnel to lead recreational, cultural, and sport activities that contribute to harmonious socialization
- Incorporate rehabilitation programmes that offer practical activities to deliver information and encourage motivation (e.g., games, group field trips to ecological and cultural places, handicraft and artistic workshops, sports events and the development of recreational proposals by the patients themselves)
- Develop strategic alliances with public or private organizations that offer recreation activities, sports, and cultural activities. (e.g., short-term intensive training can be organized in coordination with institutions specializing in occupational therapy, sports, education, and cultural activities.)
- Monitor leisure time activities, designed through mutual agreement between the therapeutic team and the person in rehabilitation, since it allows assessing treatment outcomes and reacting in a timely manner should problems occur.

Domain 3: Safe Housing and Environments Conducive to Health and Recovery

Loss of safe housing and environments conducive to health and recovery is a common situation for drug dependent clients. It is a serious risk factor for relapse and decreases the chances of social reintegration and a healthy lifestyle. Providing safe housing is an important factor in the recovery process. It allows continued contact with service providers but grants a higher level of independence and reintegration into the community than is the case with inpatient treatment. A range of benefits can be ensured. For example:

- Supported housing (half-way houses) provide a drug-free ambience that may help sustain abstinence and support the recovery process
- Collective living promotes the development of positive peer interactions and building up support groups and networks
- Stable housing provides an adequate setting for family contacts and visits and the re-establishment of trust among family members.

Different housing models and arrangements (e.g., state or publicly owned social welfare houses, halfway homes, wet hotels) are available that provide different kinds of supports along the continuum of rehabilitation and social reintegration. These supports range from housing services for the homeless and chronic drug dependent persons to housing possibilities that are more integrated in the community, and fostering growing independence and reintegration into the job market and productive work.

Examples to promote community housing:

- Families, public authorities, and society at large are informed about the benefits of housing provision for drug dependent persons. This is done through broader information-education-communication strategies to community members, education services, and policy makers
- Formal and informal leaders may choose to mobilize the community to provide housing for recovering users
- Housing strategies for drug dependent persons and recovering clients are included in the local governments' social welfare programmes
- Participation of the private sector could contribute to the sustainability of housing initiatives. Thus it is important to include them in discussions about strategies, scope of the plan, and possible outcomes, including alternative financing for sustainability
- Housing provision services need to have close links with drug dependence treatment services
- Financial support can be obtained from various sources: Where possible, through direct contributions from the families of drug dependent persons; on a limited basis from marketing products or services offered through the vocational component of a rehabilitation programme; or from public or private assistance

Domain 4: Peer-based Support

Peer-based support is necessary for persons in the process of rehabilitation and social reintegration who may be going through a transition period in their lives that requires changes in social behaviours and roles. During this period clients may feel insecure, fearful, and anxious, and such feelings may increase the risk of relapse. While facing uncertainty, it is important to have positive life strategies that may include self-help, peer group, or tutoring groups support. Support groups may act as positive mirrors, generate confidence, and offer support in times of crises. Ways of providing this critical support in a more structured way include:

- Sharing experiences through the individual recovery process and implementing this action (of sharing) in every rehabilitation process in a self-help group setting
- Having clear rules and regulations, particularly those regarding confidentiality, that are known to all members in the group
- Moderating self-help groups using professional or especially trained staff, if resources and group consensus or organizational setting allow (their main function would be the modulation and monitoring of individual and group achievements)
- Developing a qualification model for self-help tutors who can update their knowledge on drug dependence and group moderation with the support of treatment institutions
- Assigning a tutor or guide for orientation and counselling to each group member, so that the tutor can establish a close and trusting relationship with the person and act as a positive role model in the rehabilitation process. (a tutor who is knowledgeable about drug dependence treatment and rehabilitation could make the best use of contact mechanisms with the therapeutic team to assess the advances, achievements, and difficulties in the rehabilitation process)
- Employing Recovery Coaches as peer support

Domain 5: (Self-)Employment and Resolution of Legal Issues

(Self-) Employment issues are frequently linked to drug dependence. Many persons with long years of drug dependence have had difficulties in finding jobs, and unemployment is usually one of the major reasons for relapses. Invariably, they need support and guidance in reintegrating themselves into the job market. The following initiatives, when integrated into a drug dependence treatment and rehabilitation programme, can positively contribute to recovery outcomes, when current market needs are taken into account:

- Employment counselling, including job seeking training and rapid job placement
- Development of vocational skills
- Recovery work co-operatives as “safe sanctuaries” for those in transition from treatment to rehabilitation and social reintegration
- Screening for potential barriers (personal, social, structural) to achieving economic self-sufficiency, and providing assertive linkages between services to help drug dependent persons obtain meaningful and rewarding employment, while resolving challenges, such as legal and criminal issues, lack of safe housing, and access to transportation (the easing of these barriers significantly improves the abilities of persons in recovery to participate in meaningful activities and reintegrate into their communities and society at large)
- Establishing a close working relationship between treatment providers and industry, private sector companies, and/or employment agencies to make it easier for persons in the rehabilitation process to (re)enter the job market
- Making it possible for persons in recovery and/or their family members to learn how to access and manage micro-credits so that they can get small scale loans to set up small enterprises, which is an important aspect of creating sustainable livelihoods
- Implementing programmes for the development of micro enterprises with the support of governmental and nongovernmental institutions.

The resolution of legal issues is of great importance for drug dependent persons in the process of rehabilitation and social reintegration and is linked closely to the aspect of finding employment. Integrating legal support into the rehabilitation process could help prevent the destabilizing effect of unsolved legal issues, which could, be cause of the associated stress, be a risk factor for relapse.

Ways of averting relapse because of the pressures of unresolved legal issues could include:

- Making an initial assessment of the legal situation on a standardized and confidential basis, with the client’s approval
- Taking advantage of legal advice through non-governmental or public institutions (e.g., universities’ legal offices or non-profit organizations), all the while strictly respecting the autonomy and privacy of users.

Rehabilitation service providers may wish to establish ongoing communication with members of the judicial system. As always, clients' privacy needs to be respected and the confidentiality requirements that are part of the rehabilitation process need to be strictly observed.

Domain 6: Vocational Skills and educational development

Acquiring occupational and vocational skills builds self-worth and self-esteem. This is also true for drug dependent persons. Work supports the creation of individual and social participation and responsibility. Some of the positive outcomes of acquiring marketable vocational skills and involvement in productive activities are experiencing higher levels of satisfaction and security, and reducing the risk of relapse. Steps to make this possible include:

- Making vocational assessment and counselling services part of rehabilitation and social reintegration programmes aimed at the creation of sustainable livelihoods
- Developing the vocational component of the programme and embedding it into the treatment and rehabilitation plan, based on the client's initial assessment
- Conduct a market analysis to identify current needs for skills and products
- Making vocational training responsive to market needs
- Adapting and renewing vocational support and counselling services to respond to technology and market changes, in order to enhance sales options for the programmes' products and services
- Making simple and easy-to-manufacture products that are useful, have low production costs, and a ready market

Education is a necessary asset for a full life and the assurance of a sustainable livelihood. Access to different educational schemes and models is one way to address problems related to drug use and drug dependence.

Treatment providers often work with individuals who, due to the particular circumstances in their lives, might not have sufficient schooling, or did not take the necessary exams to obtain a certified degree or qualifications required to enter the job market. Having an education improves one's chances in the job market and may be an additional factor in sustaining recovery.

The following actions are aimed mainly at young people, since they are a highly vulnerable group for substance use, but also because of the important role of formal education in this stage of life. However, education aimed at exploring vocational skills and work training is, at any stage of life, a key factor for supportive interventions to be carried out. Some strategies are:

- Implementing school policies aimed at supporting strategies for rehabilitating and reintegrating students with drug dependence problems
- Integrating measures to address the special needs of young people in recovery through the development of appropriate curricula and methodologies
- Training teachers to address drug dependence as any other chronic disease, since their attitudes can help to reduce stigmatization and enhance support in the school environment to students in recovery
- Implementing coordination mechanisms between the health and educational sectors on strategies to address drug problems
- Offering educational opportunities in appropriate settings, and adapting to factors such as age, learning ability, and availability
- Including treatment and rehabilitation services that allow outpatient/community interventions that can increase options for continuity in school
- Encouraging joint family/teacher efforts to prevent drug use and relapse while encouraging healthy and protective leisure time activities at home
- Providing counselling sessions (in addition to supporting access to the formal education system), that integrate an educational/informational segment on ways to deal with peer and environmental pressures that could lead to relapse

Small credits and vocational training

Small credits or small loans which help poor households develop their business and services, participate in vocational training programs, get jobs, and earn income in their area is one of the most efficient ways of eliminating hunger and reducing poverty.

In the context of high interest rates for loans from commercial banks, it has become more difficult for households to access loans. Small credit loans at reasonable interest rates and closely monitored by participating local authorities, social organisations and community are the best alternative for poor households.

It is good for people who are affected by drug use and dependence, their families and communities for there to be access to such schemes following detoxification. Employment that suits their capacity and health status improves their lives and demonstrates the support of the whole community for recovery.

Domain 7: Community integration and cultural renewal

Community integration and cultural support often have a startling effect on alcohol and/or drug dependence. In some more traditional settings, complementary cultural and indigenous activities, when embedded in or closely linked to a treatment programme, may help to induce relaxation; facilitate self-regulation of physiological processes; release emotional trauma; alleviate isolation and alienation; encourage personal transformation; promote spontaneous manifestations of leadership skills, and, more importantly, create a sense of interconnectedness between the self and the community (Winkelman, 2003).

These methods are most helpful when:

- Applied as complementary offered components to drug dependence treatment and rehabilitation programmes to address relapse
- Integrated into major rehabilitation programmes, community centres, training programmes, weekend retreats, as well as prison systems
- Provided as additional counselling approaches that may help address severe psychological and emotional trauma through culturally accepted (traditional) methods
- Used to facilitate cognitive-emotional integration, social bonding, and community affiliation
- Incorporated in promoting self-expression and conflict resolution
- Used to promote a sense of purpose and grounding in life
- Employed as a means to engaging tribal/traditional/community leadership and encouraging training for indigenous/traditional leaders and healers to organize recovery circles
- Applied to hosting indigenous recovery celebration events
- Employed in advocating for culturally informed social policies and treatment approaches. Also in less traditional settings, activities that create a sense of community and open opportunities for (re-) integration can be helpful and may serve some of the above mentioned functions

Domain 8: Meaning and Purpose in Life

Meaning and purpose in life is central to leading a full and healthy life. Regardless of how this desire for meaning in life manifests, most persons know when it is absent and seek it.

The following steps are suggested in assisting clients in the process of rehabilitation and social reintegration to uncover what, for them, constitutes meaning in life:

- Making an initial assessment, taking into account spiritual interests of clients, is useful in defining the content of the therapeutic counselling process
- Suggesting different types and practices of spiritual practice, depending on the cultural context, might have an added value (e.g., as a relaxation strategy to face fears, anxiety, anger, and create a mental sense of recovery and well-being)
- Encouraging spiritual practice in groups, if applicable in the cultural setting, might support the connection with others and a sense of belonging
- Working with therapeutic staff to develop skills to approach and explore the spiritual and religious interests of clients in the process of rehabilitation and social reintegration. Once the “what” and the “how” of implementing the various aspects of recovery capital—an essential part of sustained recovery management—have been realized, the next step is to increase recovery supports, through a systems approach, additional funding or in-kind-contributions, for drug dependent persons. Chapter V provides helpful strategies for accomplishing this aim. It outlines: a) how to advocate for changes in policy, structure, and processes by influencing decision makers, and b) how to raise awareness and create buy-in by targeting groups at every level of society.

5. Tools

5.1 Screening questionnaires suitable for use in community setting

5.1.1 DAST-10 (Drug Abuse Screening Test)

The Drug Abuse Screening Test (DAST) was designed to be used in a variety of settings to provide a quick index of drug-related problems. The DAST yields a quantitative index of the degree of consequences related to drug abuse. The instrument takes approximately five minutes to administer. The DAST has been evaluated and demonstrated excellent reliability and diagnostic validity in a variety of populations and settings.

When the words “drug abuse” are used, they mean the use of prescribed or over-the-counter medications used in excess of the directions and any non-medical use of any drugs. Drugs referred to may include, but are not limited to, stimulants (Yama), cannabis (marijuana, hash), solvents (gas, glue, paints), tranquillisers (e.g., valium), barbiturates, cocaine, hallucinogens (LSD), and opiates. Alcohol or tobacco are excluded.

These questions refer to the past 12 months only	Yes = 1	No = 0
1. Have you used drugs other than those required for medical reasons?		
2. Do you abuse more than one drug at a time?		
3. Are you always able to stop using drugs when you want to?		
4. Have you had “blackouts” or “flashbacks” as a result of drug use?		
5. Do you ever feel bad or guilty about your drug use?		
6. Do your family and friends ever complain about your use of drugs?		
7. Have you neglected your family because of your use of drugs?		
8. Have you engaged in illegal activities in order to obtain drugs?		
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
10. Have you had medical problems as a result of your drug use (eg. memory loss, hepatitis, convulsions, bleeding, etc)		
Total score (add number of “Yes” responses as 1 point each)		

Interpretation of score

DAST-10 score	Degree of problem related to drug abuse	Suggested action
0	No problems reported	None at this time
1-2	Low level	Monitor, reassess at a later date
3-5	Moderate level	Further investigation is required
6-8	Substantial level	Assessment required
9-10	Severe level	Assessment required

5.1.2 CAGE – Screening for alcohol use problems

The CAGE is easily administered and takes less than one minute to complete. It is scored by adding the number of “Yes” answers.

	Yes = 1	No = 0
Have you ever thought you ought to cut down on your drinking?		
Have people annoyed you by criticising your drinking?		
Have you felt bad or guilty about your drinking?		
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?		

A score of 2 or more should be taken as an indication that the person may be drinking at harmful or hazardous levels and that further assessment or referral is warranted.

5.1.3 ASSIST

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed for the World Health Organization (WHO) by an international group of substance abuse researchers to detect and manage substance use and related problems in primary and general medical care settings.

The ASSIST screening test and manuals are available from:

http://www.who.int/substance_abuse/activities/assist/en/index.html

5.1.4 Diagnostic guidelines for drug dependence

International Classification of Diseases

ICD-10 criteria for a diagnosis of dependence require the presence of three or more of the following at some time during the previous year.

Have any of the following been present in the previous 12 months?	Yes = 1	No = 0
1. A strong desire or sense of compulsion to take the substance (craving).		
2. Difficulties in controlling substance-taking behaviour (eg. levels of use, starting or stopping).		
3. A physiological withdrawal state when substance use has ceased or been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms.		
4. Evidence of tolerance, such that increased doses of the psychoactive substance are needed in order to achieve the same effects as originally produced by lower doses.		
5. Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects.		
6. Persisting with substance use despite clear evidence of overtly harmful consequences.		

“Harmful use” is somewhat less severe than dependence. ICD-10 characterises harmful use as “A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected drugs) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol)”. Harmful use commonly, but not invariably, has adverse social consequences; social consequences in themselves, however, are not sufficient to justify a diagnosis of harmful use.

The diagnosis of harmful use can be made when amphetamine-type stimulant use does not meet the criteria for dependence.

Harmful use is defined by:

- Clear evidence that the substance use was responsible for (or substantially contributed to) physical or psychological harm, including impaired judgement or dysfunctional behaviour, which may lead to disability or have adverse consequences for interpersonal relationships
- The nature of the harm should be clearly identifiable (and specified)
- The pattern of use has persisted for at least 1 month and has occurred repeatedly within a 12-month period
- The disorder does not meet the criteria for any other mental or behavioural disorder related to the same drug in the same time period (except for acute intoxication)

Diagnostic and Statistical Manual of Mental Disorders

The current version of the manual (DSM-IV) defines dependence as a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by three or more of the following occurring at any time in the same 12 month period:

- Tolerance as defined by either of the following:
 - » A need for markedly increased amounts of opioids to achieve intoxication or desired effect
 - » Markedly diminished effect with continued use of the same amount of opioids
- Withdrawal as manifested by either of the following:
 - » The characteristic withdrawal syndrome for opioids
 - » Opioids or a closely related substance are taken to relieve or avoid withdrawal symptoms
- Opioids are often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful attempts to cut down or control opioid use
- A great deal of time is spent in activities necessary to obtain opioids, use opioids, or recover from their effects
- Important social, occupational, or recreational activities are given up or reduced because of opioid use
- The opioid use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids

A revision of these criteria (DSM-V) is due for release in 2013. It is expected to adopt a single category of substance-use disorder (rather than separate criteria of substance abuse and substance dependence). The criteria will be much the same, but craving will be added as an item.

5.1.5 Severity of Dependence Scale (SDS)

The SDS is a 5-item questionnaire that provides a score indicating the degree of dependence on a range of substances. Each of the five items is scored on a 4-point scale (0-3). The total score is obtained by adding the ratings for the five items. The higher the score, the higher the level of dependence. The SDS takes one to two minutes to complete.

Administration of the SDS should be repeated for each substance on which the person may be dependent.

The questions relate to the month prior to starting treatment	Never/ almost never	Sometimes	Often	Always/ Nearly always
Do you think your drug use was out of control?	0	1	2	3
Did the prospect of missing a dose make you anxious or worried?	0	1	2	3
Do you worry about your drug use?	0	1	2	3
Do you wish you could stop using drugs?	0	1	2	3
	Not difficult	Quite difficult	Very difficult	Impossible
How difficult did you find it to stop or go without drug use?	0	1	2	3

The score on the SDS that indicates dependence varies according to the substance as indicated by the table below:

Substance	Score indicating dependence
Alcohol	3 or more
Cannabis	7 or more
Opioids including heroin	5 or more
Amphetamine-type stimulants	4 or more
Cocaine	3 or more
Benzodiazepines	6 or more

5.1.6 Alcohol Use Disorders Identification Test (AUDIT)

Use this test if problems are indicated by responses to the CAGE

The AUDIT is designed to screen for a range of drinking problems and in particular for hazardous and harmful consumption. It is particularly suitable for primary health care settings and has been used in a number of different countries with diverse cultural groups.

Please circle the answer that is correct for you

(Note that a standard drink contains 10g of alcohol)

	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	≥4 times a week
2. How many standard drinks containing alcohol do you have on a typical day when drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. During the past year, how often have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. During the past year, how often have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. During the past year, how often have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. During the past year, have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the past year		Yes, during the past year
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the past year		Yes, during the past year

A score of 8 or more is associated with harmful or hazardous drinking. A score of 13 or more in women, and 15 or more in men, is likely to indicate alcohol dependence.

5.1.7 Kessler-10 Psychological Distress Scale (K-10)

The K10 is a short measure of non-specific psychological distress based on questions about the level of nervousness, agitation, psychological fatigue and depression. It has been used both as a screening tool and standardised outcome measure.

For each question, circle the response that best describes how you have been feeling during the past 4 weeks.

In the past 4 weeks how often did you feel...	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Worn out for no good reason?	1	2	3	4	5
Nervous?	1	2	3	4	5
So nervous that nothing could calm you down?	1	2	3	4	5
Hopeless?	1	2	3	4	5
Restless or fidgety?	1	2	3	4	5
So restless that you could not sit still?	1	2	3	4	5
Depressed?	1	2	3	4	5
That everything was an effort?	1	2	3	4	5
So sad that nothing could cheer you up?	1	2	3	4	5
Worthless?	1	2	3	4	5
Total score					

Interpretation of scores

Score	Level of distress
10-19	No/low psychological distress
20-24	Mild psychological distress
25-29	Moderate psychological distress
30-50	Severe psychological distress

5.1.8 Addiction Severity Index (ASI)

Addiction Severity Index 5th Edition
UNODC Treatnet ASI Version 2.9

30 December 2006

Tom McLellan & Deni Carise
Treatment Research Institute
www.tresearch.org

Remember: This is an interview, not a test

INTRODUCING THE ASI:

- All clients receive this **same standard** interview.
- Seven Potential problem areas** or **Domains**: Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Psychiatric.
- The interview will take about **30-40 minutes**.
- Patient Rating Scale**: Patient input is important. For each area, I will ask you to use this scale to let me know how bothered you have been by any problems in each section. I will also ask you how important treatment is for you for the area being discussed.
The scale is:
0 - Not at all
1 - Slightly
2 - Moderately
3 - Considerably
4 - Extremely
- All information gathered is **confidential**
- Accuracy** - You have the right to refuse to answer any question, if you are uncomfortable or feel it is too personal or painful to give an answer, just tell us, "I want to skip that question." We'd rather have no answer than an inaccurate one!
- There are **two time periods** we will discuss:
 - The past 30 days
 - Lifetime

INTERVIEWER INSTRUCTIONS:

- Leave no blanks.
- Make plenty of Comments (if another person reads this ASI, they should have a relatively complete picture of the client's perceptions of his/her problems). When noting comments, please write the question number. Probe and clarify!
- X = Question not answered. Client cannot or will not answer.
- N = Question not applicable. Must have instructions in item to use "N"
- End the interview if client misrepresents or cannot understand after two or more sections.
- Half Time Rule!
If a question asks the number of months, round up periods of 14 days or more to 1 month. Round up 6 months or more to 1 year.
- Hints and clarification notes in the ASI are bulleted "•".

Probe, cross-check and make plenty of comments!

International Standard Classification of Occupations

- Legislators, officials – Main tasks are forming government policies, laws, regulations and overseeing implementation.
- Professionals - Requires high level of professional knowledge in the fields of physical and life sciences, or social sciences/humanities.
- Technicians /assoc. professionals - Requires technical knowledge, experience in fields of physical, life or social sciences, humanities.
- Clerks - Performs secretarial duties, word processing and other customer-oriented clerical duties.
- Service & Sales - Includes services related to travel, catering, shop sales, housekeeping, and maintaining law and order.
- Skilled agricultural and fishery workers - Consists of growing crops, breeding or hunting animals, catching or cultivating fish, etc.
- Craft & Trades - Main tasks consist of constructing buildings and other structures, making various products. Includes handicrafts.
- Plant and machine operators - Main tasks consist of driving vehicles, operating machinery, or assembling products.
- Elementary Occupations – Includes simple and routine tasks, such as selling goods in streets, doormen, cleaning, and working laborers.
- Armed forces - Includes army, navy, air force workers, etc.
Excludes non-military police, customs, inactive military reserves.

LIST OF COMMONLY USED DRUGS:

Alcohol:	Beer, wine, liquor, grain (methyl alcohol)
Heroin:	Smack, H, Horse, Brown Sugar
Methadone:	Dolophine, LAAM
Opiates:	Opium, Fentanyl, Buprenorphine, pain killers - Morphine, Dilaudid, Demerol, Percocet, Darvon, etc.
Barbiturates:	Nembutal, Seconal, Tuinal, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinal, Doriden, etc.
Sed/Hyp/Tranq:	Benzodiazepines = Valium, Librium, Ativan, Serax Tranxene, Dalmane, Halcion, Xanax, Miltown, Other = Chloral Hydrate, Quaaludes
Cocaine:	Cocaine Crystal, Free-Base Cocaine, Crack, Rock, etc.
Amphetamines/:	Monster, Crank, Benzedrine, Dexedrine, Ritalin,
Stimulants	Preludin, Methamphetamine, Speed, Ice, Crystal, Khat
Cannabis:	Marijuana, Hashish, Pot, Bango Igbo, Indian Hemp, Bhang, Charas, Ganja, Mota, Anasha
Hallucinogens:	LSD (Acid), Mescaline, Psilocybin (Mushrooms), Peyote, PCP, MDMA, Ecstasy, Angel Dust
Inhalants:	Nitrous Oxide (Whippits), Amyl Nitrite (Poppers), Glue, Solvents, Gasoline, Toluene, Etc.

ALCOHOL/DRUG USE INSTRUCTIONS:

The following questions refer to two time periods: the past 30 days and lifetime. Lifetime refers to the time prior to the last 30 days.

- ⇒ 30 day questions **only** require the number of days used.
 ⇒ Lifetime use is asked to determine **extended periods of regular use**.
 ⇒ Regular use =
- Three or more times per week
 - Binges
 - Problematic irregular use
- ⇒ Ask these questions with the following sentence stems -
 → "How many days in the past 30 have you used....?"
 → "How many years in your life have you regularly used....?"

D2. Alcohol to intoxication does not necessarily mean "drunk", use the words "to where you felt the effects", "got a buzz", "high", etc. instead of intoxication. As a rule, 3 or more drinks in one sitting, 4 or more drinks in one day for women (5 or more for men) is coded under "intoxication" to designate heavy drinking

GENERAL INFORMATION

G1. Patient ID _____

G2. Country G2a. Center
 G2b. Program G2c. Modality
 See Back Page of ASI for Country, Center and Program Listings

G3. Will this treatment be delivered in a corrections facility?
 0=No 1= Yes

G4. Date of Admission / /
*Day / Month / Year

G5. Date of Interview: / /

G6 Time Begun: (Hour: Minutes) :

G7. Time Ended: (Hour:Minutes) :

G8. Class: 1. Intake 2. Follow-up

G9. Contact Code: 1. In person
 2. Telephone (Intake ASI must be in person)

G10. Gender: 1. Male 2. Female

G11. Interviewer Code No./ Initials:

 Name

G14. How long have you lived at this address? /
Years Months

G16. Date of birth: / /
Day Month Year

16a. Age Years old

G17. What race/ethnicity/nationality do you consider yourself?
 Specify _____

G18. Do you have a religious preference?
 1. Protestant 4. Muslim 7. Hindu
 2. Catholic 5. Other Christian 8. Buddhist
 3. Jewish 6. None 9. Other (specify in comments)

G19. Have you been in a controlled environment in the past 30 days?
 1. No 4. Medical Treatment
 2. Correctional Facility 5. Psychiatric Treatment
 3. Alcohol/Drug Treat. 6. Other: _____
 • A place, *theoretically*, without access to drugs/alcohol.

G20. How many days?
 • If G19=No, G20= "NN" Refers to total number of days detained in the past 30 days.

G2c. Modality Codes:
 1=Outpatient (<5 hours per week)
 2=Intensive Outpatient (≥ 5 hours per week)
 3=Residential/Inpatient
 4=Therapeutic Community
 5=Half-way house
 6=Detox – Inpatient (typically 3 – 7 days)
 7=Detox Outpatient/Ambulatory
 8=Opioid Replacement, outpatient (Methadone, Buprenorphine, etc)
 9=Other (low threshold, GP, spiritual healers, etc.)
 Specify _____

PROBLEMS	SEVERITY PROFILE									
	0	1	2	3	4	5	6	7	8	9
MEDICAL										
EMP/SUP										
ALCOHOL										
DRUGS										
LEGAL										
FAM/SOC										
PSYCH										

GENERAL INFORMATION COMMENTS
 (Include the question number with your notes)

Who referred you to treatment? (Provide details): _____

G18, if coded "Other", specify _____

MEDICAL STATUS

Treatnet ASI

M1. How many times in your life have you been hospitalized for medical problems?

- Include O.D.'s and D.T.'s. Exclude detox, alcohol/drug, psychiatric treatment and childbirth (if no complications). Enter the number of **overnight** hospitalizations for medical problems.

M3. Do you have any chronic medical problems which continue to interfere with your life? 0=No 1=Yes

- If **"Yes"**, specify in comments.
- A chronic medical condition is a serious physical condition that requires regular care, (i.e., medication, dietary restriction) preventing full advantage of their abilities.

M4. Has a health care provider recommended you take any medications on a regular basis for a physical problem? 0=No 1=Yes

- **Do not include various remedies given by a non-healthcare Provider**. Must be for a medical condition; **don't** include **psychiatric medicines**. Include medicines prescribed whether or not the patient is currently taking them. The intent is to verify chronic medical problems.

M5. Do you receive financial support for a physical disability? 0 - No 1 - Yes

- **If Yes, specify in comments.**
- Include Workers' compensation, early retirement for medical Disability. • Exclude psychiatric disability. **India code X**

M6. How many days have you experienced medical problems in the past 30 days?

- Include flu, colds, injuries, etc. Include serious ailments related to drugs/alcohol, which would continue even if the patient were abstinent (e.g., cirrhosis of liver, HIV, HCV, HBV abscesses from needles, etc.).

For Questions M7 & M8, ask the patient to use the Patient Rating scale.

M7. How troubled or bothered have you been by these medical problems in the past 30 days?

- Restrict response to problem days of Question M6.

M8. How important to you now is treatment for these medical problems?

- If client is currently receiving medical treatment, refer to the need for **additional** medical treatment by the patient.

Note: The patient is rating their need for additional medical services or referrals from your agency, above any services they may already be getting.

CONFIDENCE RATINGS

Is the above information significantly distorted by:

M10. Patient's misrepresentation? 0 - No 1 - Yes

M11. Patient's inability to understand? 0 - No 1 - Yes

M12. Have you ever been tested for hepatitis? 0 = No, 1=Yes

M12a. If Yes, what was the result?

- 1 = Hep Negative (not infected)
- 2 = Hep positive (infected)
- 3 = Don't Know
- If M12=No, M12a ="N"

M12b. Would you like help obtaining a Hepatitis test?

M13. Have you ever been tested for HIV? 0 = No, 1=Yes

M13a. If Yes, what was the result?

- 1 = HIV Negative (not infected)
- 2 = HIV positive (infected)
- 3 = Don't Know
- If M13=No, M13a = "N"

M13b. Would you like help obtaining an HIV test?

If patient is Male, code all "N" 0=No, 1=Yes, 2=Unsure

M14. Are you currently pregnant?

M14a. If pregnant; do you have prenatal care?

M14b. If unsure; would you like help obtaining a pregnancy test?

- If M14= 0 or 2 (No or Unsure), M14a = N
- If M14= 1 (Yes), M14b = N

MEDICAL COMMENTS
(Include question number with your notes)

EMPLOYMENT/SUPPORT STATUS

E1. Education completed:

- **Code Years and Months, Level # or both.**
- *Level 0 = No education
- * Level 1 = Primary 1-6 yrs Yrs. Mos.
- * Level 2 = Lower Secondary 7-9 yrs
- * Level 3 = Upper Secondary 10-12 yrs
- * Level 4 = Post Secondary, non-tertiary **OR**
- (add'l preparation for level 5) Code Level #
- * Level 5 = First Stage Tertiary
- (+4 -6 years, incl BS, MS)
- * Level 6 = Second Stage Tertiary (include doctorate, etc).
- Include formal education only.

E1a. Highest degree earned, specify _____

E2.* Training or Technical education completed:

- Formal/organized training only. Months

E4a. Are your job options limited by lack of transportation?

0=No 1= Yes

E6. How long was your longest full time job?

- Full time = 35+ hours weekly; Years Months
- does not necessarily mean most recent job.

E7.* Usual (or last) occupation?

(specify) _____

(Use International Classification references page 1)

E9 Does someone contribute the majority of your support?

0 - No 1 - Yes

- Is patient primarily financially supported on a regular basis from family/friends. Include spouse's contribution; exclude support by an institution. "Housing" is considered the majority of someone's support.

E10. Which of these represents how you spent the majority of the past three years?

1. Full time (35+ hours)	5. Military
2. Part time (regular hours)	6. Retired/Disability
3. Part time (irregular hours)	7. Unemployed
4. Student	8. In controlled environment
	9. Homemaker

- Answer should represent the majority of the last 3 years, not just the most recent selection. If there are equal times, select category which best represents the current situation.

E11. How many days in the past 30 did you work for pay?

- Include days actually worked, paid sick days and paid vacation.

EMPLOYMENT/SUPPORT COMMENTS

(Include question number with your notes)

EMPLOYMENT/SUPPORT (cont.)

For questions E12-17: How much money did you receive from the following sources in the past 30 days? * Use your local currency.

E12. Employment?
 • Net or "take home" pay, include any money earned except illegal income

E13. Unemployment Compensation

E14. Social Welfare
 • Money given by government to assist with living expenses.

E15. Pensions, benefits, social security?
 • Include disability, pensions, retirement, & workers' compensation and veterans benefits.

E16. Mate, family, or friends?
 • Money for personal expenses. Also code unreliable sources of income, windfalls (unexpected money) money from loans, inheritance. (Record *cash* payments only, etc.).

E17. Illegal?
 • *Cash* obtained from drug dealing, stealing, selling stolen goods, illegal gambling, prostitution, etc.
Do not count estimated cash value of drugs or other items obtained illegally

E18. How many people depend on you for the majority of their food, shelter, etc.?
 • Must be regularly depending on patient, do include alimony/child support, do not include the patient or self-supporting spouse, etc.

E19. How many days have you experienced employment problems in the past 30 days?
 • Include inability to find work, if they are actively looking for work, or problems with present job in which that job is jeopardized.
 • If the patient has been incarcerated or detained all of the past 30 days, code "NN", they can't have had problems

For Questions E20 & E21, ask the patient to use the Patient Rating scale.

E20. How troubled or bothered have you been by these employment problems in the past 30 days?
 • If E19=N, code N

E21. How important to you now is counseling for these employment problems?
 • Stress help in finding or preparing for a job, getting training for a job, not giving them a job.
Note: The patient is rating their need for employment/support Services, referrals, etc from your agency.

CONFIDENCE RATINGS
Is the above information significantly distorted by:

E23. Patient's misrepresentation? 0-No 1-Yes

E24. Patient's inability to understand? 0-No 1-Yes

EMPLOYMENT/SUPPORT COMMENTS

(Include question number with your notes)

Specify type of currency used: _____

ALCOHOL/DRUGS

Note: Route of Administration (ROA) Types:

1. Oral (anything swallowed)
2. Nasal (or any other sub-coetaneous membrane administration)
3. Smoking
4. Non-IV injection (such as IM or "skin popping")
5. IV (shooting directly into a vein).

• In cases where two or more routes are used, the most serious route should be coded. The routes listed are from least severe to most severe.

		Past 30 Days	Lifetime (years)	ROA
D1	Alcohol (any use at all, 30 days)	<input type="text"/>	<input type="text"/>	<input type="text"/>
D2	Alcohol - to intoxication	<input type="text"/>	<input type="text"/>	<input type="text"/>
D3	Heroin	<input type="text"/>	<input type="text"/>	<input type="text"/>
D4	Methadone	<input type="text"/>	<input type="text"/>	<input type="text"/>
D5	Other Opiates/Analgesics	<input type="text"/>	<input type="text"/>	<input type="text"/>
D6	Barbiturates	<input type="text"/>	<input type="text"/>	<input type="text"/>
D7	Sedatives/Hypnotics/ Tranquilizers	<input type="text"/>	<input type="text"/>	<input type="text"/>
D8	Cocaine	<input type="text"/>	<input type="text"/>	<input type="text"/>
D9	Amphetamines/Stimulants	<input type="text"/>	<input type="text"/>	<input type="text"/>
D10	Cannabis	<input type="text"/>	<input type="text"/>	<input type="text"/>
D11	Hallucinogens	<input type="text"/>	<input type="text"/>	<input type="text"/>
D12	Inhalants	<input type="text"/>	<input type="text"/>	<input type="text"/>
D13	More than 1 substance (including alcohol)	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/>

ALCOHOL/DRUGS COMMENTS

(Include question number with your notes)

Optional: Age of First Use

<input type="text"/>	_____
<input type="text"/>	_____
<input type="text"/>	_____
<input type="text"/>	_____
<input type="text"/>	If D5>0, Specify _____
<input type="text"/>	_____
<input type="text"/>	_____
<input type="text"/>	_____
<input type="text"/>	_____
<input type="text"/>	_____
<input type="text"/>	_____

D14a. Identify the primary substance of abuse:

D14b. Identify the secondary substance of abuse:

- Interviewer should determine the primary and secondary drugs of abuse. Code the number next to the drug in questions 01-12
- D14b can be coded N

D15. How long was your most recent period of voluntary abstinence from these major substance(s)? Months

- Most recent sobriety lasting at least one month. Periods of hospitalization/incarceration *do not count*. Periods of antabuse, methadone, or naltrexone use *do count*.
- Code 00 = never abstinent.

D16. How many months ago did this abstinence end? Months

- If D15 = 00, then D16 = NN.
- Code 00 = still abstinent.

D17.* How many times have you had: Alcohol DT's?

- **Delirium Tremens** (DT's): Occur 24-48 hours after last drink, Or significant decrease in alcohol intake, shaking, severe disorientation, fever, hallucinations, they usually require medical attention.

If any item D3 - D11 Route of Administration = 4 or 5 (injection)
Past 30 days Lifetime

D38. Have you ever used needles or works after someone else had used them?

D38a. How many times in the past 30 days?

- If D38 past 30 days = 0, then D38a = N

ALCOHOL/DRUGS (cont.)

D19a. How many times in your life have you been treated for Alcohol or Drug abuse?

- Include detoxification, halfway houses, in/outpatient counseling, and AA (if 3+ meetings within one month period).

D21a. How many of these treatments were detox only:

- If D19a = 00, then question D21a = NN
- Note: Code the number of treatments listed in D19a that consisted only of Detoxification and no other treatment.

D23. How much would you say you spent during the past 30 days on alcohol?

- Only count actual **money** spent. What is the financial burden caused by alcohol?

D24 How much would you say you spent during the past 30 days on drugs?

- Only count actual **money** spent. What is the financial burden caused by drugs?

D25. How many days in the past 30 have you been treated in an outpatient setting for alcohol or drugs in the past 30 days?

- Include days attended AA/NA, other support groups, OP detox, methadone or treatment, etc.

D26. How many days in the past 30 have you experienced Alcohol problems?

- Include: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.

For Questions D28+D30, ask the patient to use the Patient Rating scale. The patient is rating the need for additional substance abuse treatment.

D28. How troubled or bothered have you been in the past 30 days by these alcohol problems?

D30. How important to you now is treatment for these alcohol problems?

D27. How many days in the past 30 have you experienced Drug problems?

- Include: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.

For Questions D29+D31, ask the patient to use the Patient Rating scale. The patient is rating the need for substance abuse treatment.

D29. How troubled or bothered have you been in the past 30 days by these drug problems?

D31. How important to you now is treatment for these drug problems?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

D34. Patient's misrepresentation? 0-No 1-Yes

D35. Patient's inability to understand? 0-No 1-Yes

D36. How many times have you tried to quit using substances without treatment?

D37. Nicotine

	Past 30 Days	Lifetime (years)	Route of Admin
	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="checkbox"/>
1. Oral/Chew	2. Nasal	3. Smoking	4. Non-IV injection
			5. IV

D39. Using the patient rating scale, how would you rate your level of agreement with the following statements?

a. I am ready to decrease my drinking.

b. I am ready to decrease my drug use.

c. I believe I can manage my alcohol use.

d. I believe I can manage my drug use.

e. I know I have a drinking or drug problem and I am motivated to work on it!

ALCOHOL/DRUGS COMMENTS
(Include question number with your notes)

FAMILY/SOCIAL STATUS

F1. Marital Status:
 1-Married 3-Widowed 5-Divorced
 2-Remarried 4-Separated 6-Never Married
 • Common-law marriage = 1. Specify in comments.

F3. Are you satisfied with this situation?
 • Satisfied = generally liking the situation.
 • Refers to Questions F1 & F2.
 0-No 1-Indifferent 2-Yes

F4. Usual living arrangements (past 3 years):
 1-With partner & children 6-With friends
 2-With partner alone 7-Alone
 3-With children alone 8-Controlled Environment
 4-With parents 9-No stable arrangement
 5-With family
 • Choose arrangements most representative of the past 3 years

F6. Are/were you satisfied with these arrangements?
 0-No 1-Indifferent 2-Yes

F4a. Living arrangements past 30 days? (Use codes above)

Do you live with anyone who:

F7. Has a current alcohol problem? 0-No 1-Yes

F8. Uses non-prescribed drugs? 0-No 1-Yes
 (or abuses prescribed drugs)

F9. With whom do you spend most of your free time?
 1-Family 2-Friends 3-Alone

F10. Are you satisfied with spending your free time this way ?
 0-No 1-Indifferent 2-Yes
 • A satisfied response must indicate that the person generally likes the situation. Refers to Question F9.

F11a. How many of your close friends use drugs or abuse alcohol?
 Note: If patient has no close friends, code "N"

Have you had significant periods in which you have experienced serious problems getting along with: 0 - No, 1 - Yes

	Past 30 days	In Your Life
F18. Mother	<input type="checkbox"/>	<input type="checkbox"/>
F19. Father	<input type="checkbox"/>	<input type="checkbox"/>
F20. Brother/Sister	<input type="checkbox"/>	<input type="checkbox"/>
F21. Partner/Spouse	<input type="checkbox"/>	<input type="checkbox"/>
F22. Children	<input type="checkbox"/>	<input type="checkbox"/>
F23. Other Significant Family (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>
F24. Close Friends	<input type="checkbox"/>	<input type="checkbox"/>
F25. Neighbors	<input type="checkbox"/>	<input type="checkbox"/>
F26. Co-workers	<input type="checkbox"/>	<input type="checkbox"/>

• "Serious problems" mean those that endangered the relationship.
 • A "problem" requires contact of some sort, either by telephone or in person. If no contact code "N" If no relative (ex: no children) Code N.

FAMILY/SOCIAL COMMENTS

(Include question number with your notes)

FAMILY/SOCIAL (cont.)

Has anyone ever abused you?	0- No Past 30 days	1- Yes In Your Life
F28. Physically? • Caused you physical harm.	<input type="checkbox"/>	<input type="checkbox"/>
F29. Sexually? • Forced any sexual advances/acts.	<input type="checkbox"/>	<input type="checkbox"/>

How many days in the past 30 have you had serious conflicts:
F30. With your family? □ □

Ask the patient to use the Patient Rating scale:

How troubled or bothered have you been in the past 30 days by:
F32. Family problems? □

How important to you now is treatment or counseling for these:
F34. Family problems □

- Patient is rating his/her need for counseling for family problems, not whether they would be willing to attend

Note: The patient is rating their need for you/your program to provide or refer them to family services, above and beyond any services they may already be getting.

How many days in the past 30 have you had serious conflicts:
F31. With other people (excluding family)? □ □

Ask the patient to use the Patient Rating scale:

How troubled or bothered have you been in the past 30 days by:
F33. Social problems? □

How important to you now is treatment or counseling for these:
F35. Social problems □

- Include patient's need to seek treatment for such social problems as loneliness, inability to socialize, and dissatisfaction with friends. Patient rating should refer to dissatisfaction, conflicts, or other serious problems.

Note: The patient is rating their need for you/your program to provide or refer them to these types of services, above and beyond treatment they may already be getting somewhere else.

CONFIDENCE RATING

Is the above information significantly distorted by:

F37. Patient's misrepresentation?	0-No	1-Yes	□
F38. Patient's inability to understand?	0-No	1-Yes	□

	Living with you	Living outside your home
F39. How many children do you have?	□ □	□ □
F39a. How many of these are under age 18	□ □	□ □

FAMILY/SOCIAL COMMENTS
(Include question number with your notes)

PSYCHIATRIC STATUS

How many times have you been treated for any psychological or emotional problems:

P1* In a hospital or inpatient setting?

P2* Outpatient/private patient?
 • Do not include substance abuse, employment, or family counseling.
 • Treatment episode = a series of continuous visits or treatment days, not the number of visits.

P3. Do you receive financial support for a psychiatric disability? Can be from government or employer, etc.
 0-No 1-Yes

Have you had a significant period of time (that was not a direct result of alcohol/drug use) in which you have:

	0-No Past 30 Days	1-Yes Lifetime
P4. Experienced serious depression-sadness, hopelessness, loss of interest? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P5. Experienced serious anxiety/tension uptight, unreasonably worried, inability to feel relaxed? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P6. Experienced hallucinations-saw things/heard voices that others didn't see/hear? Code other psychotic symptoms here also. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P7. Experienced trouble understanding, concentrating, or remembering? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note: Patient can be under the influence of alcohol/drugs for these questions.

Have you had a significant period of time (regardless of alcohol and drug use) in which you have:

	0-No Past 30 Days	1-Yes Lifetime
P8. Experienced trouble controlling violent behavior including episodes of rage, or violence? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P9. Experienced serious thoughts of suicide? • Patient seriously considered a plan for taking his/her life. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P10. Attempted suicide? • Include actual suicidal gestures or attempts. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

P11. Has a health care provider recommended you take any medications for psychological or emotional problems?

• Recommended for the patient by a physician or other health care provider as appropriate. Record "Yes" if a medication was recommended even if the patient is not taking it.

P12. How many days in the past 30 have you experienced these psychological or emotional problems?
 • This refers to problems noted in Questions P4-P10.

For Questions P13-P14, ask the patient to use the Patient Rating scale

P13. How troubled or bothered have you been by these psychological or emotional problems in the past 30 days?
 • Patient should be rating the problem days from Question P12.

P14. How important to you now is treatment for these psychological or emotional problems?

Note: The patient is rating their need for you/your program to provide or refer them to psychological/psychiatric services, above and beyond treatment they may already be getting somewhere else.

CONFIDENCE RATING

Is the above information significantly distorted by:

P22. Patient's misrepresentation? 0-No 1-Yes

P23. Patient's inability to understand? 0-No 1-Yes

PSYCHIATRIC STATUS COMMENTS
 (Include question number with your comments)

Specify Diagnoses if known: _____

5.2 Forms and tools for use in treatment

5.2.1 Clinical Opiate Withdrawal Scale (COWS)

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase in pulse rate would not add to the score.

Patient's Name: _____ Date and time: _____				
Reason for this assessment:				
Resting Pulse Rate: (record beats per minute) <i>Measured after patient is sitting or lying for one minute</i> 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120				
Sweating: <i>over past ½ hour not accounted for by room temperature or patient activity.</i> 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face				
Restlessness <i>Observation during assessment</i> 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds				
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible				
Bone or Joint aches <i>If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</i> 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny nose or tearing <i>Not accounted for by cold symptoms or allergies</i> 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks				

<p>GI Upset: <i>over last ½ hour</i></p> <p>0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting</p>				
<p>Tremor <i>observation of outstretched hands</i></p> <p>0 No tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching</p>				
<p>Yawning <i>Observation during assessment</i></p> <p>0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute</p>				
<p>Anxiety or Irritability</p> <p>0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult</p>				
<p>Gooseflesh skin</p> <p>0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection</p>				
<p style="text-align: right;">Total</p> <p style="text-align: center;">scores The total score is the sum of all 11 items with observer's initials</p>				

5.2.2 Level of Agitation Scale

Item	Score
Patient is asleep	1
Patient is awake but calm, without verbal aggression or agitation	2
Patient is angry, but this is primarily focused on the situation, and requests are not delivered in an obviously threatening or aggressive manner	3
Patient is awake and agitated with some verbal outbursts but no physical aggression	4
Patient is severely agitated with extreme verbal outbursts and/or physical aggression	5

5.2.3 Features of a methadone prescription

To be written indelibly in ink on paper for a sealed envelope and inclusion in patient records; affix photo if appropriate.

Drug treatment centre	
Name, contact details of prescriber	
Name of the patient	
Date of birth	
National registration number	
Narcotic registration number	
Address	
Date	
Methadone solution	(Usually 5mg/ml)
Dispense	(in words) mg
From	(start date)
To	(end date)
At	(dispensary)
Clinical remarks	
Prescriber's signature	

5.2.4 Features of methadone client transfer documentation

To:	Prescriber/Drug treatment centre
Address and fax number	
From	Referring prescriber
Referring prescriber details	Address and contact
Patient name	
Hospital registration number	
Date of birth	
National registration number	
Narcotic treatment board number	
Father's name	
Date of last dose (including takeaway doses) provided by referring dispensary	(Date last dose to be taken, not date dose dispensed)
Amount of final dose	mg
Prescriber's signature	

5.2.5 Methadone dispensing record for patient

Drug treatment centre/dispensary:

Patient name:

Registration no.:

Date	Time	Dose (mg)	Dose (ml of 5mg/ml solution)	Patient signature	Dispenser signature	Comment

5.2.6 Example service agreement and consent form

I, _____, am requesting treatment from the staff of _____. As a condition of that treatment, I acknowledge the following items and agree to them.

I understand:

1. The staff believes that the outpatient treatment strategies the program uses provide a useful intervention for chemical dependence problems; however, no specific outcome can be guaranteed.
2. Treatment participation requires some basic ground rules. These conditions are essential for a successful treatment experience. Violation of these rules can result in treatment termination.

I agree to the following:

- It is necessary to arrive on time for appointments. At each visit I will be prepared to take urine and breath-alcohol tests
 - Conditions of treatment require a goal of abstinence from all drugs and alcohol. If I am unable to make this commitment, I will discuss other treatment options with the program staff
 - I will discuss any drug or alcohol use with the staff and group while in treatment
 - Treatment consists of individual and group sessions. Individual appointments can be rescheduled, if necessary. I understand that group appointments cannot be rescheduled and attendance is extremely important. I will notify the counsellor in advance if I am going to miss a group session. Telephone notification may be made for last-minute absence or lateness
 - Treatment will be terminated if I attempt to sell drugs or encourage drug use by other clients
 - I understand that all matters discussed in group sessions and the identity of all group members is absolutely confidential. I will not share this information with non-members
 - All treatment is voluntary. If I decide to terminate treatment, I will discuss this decision with the staff
3. Staff: Services are provided by staff who have completed training courses in drug dependence treatment
 4. Consent to recording: To help ensure the high quality of services provided by the program, therapy sessions may be recorded (audio or video) with consent from the client and, if applicable, the client's family (for a session involving family members, or for sessions involving a juvenile client)
 5. Confidentiality: All information disclosed in these sessions is strictly confidential and may not be revealed to anyone outside the program staff without the written permission of the client or the client's family. The only exceptions are when disclosures are required or permitted by law. Those situations typically involve substantial risk of physical harm to oneself or to others or suspected abuse of children or the elderly.
 6. Accomplishing treatment goals requires the cooperation and active participation of clients and their families. Very rarely, lack of cooperation by a client may interfere substantially with the program's ability to render services effectively to the client or to others. Under such circumstances, the program may discontinue services to the client.

I certify that I have read, understand, and accept this service agreement. This agreement and consent covers the length of time I am involved in treatment activities at this facility.

Client's signature: _____ Date: _____

5.2.7 Case notes form for individual counselling session

Client's name: _____ Counsellor: _____

Part I: General

Has the client engaged in drug use since last meeting with the counsellor? If yes, what was the nature of his/her usage?

Did the client present any new issue during the counselling session?

Describe the client's mood

Was the client optimistic, neutral or pessimistic regarding their recovery process?

Was any ancillary service indicated (medical, psychological, family, other support)?

Part II: Reviewing progress

In reviewing his/her treatment goals, was the client satisfied with the existing goals or were adjustments made? (Not adjustments below.)

What achievements were noted as signs of progress?

What obstacles were identified as barriers to progress?

What skill areas were identified for further development? If specific skills were identified, what plan was put in place to develop these skills?

What concrete next steps were identified to move forward the implementation of the client's treatment plan?

Did the client recommit to the recovery plan?

What factors are affecting the client's commitment and motivation at this time? How would the counsellor assess the client's commitment and motivation?

When is the follow-up meeting scheduled (date, time)?

Additional notes:

5.2.8 Client change plan

The changes I want to make are:

.....

.....

.....

The most important reasons why I want to make these changes are:

.....

.....

.....

The steps I plan to take in changing are:

.....

.....

.....

The ways other people can help me are:

Person	Possible way to help

I will know that my plan is working if:

.....

.....

.....

Some things that could interfere with my plan are:

.....

.....

.....

Client signature _____

Counsellor signature _____

This plan will be reviewed _____ days from today: ___/___/___

5.2.9 Recovery checklist

Outpatient treatment requires a great deal of motivation and commitment. To get the most from treatment, it is necessary for you to replace many old habits with new behaviours.

Check all the things that you do regularly or have done since entering treatment:

- | | |
|---|--|
| <input type="checkbox"/> Schedule activities daily | <input type="checkbox"/> Avoid triggers (when possible) |
| <input type="checkbox"/> Visit physician for checkup | <input type="checkbox"/> Use thought stopping for cravings |
| <input type="checkbox"/> Destroy all drug paraphernalia | <input type="checkbox"/> Attend individual/conjoint sessions |
| <input type="checkbox"/> Avoid people who use alcohol | <input type="checkbox"/> Attend group counselling sessions |
| <input type="checkbox"/> Avoid people who use drugs | <input type="checkbox"/> Attend mutual-help meetings |
| <input type="checkbox"/> Avoid bars and clubs | <input type="checkbox"/> Get a sponsor |
| <input type="checkbox"/> Stop using alcohol | <input type="checkbox"/> Exercise daily |
| <input type="checkbox"/> Stop using all drugs | <input type="checkbox"/> Discuss thoughts, feelings and behaviours honestly with your counsellor |
| <input type="checkbox"/> Pay financial obligations promptly | |
| <input type="checkbox"/> Identify addictive behaviours | |

What other behaviours have you decided to start since you entered treatment?

.....

.....

Which behaviours take the least effort for you to do?

.....

.....

Which behaviours take the most effort for you to do?

.....

.....

What behaviours have you not begun yet? What might need to change for you to begin this behaviour?

Behaviour not begun	Change needed

5.2.10 Relapse analysis chart

Name: Date of relapse:

A relapse episode does not begin when you take a drug. Often, things that happen before you use indicate the beginning of a relapse. Identifying your patterns of behaviour will help you recognise and interrupt the relapse. Using the chart below, note events that occurred during the week immediately before the relapse.

Career Events	Personal Events	Treatment Events	Drug-related Behaviours	Behavioural patterns	Relapse thoughts	Health status
Feelings about the above events						

5.2.11 Treatment evaluation form

Recovery requires specific actions and behavioural changes in many areas of life. Before ending your treatment, it is important for you to set new goals and plan for a different lifestyle. This guide will help you develop a plan and identify the steps necessary for reaching your goals. Write your current status and goals for the areas of life listed in the left column.

Subject	Where are you now?	Where would you like to be?	What steps do you need to take?	When?
Family				
Work/Career				
Friendships				
Financial, Legal obligations				

Subject	Where are you now?	Where would you like to be?	What steps do you need to take?	When?
Education				
Exercise				
Leisure activities				
12-step or mutual-help meetings				

Client's signature: Date: Counsellor's signature:

5.2.12 Continuing treatment plan

Recovery is a lifelong process. You can stop drug and alcohol use and begin a new lifestyle during the first four months of treatment. Developing an awareness of what anchors your recovery is an important part of that process. But this is only the beginning of your recovery. As you move forward with your recovery after treatment, you will need a lot of support. And you may need different kinds of support than what you did during treatment. You and your counsellor can use the information below to help you decide how best to support your recovery.

Group work

You should participate in at least one mutual-help group every week after treatment. The community-based drug treatment program offers a mutual-help group that meets once a week. In addition, you can ask your counsellor about other local recovery groups.

Individual therapy

Individual sessions with an addiction counsellor might be helpful. When your current treatment ends, you have choices about continuing with therapy. You may choose this time to enter therapy with another professional, or you may choose to continue to see your current counsellor.

My plan for the months following treatment is:

Client's signature: _____ Date: _____

Counsellor's signature: _____ Date: _____

5.2.13 Functional Analysis or high-risk situation record

Antecedent situation	Thought	Feelings and sensation	Behaviour	Consequences
Where was I?	What was I thinking?	How was I feeling?	What did I do?	What happened after?
Who was with me?			What did I use?	How did I feel right after?
			How much did I use?	
What was happening?		What signals did I get from my body?	What paraphernalia did I use?	How did other people react to my behaviour?
			What did other people around me do at the time?	Any other consequences?

5.2.14 External trigger questionnaire

Place a checkmark next to activities, situations, or settings in which you frequently used substances; place a zero (0) next to activities, situations, or settings in which you never used substances.

- | | | |
|---|--|--|
| <input type="checkbox"/> Home alone | <input type="checkbox"/> Before a date | <input type="checkbox"/> After payday |
| <input type="checkbox"/> Home with friends | <input type="checkbox"/> During a date | <input type="checkbox"/> Before going out to dinner |
| <input type="checkbox"/> Friend's home | <input type="checkbox"/> Before sexual activities | <input type="checkbox"/> Before breakfast |
| <input type="checkbox"/> Parties | <input type="checkbox"/> During sexual activities | <input type="checkbox"/> At lunch break |
| <input type="checkbox"/> Sporting events | <input type="checkbox"/> After sexual activities | <input type="checkbox"/> While at dinner |
| <input type="checkbox"/> Movies | <input type="checkbox"/> Before work | <input type="checkbox"/> After work |
| <input type="checkbox"/> Bars/clubs | <input type="checkbox"/> When carrying money | <input type="checkbox"/> After passing a particular street or exit |
| <input type="checkbox"/> Beach | <input type="checkbox"/> After going past dealer's residence | <input type="checkbox"/> School |
| <input type="checkbox"/> Concert | <input type="checkbox"/> Driving | <input type="checkbox"/> The park |
| <input type="checkbox"/> With friends who use drugs | <input type="checkbox"/> Liquor store | <input type="checkbox"/> In the neighbourhood |
| <input type="checkbox"/> When gaining weight | <input type="checkbox"/> During work | <input type="checkbox"/> Weekends |
| <input type="checkbox"/> Vacations/holidays | <input type="checkbox"/> Talking on the phone | <input type="checkbox"/> With family members |
| <input type="checkbox"/> When it's raining | <input type="checkbox"/> Mutual-help groups | <input type="checkbox"/> When in pain |

List any other activities, situations, or settings where you have frequently used:

List any other activities, situations or settings in which you would not use:

List people you could be with and not use:

5.2.15 Internal trigger questionnaire

During recovery certain feelings or emotions often trigger the brain to think about using substances. Read the following list of feelings and emotions, and place a checkmark next to those that might trigger thoughts of using for you. Place a zero (0) next to those that are not connected with using.

- | | | |
|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Afraid | <input type="checkbox"/> Frustrated | <input type="checkbox"/> Neglected |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Guilty | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Confident | <input type="checkbox"/> Happy | <input type="checkbox"/> Passionate |
| <input type="checkbox"/> Criticised | <input type="checkbox"/> Inadequate | <input type="checkbox"/> Pressured |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Insecure | <input type="checkbox"/> Relaxed |
| <input type="checkbox"/> Embarrassed | <input type="checkbox"/> Irritated | <input type="checkbox"/> Sad |
| <input type="checkbox"/> Excited | <input type="checkbox"/> Jealous | <input type="checkbox"/> Bored |
| <input type="checkbox"/> Exhausted | <input type="checkbox"/> Lonely | <input type="checkbox"/> Envious |
| <input type="checkbox"/> Deprived | <input type="checkbox"/> Humiliated | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Aroused | <input type="checkbox"/> Revengeful | <input type="checkbox"/> Worried |
| <input type="checkbox"/> Grieving | <input type="checkbox"/> Resentful | <input type="checkbox"/> Overwhelmed |
| <input type="checkbox"/> Misunderstood | <input type="checkbox"/> Paranoid | <input type="checkbox"/> Hungry |

What emotional states that are not listed above have triggered you to use substances?

Was your use in the weeks before entering treatment:

- Tied primarily to emotional conditions?
- Routine and automatic without much emotional triggering?

Were there times in the recent past when you were not using and a specific change in your mood clearly resulted in your wanting to use (for example, you got in a fight with someone and wanted to use in response to getting angry)?

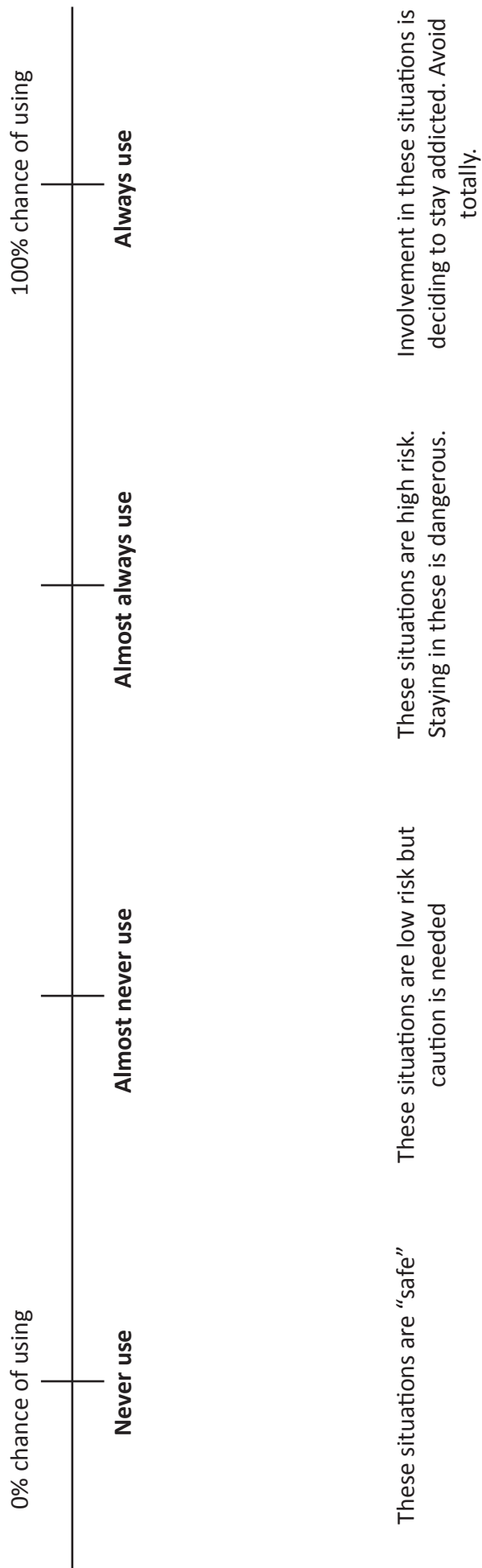
Yes No

If yes, describe:

5.2.16 External trigger chart

Client name: _____ Date: _____

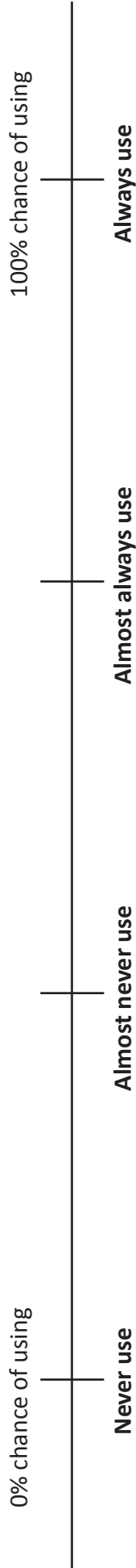
Instructions: List people, places, objects or situations below according to their degree of association with substance use.



5.2.17 Internal trigger chart

Client name: _____ Date: _____

Instructions: List emotional states below according to their degree of association with substance use.



These emotions are “safe” These emotions are low risk but caution is needed These emotions are high risk. Persisting in these emotions is deciding to stay addicted. Avoid them totally.

5.3 Forms for evaluation of services

5.3.1 Questionnaire for the assessment of standards of care

This questionnaire is based on the WHO Schedules for the Assessment of Standards of Care in Substance Abuse Treatment (1992), as adapted and shortened for the WHO Collaborative Study on Substitution Therapy of Opioid Dependence and HIV/AIDS.

The “status” column should be used to indicate the importance of each standard (E=essential, ADV=advisable or NI=not indicated).

The “adequacy” should be used to indicate the extent to which each standard is met (AM=adequately met, IM=inadequately met, or NM=not met at all).

The comment column should be completed for standards which are not met or are met inadequately. Comments should indicate why this is the case and what action is proposed to improve the situation.

	Status	Adequacy	Comment
A. Standards on access, availability and admission criteria			
A1 Service is easily accessible with regard to location, travel time and transportation			
A2 Service is available irrespective of ethnic, political or religious background or beliefs of client			
A3 Treatment is available without delays creating risks for client			
A4 Service is available irrespective of age and gender			
A5 Service is available irrespective of the somatic or psychiatric condition of the client (including HIV)			
A6 Service is available irrespective of the client’s legal status or of past or ongoing prosecution (including those related to drug use)			
A7 Service is available irrespective of the patient’s ability to pay			
A8 Service is available irrespective of current drug use of the patient			
A9 Service is available irrespective of history of prior treatments			
B. Standards on assessment			
B1 An initial assessment is made in order to prioritise interventions in a coordinated treatment plan			
B2 An assessment is made to detect complicating physical and neurological disorders			
B3 A psychiatric/psychological assessment is made to detect complicating disorders (eg. depression)			
B4 An assessment is made of the social circumstances (eg. family, employment, housing, financial and legal position)			
B5 Standardised instruments for diagnosis are used (eg. ICD-10, DSM)			

B6 Laboratory facilities are available to assist in the assessment of physical and psychiatric/psychological disorders			
B7 Laboratory facilities are available for the identification of drugs in body fluids			
B8 Detailed records are kept on assessment results at entry			
C. Standards on treatment content, provision and organisation			
C1 Records of client management, progress and referral are kept			
C2 Treatments are chosen on the basis of drug use, somatic and mental state and social circumstances			
C3 Medication-assisted treatment is chosen on the basis of a dependence diagnosis using a standardised classification system (eg. ICD-10)			
C4 Defined protocols exist for prescribing and other interventions			
C5 Clients are informed on the range of available treatment options			
C6 Access to self-help and other support groups is available			
C7 Information about 24-hour emergency facilities is provided			
C8 Clients with overdose receive immediate care in-house or through referral to another service that is well equipped			
C9 There is regular evaluation of the service/program			
C10 There are links to other services for the care of children or other family members in need of care and support			
D. Standard on discharge, aftercare and referral			
D1 There are defined criteria for the expulsion of patients due to violation of treatment service rules			
D2 Discharge is based on determination of patient recovery status and on client's consent			
D3 Referral to other services is offered in case of discharge			
E. Standards on patients' rights			
E1 The Universal Declaration of Human Rights applies in treatment programs			
E2 Information about the client's condition, progress and treatment involvement is not divulged to anybody without the client's consent			
E3 Clients are fully informed about the nature and content of the treatment as well as the risks and benefits to be expected			
E4 Prior informed consent is obtained from clients regarding the content, conditions and restrictions of treatment			



UNODC

United Nations Office on Drugs and Crime

Regional Office for Southeast Asia and the Pacific

United Nations Building, 3rd floor B Block, Secretariat Building, Raj Damnern Nok Avenue, Bangkok 10200, Thailand

Tel. (66-2) 288-2091 Fax. (66-2) 281-2129 E-mail: fo.thailand@unodc.org

Website: <http://www.unodc.org/southeastasiaandpacific>