Standards for the treatment of drug use disorders

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Central Asia Drug CADAP Action Programme

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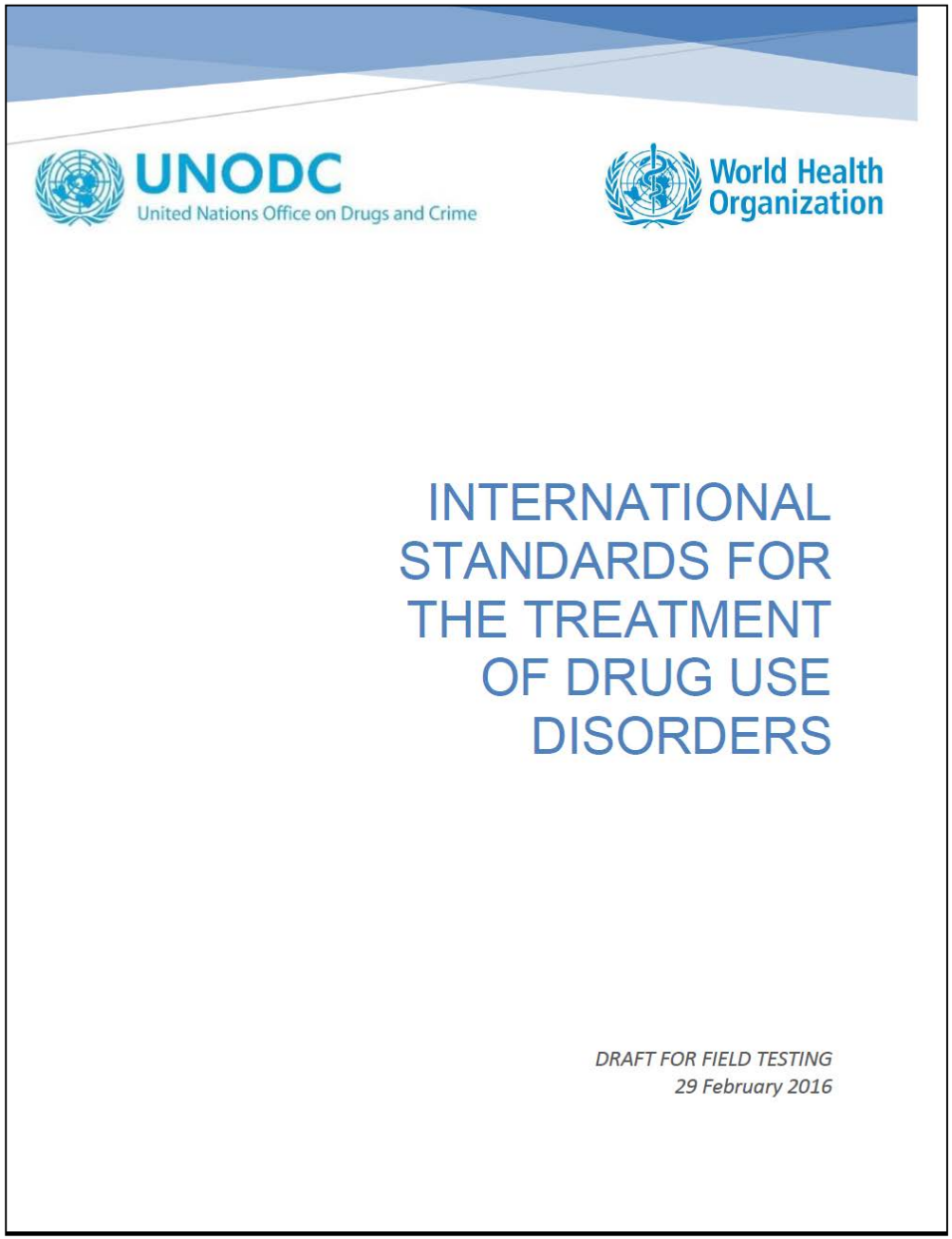
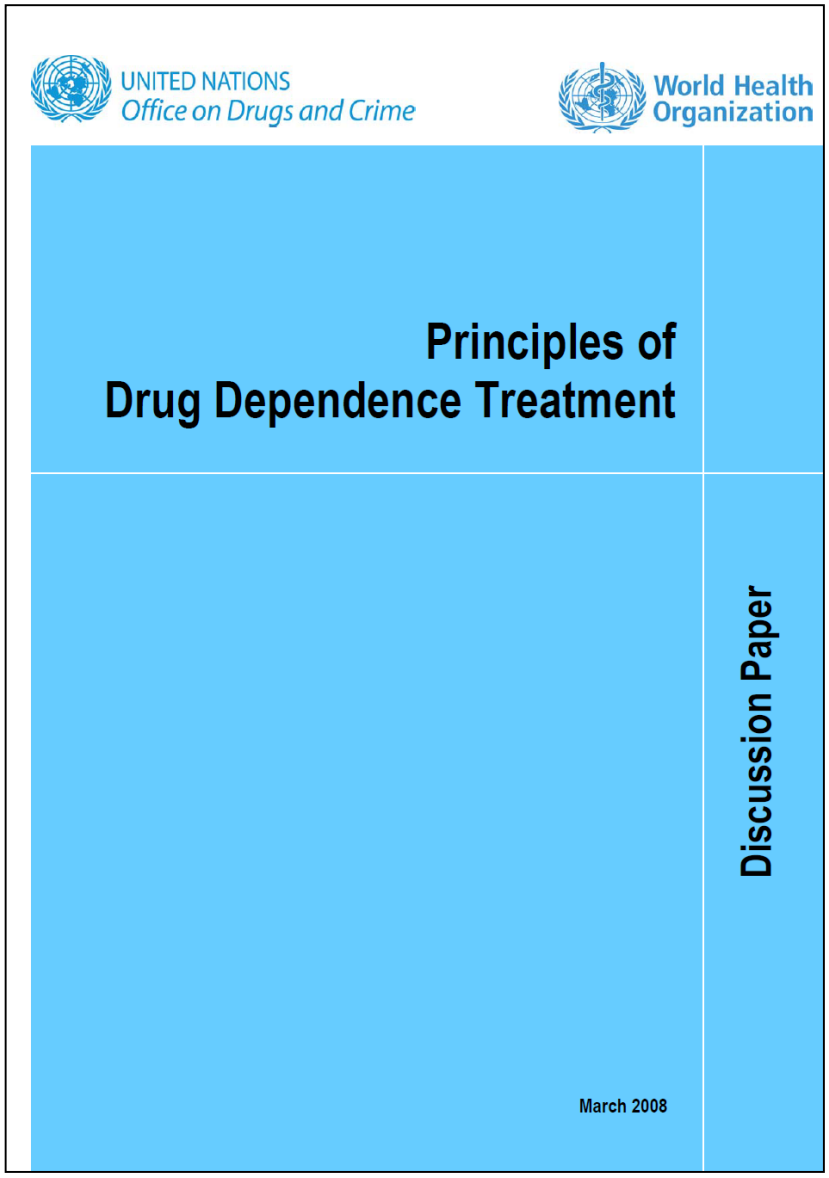
HARMREDUCTION·EU



www.unodc.org/docs/treatment/UNODC-WHO_2016_treatment_standards_E.pdf



www.unodc.org/docs/treatment/Principles_of_Drug_Dependence_Treatment_and_Care.pdf

Treatment of drug use disorders

- Effective:
  - evidence – based according to scientific standards
- Ethical:
  - consistent with Human Rights and UN covenants
  - promote individual and societal safety
  - Promote personal autonomy
  - build on existing experience and standards

Treatment of drug use disorders

- psycho-social
- pharmacological

Goals of treatment

- Reduce demand for drugs and use of drugs
- Improve health and psycho-social function
- Prevent harm

Principles

- Available, accessible, attractive, appropriate, affordable
- Ethical: consent, confidentiality, legally protected, trained staff, research subject to ethical committees
- Coordination: criminal justice systems/health and social services
- Based on scientific evidence and personal needs
- Respecting needs of special subgroups (women, juveniles, minorities, sex workers…)
- Clinical governance (protocols on training, staffing, networking, recording
- Monitoring of treatment policies, needs assessments, services, treatment planning, evaluation and quality control

Treatment modalities and interventions

- Community based outreach
- Screening, brief interventions, referral SBIRT
- Short-term inpatient or residential treatment
- Outpatient treatment
- Long-term residential treatment
- Recovery management – after-care

Screening, brief interventions, referral to treatment (SBIRT)

- Screening on admission: ASSIST* (WHO): 8 Qs
- Brief intervention: motivational interviewing
  FRAMES**(Miller/Rollnick)
- Referral to treatment

*ASSIST: Alcohol, Smoking, Substance Involvement Screening Test
**FRAMES: Feedback, Responsibility, Advice, Menu, Empathy, Self-efficacy

Short-term inpatient or residential treatment: Goals

- Stabilizing physiological and emotional state
- Safe and compassionate reduction of withdrawal symptoms
- Determining severity of dependence
- Identifying medical and psychiatric co-morbidities
- Motivate to further treatment
- Discharge planning and after care

Assessment tools

ASI	Addiction Severity Index
MINI	Mini International Neuropsychiatric Interview
SCID	Structured Clinical Interview DSM IV mental disorders
CIDI-SAM	Composite International Diagnostic Interview- Substance Abuse Module

Short-term inpatient or residential treatment: Methods

- Pharmacotherapy (detox treatment, opiate substitution treatment, treatment of co-morbidities)
- Motivational counseling, psycho-education, behavioral therapy, self-help groups

Treatment of withdrawal syndromes

! Severe in alcohol, benzodiazepine, barbiturate and opiate dependencies: Clinical care!

Opiate withdrawal: opiates and α-2-adrenergic agonists

Sedative-hypnotic, alcohol withdrawal: long-acting benzodiazepines

Stimulant and canabis withdrawal: symptom-orientated

Identification of co-morbidities

Medical and psychiatric history, physical and mental status examination, laboratory

Hepatitis B and C, HIV, TB, STDs, chronic pain

Depressive disorders, anxiety disorders, psychotic disorders: indpendent or substance-related?

PTSD

Opiate dependence

Initiation of long-term maintenance medication:
Oral opiate substitution treatment:

- Reduce drug use
- Reduce blood borne infections
- Reduce criminal offenses
- Reduce mortality

Evidence-based psycho-social therapy

- CBT Cognitive behavioral therapy
- MI Motivational interviewing
- MET Motivational enhancement therapy
- FT Family therapy
- CM Contingency management
- Drug counseling
- 12-step group facilitation

Cognitive behavioral therapy CBT

- Aims to modify learned drug use patterns
- Introduces new coping skills and cognitive strategies for replacing dysfunctional behavior and thinking
- Structured sessions with specific goals in individual or group therapy

Motivational interviewing and enhancement therapy (MI, MET)

- Recognizes patient‘s autonomy and own values
- Builds therapeutic allience by empathy
- Therapist‘s role advisory rather than authoritative

Contingency management

- Applies rewards to reinforce positive behavior and treatment goals (abstinence, compliance)
- Monitored by drug testing for feedback
- Often combined with CBT
- Particularly useful with amphetamine and cocain use disorders

Evidence-based pharmacologic treatment

- Drug intoxication/overdose treatment
- Drug withdrawal syndrome treatment
- Treatment of drug use disorder and harm reduction - maintenance treament
- Treatment of psychiatric complications and co-morbidity

WHO Recommendations (2014)
Naloxone should be available in all health-care facilities that may be called upon to respond to opioid overdose.
Use of a range of treatment options for opioid dependence which include psychosocial support, opioid maintenance treatments such as methadone and buprenorphine, supported detoxification and treatment with opioid antagonists such a naltrexone.
Naloxone should be made available to people likely to witness an opioid overdose, as well as training in the management of opioid overdose.

Treatment of opiate withdrawal syndrome

WHO Recommendations	
Standard For the management of opioid withdrawal, tapered doses of opioid agonists should generally be used, although alpha-2 adrenergic agonists may also be used. Clinicians should not routinely use the combination of opioid antagonists and minimal sedation in the management of opioid withdrawal. Psychosocial services should be routinely offered in combination with pharmacological treatment of opioid withdrawal.	**Strong** Clinicians should not use the combination of opioid antagonists with heavy sedation in the management of opioid withdrawal.

Opiate Maintenance Substitution Treatment

WHO Opioid agonist maintenance treatment recommendations.	
Standard Recommendation	**Strong Recommendation**
Average buprenorphine maintenance doses should be at least 8 mg per day.	For opioid agonist maintenance treatment, most patients should be advised to use methadone in adequate doses in preference to buprenorphine.
Take-away doses may be provided for patients when the benefits of reduced frequency of attendance are considered to outweigh the risk of diversion, subject to regular review.	During methadone induction, the initial daily dose should depend on the level of neuroadaptation; it should generally not be more than 20 mg, and certainly not more than 30mg.
	On average, methadone maintenance doses should be in the range of 60–120 mg per day.
	Methadone and buprenorphine doses should be directly supervised in the early phase of treatment.
	Psychosocial support should be offered routinely in association with pharmacological treatment for opioid dependence.

Methadone Maintenance Treatment

WHO Recommendations for use of methadone in maintenance treatment

Pharmacological treatment options should consist of both methadone and buprenorphine for opioid agonist maintenance and opioid withdrawal, alpha-2 adrenergic agonists for opioid withdrawal, naltrexone for relapse prevention, and naloxone for the treatment of overdose

The initial methadone dose should be 20mg or less, depending on the level of opioid tolerance, allowing a high margin of safety to reduce inadvertent overdose.

The dosage should be then quickly adjusted upwards if there are ongoing opioid withdrawal symptoms and downwards if there is any sedation.

A gradual increase to the point where illicit opioid use ceases; this is likely to be in the range of 60–120 mg methadone per day.

Patients should be monitored with clinical assessment and drug testing.

Psychosocial assistance should be offered to all patients.

Methadone use should be supervised initially .

The degree of supervision should be individually tailored, and in accordance with local regulations; it should balance the benefits of reduced dosing frequency in stable patients with the risks of injection and diversion of methadone to the illicit drug market.

Treatment of co-morbid conditions

Integrated treatment of

- Mental disorders
- Infectious diseases HIV, Hepatitis B,C, TB:

➢ No need to wait for abstinence

➢ Consider drug interactions

Long-term residential treatment – therapeutic communities (TC)

- Therapy + community living according strict rules
- Drug-free environment + self-help philosophy
- Supportive care by community replaces previous lack of parental care
- Develop impuls control, frustration tolerance, accountability, relationships in the community
- Educational and vocational training

➢ Weak evidence of efficacy outside prisons

Recovery management – after care

Goals:

- reduce risk of relapse
- stabililize well-being and social functioning
- strengthen confidence and personal responsibility

Recovery-oriented continuing care

- Long-term pharmacological, psycho-social and environmental treatment strategies, intensity according to needs (case manager)
- Increasing strengths > reducing deficits
  Flexible > fixed approach
  Patient self directed
  Participation of community
- Structured follow-up (checklists)

Special populations

- Pregnant women with substance use disorders
- Newborns passively exposed to opiates in utero
- Children/adolescents with substance use disorders
- Treatment in criminal justice settings

Pregnant women

- Urgent medical attention
- Prevention of harm for both
- Avoid withdrawal!
- Continue OST – reassess doses
- Comprehensive and specialized care in delivery, post-natal care and breast feeding

World Health Organization. (2014). Guidelines for the identification and management of substance use and substance use disorders in pregnancy. WHO, Geneva. Retrieved November 24, 2014., from http://apps.who.int/iris/bitstream/10665/107130/1/9789241548731_eng.pdf

Newborns passively exposed to opiates in utero

- NAS (neonatal abstinence syndrome):
  irritability, high-pitch cry, tremor, hypertension, hyperreflexia, sleep disturbance, diarrhea, yawning, disturbed sucking, poor intake
- Treatment: and specialized care and tapering medication of opiates if needed

Children, adolescents

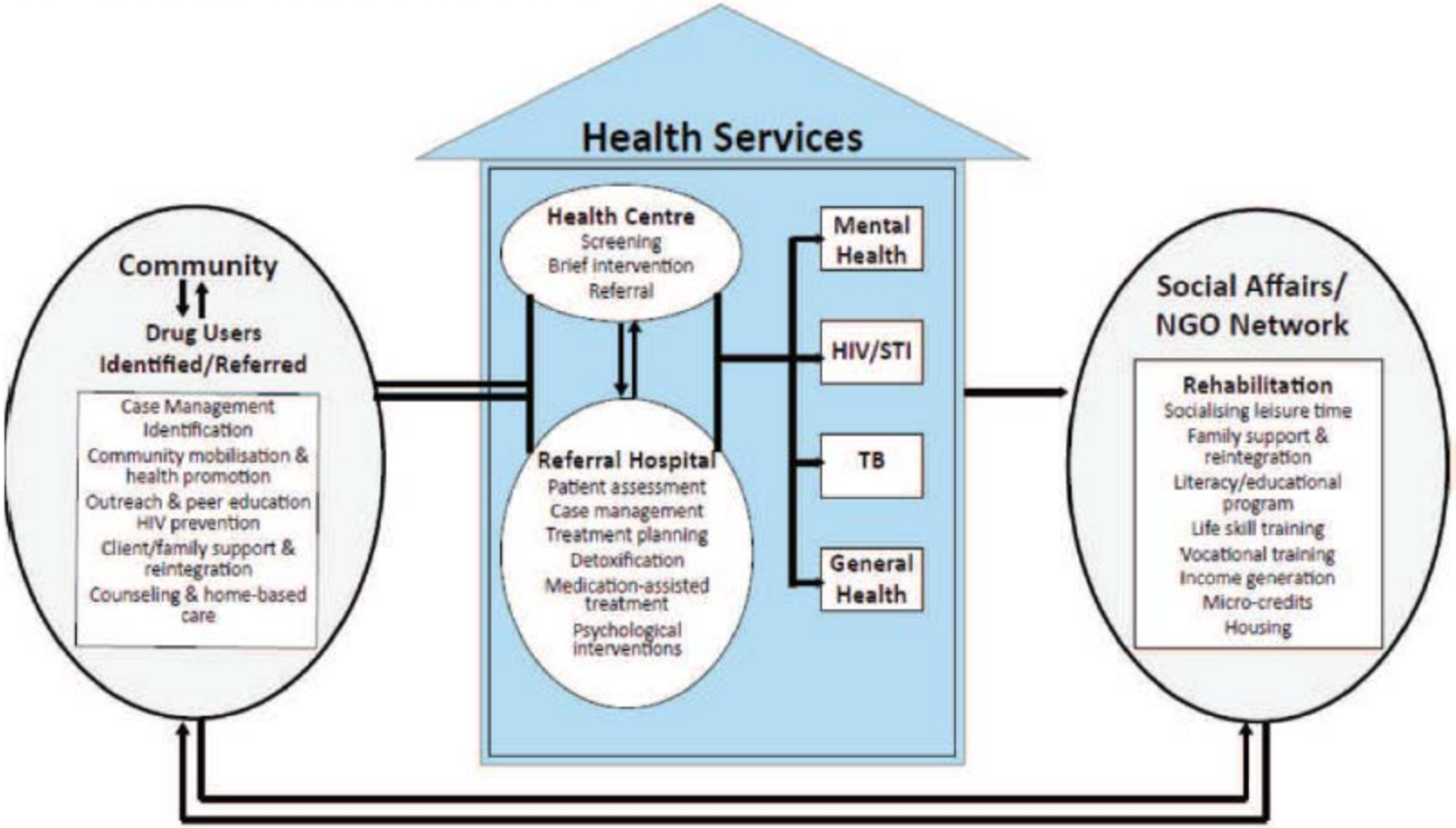
- Unique treament needs, different motivation patterns
- Victims of violence, abuse, neglect
- High prevalence of psychiatric co-morbidities
- Less cognitive abilities
- Scarce research data

Treatment in criminal justice settings

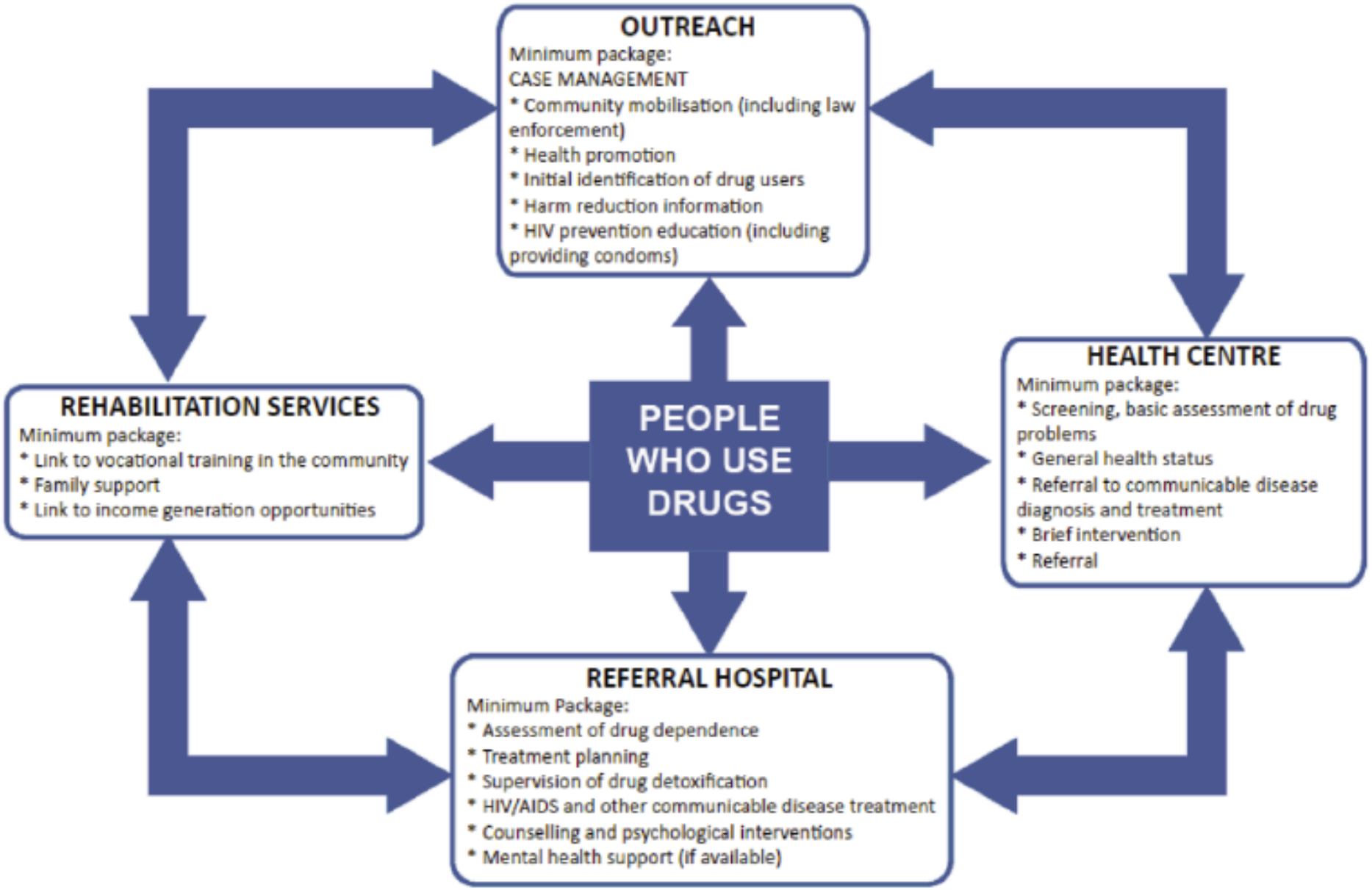
- If possible: alternatives to incarceration
- Equivalence: in prison same treatment principles and services as in free world
- Treatment voluntary, informed consent
- Assessment of antisocial behavior
- Close linkage with community services for continuity of aftercare and prevention of death from overdose!

One-stop-shop

Model of community based treatment



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



Essential supports for achieving rehabilitation and social reintegration