INTERNATIONAL STANDARDS FOR THE TREATMENT OF DRUG USE DISORDERS

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I. INTRODUCTION

This article describes the policy background, purpose, content as well as the dissemination process of the International Standards for the Treatment of Drug use Disorders (UNODC/WHO, 2016).

Drug Use Disorders (DUDs) are a public health, developmental and security problem both in industrialized and developing countries. They are associated with health problems, poverty, violence, criminal behaviour and social exclusion. Prevention of illicit drug use and treatment of drug use disorders are essential demand reduction strategies of significant public health importance. Therefore, the implementation of adequate programmes is key in ensuring an appropriate response to the need for evidence-based prevention and treatment interventions of people at risk or affected by drug use disorders and their negative health and social consequences.

The *International Standards for the Treatment of Drug Use Disorders*[1] (the *Standards*) were prepared in the framework of the UNODC-WHO Programme on Drug Dependence Treatment and Care[2] to support UN Member States in their efforts to develop and implement effective and ethical services and systems for the treatment and care of drug use disorders. The *Standards* were launched as a draft for field testing during the 2016 Commission on Narcotic Drugs (CND).

Prior to the *Standards*, UNODC and WHO had already jointly published the Principles of Drug Dependence Treatment (the *Principles*)[3] (UNODC/WHO, 2008) which specify general requirements for comprehensive drug dependence treatment that is accessible, affordable, evidence-based, diverse and compliant with human rights and ethical standards. Building on the *Principles*, the *Standards* describe a range of effective treatment interventions that can be implemented in a variety of settings (outreach, outpatient treatment, short-term inpatient treatment, longer-term residential treatment to sustained recovery management) with a view to the implementation of a full continuum of care for the treatment of drug use disorders at the service and the systems levels.

About 275 million people worldwide or 5.6% of the global population aged 15-64 years have used drugs at least once in the year 2016 and 31 million people globally suffer from drug use disorder. Cannabis remains the most widely used illicit drug worldwide while opioids are responsible for most of the negative health impact of drug use. There are an estimated 11 million people who inject drugs (PWID) and are thus exposed to further health and social risks. 1 in 8 persons who inject drugs is living with HIV, and every second person who injects drugs has Hepatitis C. There remains a discrepancy between the number of people who actually receive treatment for drug use disorders and the number of people who need it as globally only 1 in 6 persons in need of drug use disorder treatment has access to it[4]. Women with drug use disorders are even more underrepresented in treatment. 1 in 3 persons who use drugs is a woman, but women account only for 1 in 5

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[1] UNODC/WHO (2016). International Standards for the Treatment of drug use Disorders. Draft for Field Testing. Available online at: http://www.unodc.org/documents/International_Standards_2016_for_CND.pdf

[2] http://www.unodc.org/unodc/en/treatment-and-care/our-projects.html

[3] United Nations Office on Drugs and Crime and the World Health Organization, *Principles of Drug Dependence Treatment* (Vienna, Austria, 2008).

[4] United Nations Office on Drugs and Crime, *World Drug Report 2018* (Vienna, Austria, 2018).

people in treatment[5].

Limitations inherent in the data regarding drug use in general, and treatment specifically, must be considered. Reporting practices on drug use tend to be weak, and the data for drug use disorder treatment is greatly affected not only by the demand for it but also by the extent to which treatment services are available and accessible, and supported through public funding.

II. DEVELOPMENT OF THE STANDARDS AS PART OF THE INTERNATIONAL DRUG POLICY CONTEXT

A. Commission on Narcotic Drugs (CND) Political Declaration and Plan of Action 2009[6]

In the *Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem (2009)*, Member States expressed great concern regarding the consequences of drug use and drug use disorders for people who use drugs, their families and their communities. Member States restated their commitment to work towards the goal of universal access to comprehensive prevention programmes and treatment, care and related support services and recognized that a lack of quality standards hinder the effective implementation of demand reduction measures based on scientific evidence, therefore requesting the development and adoption of appropriate health-care standards.

In response, the UNODC and WHO jointly created a Global Programme on Drug Dependence Treatment and Care in 2009[7]. This programme supports UN Member States in their efforts to develop effective treatment policies, systems services through capacity building and technical assistance. As part of their collaboration, UNODC and WHO developed initially the *Principles* and then the *Standards* as guidance to Member States on the provision of ethical and evidence-based drug-use-disorder treatment and care interventions to be implemented as a continuum of care in a variety of settings within a comprehensive drug-use-disorder treatment system.

B. CND Resolution 59/4 – Development and Dissemination of International Standards for the Treatment of Drug Use Disorders

The *Standards* were released as a draft for field testing at the 59th session of the Commission on Narcotic Drugs in April 2016. In resolution 59/4 Member States noted with appreciation the work of the United Nations Office on Drugs and Crime and the World Health Organization in developing the international standards for the treatment of drug use disorders, and encouraged all Member States to consider expanding the coverage and improving the quality of drug treatment systems, interventions and policies based on scientific evidence, using the scientific evidence-based international standards for the treatment of drug use disorders developed by the UNODC and the WHO.

C. Outcome Document of the 2016 United Nations General Assembly Special Session on the World Drug Problem[8]

The United Nations General Assembly conducted a Special Session on Drugs in April 2016, during which it clearly recognized drug dependence as a complex, multifactorial health disorder characterized by a chronic and relapsing nature with social causes and consequences that can be prevented and treated through scientific evidence-based treatment, care and rehabilitation. It furthermore recommended to promote and implement the standards on the treatment of drug use disorders developed by UNODC and WHO along with a range of other concrete suggestions to improve treatment and care for people affected by drug use disorders, for example, to encourage the voluntary participation of persons with drug use disorders in treatment programmes, with informed consent.

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[5] Ibid.

[6] United Nations Office on Drugs and Crime, *Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem* (Vienna, Austria, 2009).

[7] More information available from: http://www.unodc.org/unodc/en/frontpage/unodc-and-who-launch-joint-drug-dependence-treatment-programme.html; http://www.unodc.org/unodc/en/treatment-and-care/our-projects.html

[8] United Nations General Assembly, *Outcome Document of the 2016 United Nations General Assembly Special Session on the World Drug Problem – Our Joint Commitment to Effectively Addressing and Countering the World Drug Problem* (New York, 2016).

D. Sustainable Development Goals

The *Standards* support the implementation of the Sustainable Development Goals (SDG), especially SDG 3[9] – Ensure healthy lives and promote well-being for all at all ages; particularly target 3.5 – to strengthen the treatment of substance abuse, and 3.8 – to achieve universal health coverage, access to quality essential health-care services and affordable essential medicines for all.

III. INTERNATIONAL STANDARDS FOR THE TREATMENT OF DRUG USE DISORDERS[10]

A. Key Principles and Standards for the Treatment of Drug Use Disorders

Seven key principles have been outlined in the *Standards* as a cross-cutting requirement for the delivery of treatment of drug use disorders, to

- *Principle 1.* Be available, accessible, attractive and appropriate;
- *Principle 2.* Ensure ethical standards of care in treatment services;
- *Principle 3.* Promote treatment of drug use disorders by effective coordination between the criminal justice system and health and social services;
- *Principle 4.* Be based on scientific evidence and respond to specific needs of individuals with drug use disorders;
- *Principle 5.* Respond to the needs of specific populations;
- *Principle 6.* Ensure good clinical governance of treatment services and programmes for drug use disorders;
- *Principle 7.* Ensure an integrated treatment approach where linkages to complementary services must be constantly monitored and evaluated.

B. Comprehensive Treatment Modalities and Interventions

The Standards then describe how a range of evidence-based interventions needs to be implemented throughout a continuum of care including modalities such as outreach, screening and brief interventions, outpatient treatment, short-term inpatient treatment, longer-term residential treatment and sustained recovery management.

Assessment and treatment planning are considered relevant for all settings, as drug use disorders can be described on a spectrum from lower to higher severity and complexity. Treatment plans, to be developed with the patients, would therefore need to count on a diversity of treatment and care approaches taking into account the overall life situation of the patient including health, social, legal, educational, financial and other aspects. It is recommended that treatment plans be developed with the help of a multi-professional team with patient involvement. Treatment plans should be individualized and consistent with the management of other chronic illnesses.

DUDs are often associated with other mental and somatic disorders. A comprehensive assessment should be administered upon entry into any treatment programme that includes a full medical history, presence of chronic and acute diseases and related pharmaceutical therapies, as well as a routine documentation of infectious diseases including HIV, tuberculosis, and hepatitis. It is also critical to distinguish independent metal health disorders from substance-induced disorders that will improve with abstinence.

1. Community-Based Outreach

Community-based outreach services approach and engage with people who use drugs (PWUD) in their community in an unconditional way. Outreach specifically targets PWUDs who, because of the unavailability, inaccessibility or unacceptability of existing services are not currently receiving treatment. This treatment modality aims to identify affected populations, engage them, provide community-based care including for the reduction of the negative health and social consequences of drug use and dependence, and link people to outpatient and inpatient health and social services according to their needs.

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[9] https://sustainabledevelopment.un.org/SDG3
[10] The Standards are available for download at https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_59/ECN72016_CRP4_V1601463.pdf

Outreach depends heavily on community workers; often peer workers, as they are knowledgeable of the local communities they serve. They should have adequate basic training in relevant health conditions and health and social services available in the community.

2. Screening, Brief Interventions, and Referral to Treatment

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent drug use disorders and can be applied in different non-specialized contexts. Health service providers, which are not specialized in the treatment of drug use disorders, can be trained to deliver SBIRT in a rapid and cost-efficient manner that causes minimal interference with the provision of other services (WHO, 2012). For people who screen positive for drug use, a brief intervention carried out in a non-judgmental and motivational style can be effective in altering the trajectory of people at risk of developing drug use disorders or experiencing other severe negative complications related to their drug use. Screening may also identify a smaller subset of persons with already more significant, chronic or complex substance use problems who will require a more extensive assessment and referral for specialized drug use disorder treatment.

3. Short-Term In-Patient Treatment

The short-term inpatient treatment setting is ideal for persons likely to experience a severe withdrawal syndrome following cessation of drug use, and for people whose current drug use is causing a significant risk of harm and who might only have limited social support. Short-term inpatient treatment typically takes place in an environment in which 24-hour care is available to manage the symptoms and complications likely to occur following the cessation of drug use (management of withdrawal) or acute symptoms related to other comorbid disorders.

There are established withdrawal protocols usually employing pharmacotherapy combined with rest, nutrition and motivational counselling. Staff should be knowledgeable about withdrawal and able to prescribe effective medication. They should also be prepared to offer psychological support to motivate the patient to move past the withdrawal phase. Detoxification alone cannot be considered an effective treatment response as the risk of relapse is high following detoxification and the risk of overdose due to decreased tolerance increases significantly after discharge. An effective follow-up treatment plan should therefore include strategies for patients to successfully transition to the next level of care and maximize the chances to maintain medical and psychological health.

4. Outpatient Treatment

Outpatient treatment requires persons with drug use disorders to visit the treatment facility only for treatment interventions. It is intended to help patients stop or reduce drug use; to minimize medical, psychiatric and social problems associated with drug use; to reduce the risk of relapse; and improve general well-being as part of a long-term recovery process. Its components vary considerably in terms of the level of intensity and the interventions offered, but is nonetheless usually performed in health and social services specializing in the treatment of substance use disorders, or within the broader context of community mental health services. The range of treatment offered in the outpatient setting include psychological and pharmacological interventions, and social support. Treatment objectives can be best accomplished by using a combination of evidence-based pharmacological and psychosocial interventions. Ideally, outpatient treatment programmes for drug use disorders offer a comprehensive range of services to manage various problems affecting patients across several life domains. Routine cooperation with allied care services is essential and should include integration of outpatient treatment with medical services for HIV, viral hepatitis, TB and sexually transmitted infections. Routine cooperation with social support and other agencies, including education, employment, welfare, housing, or legal assistance should also be present. Outpatient treatment and care services can help patients in establishing a level of stability and resources in their lives that makes it easier to follow a course of ambulatory health interventions.

5. Long–Term Residential Treatment

Long–term residential treatment can take place in a hospital environment, typically a psychiatric hospital, or for example in a therapeutic community. Although traditional models of long-term residential treatment include only psychosocial treatment methods, modern approaches may involve the use of medications to decrease drug cravings and manage comorbid psychiatric symptoms. The primary focus of treatment is on learning skills to control cravings and on developing new interpersonal skills, personal accountability,

responsibility, and improving self-esteem. Additionally, the structured activities and the rules of the residential programme help patients develop better impulse control and delay gratification while learning skills to deal with frustration and to cope with stress. Comprehensive services including vocational skills and employment training may also be provided in the residential setting.

Patients who are unlikely to maintain abstinence outside of a structured environment or to participate in health and social integration are most likely to benefit the most from long-term residential treatment. Staying long-term in a residential setting allows patients to take a break from the chaotic and stressful environment that might have contributed to their drug use. At the end of a long-term residential treatment programme the transition to the community must be carefully planned and supported. The duration of treatment necessary to consolidate and internalize behavioural change and prepare to live a drug-free life varies for each resident; however residents who stay at least 3 months in treatment usually have better outcomes. Residential treatment which intends to promote therapeutic change must be distinguished from supported accommodation that primarily functions as a housing intervention that is not providing active treatment.

6. Sustained Recovery Management

Post-discharge relapse and eventual re-admission in treatment are very common; sustainable recovery, however, is possible, and up to 40% of persons with DUDs achieve it. Recovery management describes a long-term recovery-oriented model that follows the stabilization of abstinence achieved during outpatient or residential treatment. The primary goal of recovery management is to maintain benefits obtained in earlier treatment: it focuses on reducing the risk of relapse to drug use by comprehensively supporting social functioning, well-being, and social reintegration.

Ideally, both long-term residential and intensive outpatient care should be followed by a step down to a less intensive level of care that continues long-term. Recovery-oriented continuing care is an approach to long-term management of patients within the network of community-based supports and services. Instead of a discharge process, in recognition of the chronic and relapsing nature of this complex disorder, there is post-stabilization monitoring, recovery education, recovery and coaching, active linkage to communities of recovery, recovery community resource development, and early re-intervention when needed. Given the chronic and relapsing nature of drug use disorders, recovery management approaches include long-term pharmacological, psychosocial, and environmental interventions targeted at maintaining reductions in substance use and contact with the criminal justice system as well as maintained improvements in physical and mental health, and social functioning.

C. Treatment Systems

An effective national system for the treatment of drug use disorders requires a coordinated and

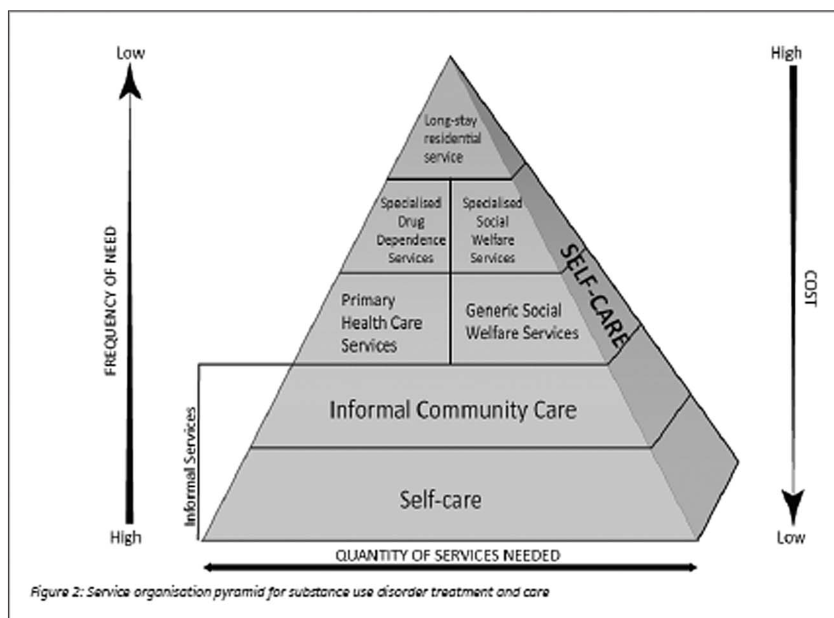

Figure 2: Service organisation pyramid for substance use disorder treatment and care

integrated response of many actors to implement policies and interventions based on scientific evidence in multiple settings and targeting different groups at different stages with regard to the severity of their drug use disorders. The public health system is best placed to take the lead in the provision of effective treatment services for people affected by drug use disorders, often in close coordination with social care services and other community services. Case management is a strategy to support patients in accessing various services offered in a network of community-based health and social services. Treatment services should be available, accessible, affordable, evidence-based, and diversified. When developing a comprehensive treatment system that wisely allocates available resources and responds best to patient's needs, the key public health principle to apply is offering the least invasive intervention possible with the highest level of effectiveness and the lowest cost possible. Investments of public funds should therefore be made according to the frequency of treatment services needed as shown in the service organization pyramid.

IV. FIELD TESTING AND IMPLEMENTATION OF THE STANDARDS

Following the launch of the *Standards* and their wide policy level acknowledgement, a process of field testing was initiated in the framework of the UNODC/WHO Programme on Drug Dependence Treatment and Care to assess further the comprehensiveness, appropriateness, feasibility, utility and evaluation capability of the *Standards* in different contexts. Data so far were formally collected from 9 countries, involving about 1,000 survey respondents, results from more than 30 focus groups, 40 expert reviews and 30 site visits. Data analysis has begun, and a comprehensive field testing report will accompany the future dissemination of the *Standards*. In parallel, the *Standards* have already been applied by countries in the development of national level quality assurance mechanisms for drug-use-disorder treatment services. *Quality Assurance Tools for Drug Treatment Services and Systems* were developed and piloted by UNODC to further support UN Member States in the operationalization and putting the *Standards* into practice.