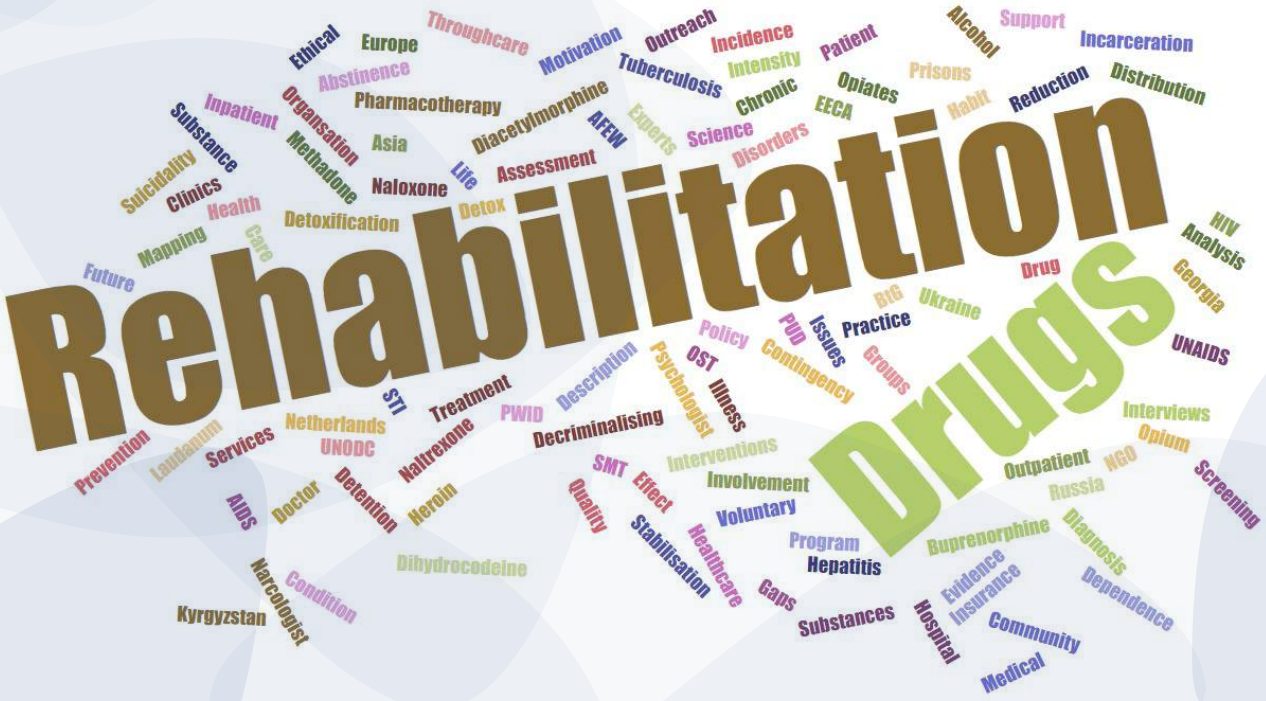
BRIDGING THE GAPS
Health and rights for key populations

AFEW Network Сеть

AIDS Foundation East West
СНІД Фонд Схід Захід

Needs and gaps in treatment and rehabilitation for people who use drugs in selected countries of EECA

Project: 'Bridging the Gaps: Health and rights for key populations 2.0'



CONTENTS

0_ACRONYMS & ABBREVATIONS

AA	Alcoholics Anonymous
ART	Antiretroviral therapy
CBT	Cognitive behavioral therapy
CBT4CBT	Computer-Based Training for Cognitive Behavioural Therapy
CRA	Community Reinforcement Approach
CRAFT	Community Reinforcement and Family Training
CRT	Community Reinforcement Training
DSM5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
EECA	Eastern Europe and Central Asia
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESPAD	European School Survey Project on Alcohol and Other Drugs
EU	European Union
GEL	Georgian Lari
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HRTC	Harm Reduction Therapy Centre
ICD-10	10th Revision of the International Statistical Classification of Diseases and Related Health Problems
KGS	Kyrgzystani Som
KSMIRPD	Kyrgyz State Medical Institute for Retraining and Professional Development
LAAM	Levo-alpha acetyl methadol
MMT	Methadone Maintenance Therapy
MMTP	The methadone maintenance therapy programme
MOHLSA	Ministry of Labour, Health and Social Affairs (Georgia)
NA	Narcotics Anonymous
N.E.T.	Neuroelectric therapy
NGO	Non-governmental organisation
NIDA	National Institute on Drug Abuse (US)
NPS	New psychoactive substances
NREPP	National Registry of Evidence-based Programmes and Practices
OHIF	Obligatory Health Insurance Fund (Kyrgyz Republic)
ORP	Outpatient rehabilitation programme
OST	Opioid substitution treatment
PAS	Psychoactive substances
PMTCT	Prevention of mother-to-child HIV transmission
PWID	People who inject drugs
PWUD	People who use drugs
RUB	Russian Rouble
SAMHSA	Substance Abuse and Mental Health Services Administration
SES	Sentinel epidemiological surveillance
SMT	Substitution maintenance treatment
SSDC	State Service on Drugs Control (Ukraine)

0_ACRONYMS & ABBREVATIONS

ST	Substitution treatment
STI	Sexually transmitted infections
SUD	Substance use disorder
TB	Tuberculosis
TC	Therapeutic community
TTM	Transtheoretical Model of Change
UAH	Ukrainian Hryvnia
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
UROD	Ultra-rapid opiate detoxification
WHO	World Health Organization

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2_INTRODUCTION

This report presents the results of an assessment on the availability of and access to treatment and rehabilitation services for people who use drugs (PWUD) in selected countries of the Eastern European and Central Asian (EECA) region. It was carried out through a regional approach developed by the *AFEW Network* within the programme 'Bridging the Gaps: health and rights for key populations. Phase 2', financed by the Ministry of Foreign Affairs of the Netherlands.

The regional approach adopted by the *AFEW Network* began in mid-June 2016 and will continue through December 2020 within the PWUD project of the Bridging the Gaps programme. The priority areas defined for this regional approach consist of addressing 1) migration and mobility amongst key populations, 2) harm reduction friendly rehabilitation and 3) the shrinking space for civil society in EECA.

As such, the objectives of the 'Bridging the Gaps' programme are:

- To facilitate exchanges between and build the capacity of the *AFEW Network* and its partners within the EECA region in the field of key populations (specifically PWUD), public health and human rights;
- To link regional and local expertise to international expertise in the fields of public health and key populations (with an emphasis on PWUD) and human rights;
- To initiate an international dialogue on upholding human rights for key populations in the EECA region; and
- To introduce innovations and push for activities currently lacking within the above-mentioned fields.

The assessment described here focused primarily on the topics of rehabilitation and human rights and was conducted in June to September 2017. *AFEW International* was responsible for information at the international level, whilst regional level assessments focused on EECA countries where the *AFEW Network* implements the project amongst PWUD, namely, Georgia, the Kyrgyz Republic, the Russian Federation and Ukraine.

This document consists of two main parts: a review of international best practices and standards and an overview of the four selected countries. A description of the assessment includes its overall purpose, methodology, background and context vis-à-vis treatment for PWUD, treatment classification of drug use disorders, international standards and approaches to measuring and ensuring treatment quality and country profiles specifying the current situation, gaps and needs. Annexes contain details on the assessment design, methods and tools used to gather data.

The description and analysis for each country relies on the key assessment objectives and includes the following components:

- Summary,
- National drug policy,
- Characteristics of the drug use situation in the country,
- Regulatory framework for the treatment and rehabilitation of PWUD,
- Available treatment formats (state-run, faith-based, commercial or non-governmental),
- The most common approaches to treatment and rehabilitation,
- Access to treatment and rehabilitation services,
- Quality of services,
- Recommendations and
- References.

2_INTRODUCTION

We expect the results of this assessment will be used to improve the current situation with access to treatment and rehabilitation services for PWUD in the EECA region, particularly in those countries in which the *AFEW Network* works. Findings from this analysis of existing gaps, this assessment represents the first step to developing rehabilitation services and human rights under the *AFEW* regional approach. Furthermore, the findings will inform the development of pilot projects on advocacy, service delivery or capacity building and the continuous monitoring of results.

3_METHODOLOGY

This assessment of treatment and rehabilitation services for PWUD took place between June and September 2017 in four countries of EECA – Georgia, the Kyrgyz Republic, the Russian Federation and Ukraine. These countries were chosen by *AFEW Network* organisations based on the relevance of the topic and the needs of the specific key population.

Assessment goals

The goals of this assessment consist of:

1. Exploring the needs related to improving the quality of existing rehabilitation programmes or establishing new services aimed at treatment and rehabilitation options for PWUD.
2. Defining the priority areas for investing resources from the *AFEW Network* vis-a-vis initiating or supporting treatment and rehabilitation programmes for PWUD in EECA.
3. Building the capacity of 'Bridging the Gaps' partners in Georgia, the Kyrgyz Republic, the Russian Federation and Ukraine as well as other EECA countries on rehabilitation services and European approaches to rehabilitation.

Assessment objectives

The objectives of this assessment were:

1. To analyse international experience on treatment and rehabilitation for PWUD.
2. To identify and document all available forms of treatment and rehabilitation for PWUD in selected countries of EECA.
3. To collect information on the approaches and methods used in drug treatment and rehabilitation.
4. To evaluate access to treatment and rehabilitation services for PWUD in the region.
5. To assess the quality of the services provided.
6. To analyse existing normative guidance and specify gaps in legislation, protocols, standards and educational programmes for specialists.
7. To provide recommendations on building the capacity of key local actors and the *AFEW Network* based on international evidence-based practices.

The assessment methods and instruments were chosen in order to fulfil each of the above-mentioned objectives, and consisted of desk research, mapping and semi-structured interviews with experts.
These methods were chosen to allow us to analyse the needs and gaps from different perspectives and to link theoretical approaches to practical implementation.

Desk research covered international and national approaches to treatment and rehabilitation, national legislation and available standards, protocols and other related policies. Data collected during the desk research phase allowed us to gain an overall picture of the current situation in each country and to compare that situation to internationally recognised standards and best practices. In addition, desk research allowed us to describe existing programmes and services and identify any gaps and limitations. A detailed list of the sources and references we used within the desk research phase of this assessment appears at the end of each relevant section.

Mapping allowed us to accurately indicate the actual points of treatment and rehabilitation services in each of the selected countries. This method supported the more theoretical phase of the desk research, and allowed us to correlate and systematise the theoretical and practical information we gathered. Furthermore, the mapping method allowed us to identify and analyse 1408 service points providing treatment and rehabilitation services in 4 counties. These included 990 state facilities offering treatment or rehabilitation services (e.g., detox) (48 in the Kyrgyz Republic, 135 in the Russia Federation and 807 in Ukraine), 224

3_METHODOLOGY

substitution maintenance treatment (SMT) sites (18 in Georgia, 32 in the Kyrgyz Republic, 0 in the Russian Federation and 174 in Ukraine), 10 separate state-run rehabilitation centres (0 in Georgia, 1 in the Kyrgyz Republic, 3 in the Russian Federation and 6 in Ukraine) and 184 non-governmental, commercial and faith-based rehabilitation centres and clinics (9 in Georgia, 2 in the Kyrgyz Republic, 80 in the Russian Federation and 93 in Ukraine).

The *expert interviews* conducted in each country provided valuable information confirming what we learned through the desk research and mapping phases of this assessment. All interviews were analysed using a content analysis tool and selected expert statements support data on the overall country situation. We selected experts based on their experience working with PWUD, their position, recognition within the field vis-à-vis services provided to PWUD and recommendations from other experts as well as their general expertise on the selected topics. Based on these inclusion criteria, we conducted 31 expert interviews across 4 countries. Experts, aged 35 to 70 years, consisted of 11 women and 20 men. Geographically, we interviewed 7 experts from Georgia (3 women, 4 men aged 37–58), 8 experts from the Kyrgyz Republic (5 women, 3 men aged 42–69), 8 experts from the Russian Federation (1 woman, 7 men aged 35–60) and 8 experts from Ukraine (2 women, 6 men aged 35–70).

Among these, professionals worked in the following occupations:

- psychiatrist,
- narcologist,
- head or project coordinator at a non-governmental organisation (NGO),
- head physician at a narcological service or drug clinic,
- SMT doctor,
- deputy head of the medical service of the penitentiary system,
- head of a rehabilitation centre,
- medical psychologist,
- psychologist,
- clinical director of a medical centre,
- member of an association of addictology,
- head of a research institute on psychiatry or narcology,
- chief doctor of a city drug treatment clinical hospital and
- rector of a church or the head of a diocesan department for counteracting drug addiction.

The description and analysis for each country relies on the key assessment objectives and includes the following components:

- Summary,
- National drug policy,
- Characteristics of the drug use situation in the country,
- Regulatory framework for the treatment and rehabilitation of PWUD,
- Available treatment formats (state-run, faith-based, commercial or non-governmental),
- The most common approaches to treatment and rehabilitation,
- Access to treatment and rehabilitation services,
- Quality of services,
- Recommendations and
- References.

3_METHODOLOGY

Limitations

Although the research achieved its aims, some unavoidable limitations exist. First, due to time constraints, we planned no interviews with treatment or rehabilitation programme clients. In future, to assess the quality of drug treatment services, client feedback on the various types of programmes is crucial. Second, translating interviews from their original language (for instance, Georgian) before content analysis provided difficult, and we thus miss crucial information. Third, due to limited resources, all experts interviewed in the Russian Federation were selected from one region. Therefore, we were unable to capture any variations in the quality and accessibility of drug treatment throughout the entire country. Finally, the lack of prior research on this topic in EECA made a comparison of practices in these countries to international practices rather difficult. (For further details on the methodology (such as the assessment instruments), see the annexes.

4_BACKGROUND AND CONTEXT OF THE ASSESSMENT

Because of the many inaccurate interpretations prevailing in the past, drug dependence has been considered a social problem, a moral failure, a pathology, a behaviour to be punished or the simple result of inappropriate exposure to dependence-producing drugs. These simplistic and ideological notions were proposed before we had a scientific understanding of the brain's mechanisms that play a central role in the development and persistence of behavioural signs and symptoms of drug use disorders. Following many years of medical research, we now have a solid understanding of drug dependence as a complex multifactorial biological and behavioural disorder. These scientific advances allow us to develop treatments that help normalise the brain functioning of affected individuals and support them to change their behaviour. Offering treatment based on scientific evidence now helps millions of affected individuals to regain control over their lives and lead productive lives in recovery (UNODC-WHO International Standards for the Treatment of Drug Use Disorders. Draft for field testing, 2016). We should also distinguish between 'drug use' and 'drug dependency' according to the United Nations Office on Drugs and Crimes' (UNODC) World Drug Report (2015), whereby only one in ten drug users suffers from drug use disorders.

Unfortunately, outdated views of drug use disorders persist in many parts of the world. Stigma and discrimination commonly directed towards drug dependent individuals and to professionals working with them significantly compromise the implementation of quality treatment interventions. This in turn undermines the development of treatment facilities, the training of health professionals and investment in recovery programmes.

Whilst evidence clearly shows that drug use disorders are best managed within a public health system, similar to other medical issues such as HIV or hypertension, the inclusion of addiction treatment in the healthcare system remains quite difficult in many countries, where huge gaps persist between science, policy and clinical practice.

Managing individuals with drug use disorders through agencies such as interior ministries, or ministries of justice or defence, without the supervision of or engagement with ministries of health, is unlikely to lead to long-lasting beneficial outcomes. Only treatment understands drug dependence as primarily a behavioural disorder treated using medical and psychological approaches, and improving the chances of recovery. Relying only on law enforcement strategies and methods is unlikely to result in any sustained positive result.

Currently, UNODC data suggests that globally only one out of every six individuals in need of drug dependence treatment has access to such programmes. Treatment in many countries is only available in large cities, but not in all regions, particularly more rural areas. Unfortunately, in many places, the treatment available is often not effective, not supported by scientific evidence and sometimes not aligned with the principles of human rights nor voluntary. This remains true in otherwise highly developed countries, where the availability of evidence-based treatment programmes is often insufficient to meet demand.

Another challenge lies in the changing drug scene worldwide. Traditionally, misused drugs included plant-derived substances such as cocaine, heroin and cannabis. More recently, amphetamines and related stimulants synthesised in illicit laboratories have become widely available. In order to avert legal efforts aimed at controlling the distribution of psychoactive substances, hundreds of new psychoactive substances (NPSes) are synthesised, distributed and used each year with some unpredictable and sometimes dramatic adverse consequences amongst users. The production and trafficking of NPSes purchased via the internet makes monitoring and control even more difficult. In addition, very few countries have in place an early warning

4_BACKGROUND AND CONTEXT OF THE ASSESSMENT

system to collect and share information on these new substances. Because of the emergence of NPSes and changes in the distribution routes of the drugs traditionally misused in many countries and parts of the world, health institutions are poorly prepared and less able to respond appropriately to the emergence of new behavioural and medical problems affecting drug users. For example, in parts of the world where opioids were previously used, large increases have been reported in the prevalence of psychostimulant use disorders. Furthermore, the treatment system developed to manage opioid–related problems cannot respond appropriately to these new types of patients. Similarly, the trend toward polydrug use amongst young consumers, combining 'traditional' drugs, prescription drugs, alcohol and NPSes, has provided a more dramatic picture requiring urgent investment in treatment programmes and human resources.

In accordance with the *AFEW Network*'s perspective on drug use and the comprehensive package required to support all people to improve their quality of life (with an emphasis on health), rehabilitation stands as an integral component of the continuum of care for PWUDs, and part of an extended harm reduction package we aim to introduce and improve. The strict separation of harm reduction services from drug treatment represents an imaginary division, based on an HIV control model. In reality, PWUD need a continuum of care that includes their health status (including infectious diseases control), but also respecting their mental health, quality of life and their human rights. All of these areas are united within each individual rendering all of it interconnected.

The strict split in harm reduction services and drug treatment services also stands in the way of offering effective drug treatment. When examining solid examples such as those in the Netherlands, we can conclude that drug treatment also includes a continuum of methods and means to control drug misuse and complete abstinence can occupy different positions along a continuum, whereby each individual has different needs, depending on their position in their drug use career as well as their own motivation.

In the context of harm reduction and HIV, drug treatment (or rehabilitation including detoxification) is often ignored, since it is typically approached as completely abstinence-focused and, in that sense, is not included in the World Health Organization's (WHO) harm reduction package. However, in the **'Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations'** (WHO, 2016), one recommendation in relation to drug users and prisons suggests that countries should affirm and strengthen the principle of providing treatment, education and rehabilitation as an alternative to conviction and punishment for drug-related offences.

5_CLASSIFICATION OF DRUG USE DISORDERS

Over time, approximately 10% of individuals who begin to use drugs will develop changes in their behaviour and other symptoms that constitute a 'drug use disorder' as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM5) or a diagnosis of 'drug dependence and harmful use of a substance' as defined by the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

At the core of drug dependence syndrome lies the strong and overpowering desire to take the drug and an inability to control the amount of drug taken. This results in using excessive amounts and spending excessive amounts of time on drug-related activities. The desire to take the drug can persist or be easily reactivated even after a period of abstinence, leading to the resumption of regular use despite a strong wish otherwise and a frequent desire to stop using. Over time, the use of the drug takes on a much higher priority for the individual, displacing other activities that once held greater value.

Individuals with this disorder often lose interest in and neglect their family and social life, education, work and recreation. They continue to use despite recurrent social or interpersonal problems, engage in high-risk behaviours and continue to use despite knowledge of persistent problems resulting from their drug use. In combination with the effects of the criminalisation, stigma and discrimination associated with drug use, the negative consequences multiply. Finally, some drugs may produce over time a decrease in effects to the same repeated dose of a drug or tolerance, or a withdrawal syndrome - a set of characteristic aversive symptoms, when the amount ofdrug taken is reduced or drug use has stopped.

Scientific advances and efforts at educating the general public are beginning to change perceptions of drug dependence throughout civil society. A greater recognition is emerging that drug use disorders represent complex health problems with psychosocial, environmental and biological determinants, requiring a multidisciplinary and comprehensive response from different institutions working together. Many policymakers and the public in general are beginning to view drug dependence not as a 'self-acquired bad habit', but rather resulting from a series of biological and environmental factors, disadvantages and adversities. That is, drug dependency can be prevented and treated. Still, the notion that drug use is not a result of moral problems and criminal behaviour requires introducing treatment rather than punishment.

It is also important to underline that the term 'treatment' in the European Union (EU) and some countries of EECA may carry a slightly different meaning. In the EU, treatment includes all possible approaches and methods aimed at providing assistance to drug users. In the international literature, rehabilitation and social reintegration represent treatment goals or components (UNODC-WHO standards). The term 'pharmacotherapy' (e.g. detox or opioid substitution treatment (OST)) emphasises its medical character. By contrast, in EECA experts and guidance packages consider treatment as simply necessitating medical care whilst rehabilitation refers to social and psychological support.

Studies on dependency treatment typically classify programmes into several general types or modalities. Treatment approaches and individual programmes continue to evolve and diversify, and many programmes today do not fit neatly into traditional drug treatment classifications. Regardless, in what follows, we summarise several approaches to classifying treatment and rehabilitation programmes.

In general, all approaches can be divided into two main categories: pharmacotherapies and behavioural therapies. Pharmacotherapies include detoxification and substitution treatment.

5_CLASSIFICATION OF DRUG USE DISORDERS

PHARMACOTHERAPIES

Detoxification programmes

Detoxification (or detox), the process by which the body clears itself of drugs, is designed to manage the acute and potentially dangerous physiological effects of stopping drug use. The main purpose of any type of drug detox is the safe, comfortable elimination of drugs from the body and preparing the individual for further rehabilitation. Detox itself is not designed to solve psychological, social and behavioural aspects of dependency. Unless all components of addiction are also treated, relapse is highly probable. Furthermore, drug detoxification does not cure drug dependency. It merely represents the first step in the treatment process. The selection of a particular method depends on the diagnosis, individual patient characteristics, risk factors and the patient's wishes.

In the EECA region, two types of opioid detoxification are relied upon: ultra fast and normal. The fastest detoxification process takes 8 to 12 hours, during which time the patient is under anaesthesia (e.g., asleep) and administered an opioid receptor antagonist, which completely displaces the remnants of morphine from the nerve cells and nerve endings. Ultra-fast detox is a highly dangerous procedure to the patient's health and life which does not actually 'break' the habit. The patient does not feel pain only when under anaesthesia; when they awake, they still suffer from withdrawal for a few days, experiencing joint pain, insomnia and stomach discomfort amongst other symptoms.

Normal detoxification lasts 7 to 14 days aided by anaesthetics, sedatives and hypnotics, during which time the withdrawal syndrome passes less painfully.

Following detox, the patient is offered the option of taking Naloxone or Naltrexone (an opioid receptor antagonist) in the form of pills, injections or via a capsule under the skin which acts for 3, 6 or 12 months.
In international practice, other forms of detox consist of heroin detoxification, ibogaine therapy, Subutex detox, neuroelectric therapy (N.E.T.) and ultra-rapid opiate detoxification (UROD).

In many countries (such as the United Kingdom), officially described unassisted or self-detoxification methods exist, defined as 'the deliberate attempt to achieve abstinence from drugs which is sustained for longer than 24 hours in the absence of clinical assistance' (Gossop et al., 1991; Noble et al., 2002). Such methods have been the subject of concern for some time, not least because epidemiological studies show that a significant number of people stop misusing opioids without formal treatment. However, it is not clear if these individuals who attempt to self-detoxify are likely to experience more harm or be less successful than those undergoing professional detoxification procedures (Drug misuse: Opioid detoxification 2007 United Kingdom English (EMCDDA)). Some sources also refer to natural detox, whilst others still mention non-traditional methods, such as xenon gas therapy and acupuncture amongst others.

Most studies, however, start with detoxification and medically managed withdrawal, which are often considered the first stage of treatment. As stated previously, detox alone does not address the psychological, social and behavioural issues associated with dependency and, therefore, does not typically produce the lasting behavioural changes necessary for recovery. Detoxification should, thus, be followed by a formal assessment and referral to a drug treatment programme.

5_CLASSIFICATION OF DRUG USE DISORDERS

Because it is often accompanied by unpleasant and potentially fatal side effects stemming from withdrawal, detoxification is often managed with medications administered by a physician in an inpatient or outpatient setting. Therefore, it is referred to as 'medically managed withdrawal'. Medications are available to assist in withdrawal from opioids, benzodiazepines, alcohol, nicotine, barbiturates and other sedatives (Kleber, H.D. Outpatient detoxification from opiates).

Substitution maintenance treatment (SMT)

Substitution therapy (also referred to as 'agonist pharmacotherapy', 'agonist replacement therapy', 'agonist-assisted therapy') is defined as the administration of a prescribed psychoactive substance under medical supervision pharmacologically related to the one producing dependence to people with a substance dependence in order to achieve the defined treatment aims. Substitution therapy is widely used in the management of nicotine ('nicotine replacement therapy') and opioid dependence (WHO/UNODC/UNAIDS position paper 'Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention').

SMT relies on the long-term (six or more months) use of permanent doses of a substitute medication in the comprehensive treatment of opioid dependence in order to achieve the following:

- stabilise a patient's physical and mental condition;
- reduce the medical and social effects associated with using illicit drugs;
- create the conditions necessary for the rehabilitation and treatment of other attendant health problems (HIV, viral hepatitis B & C, tuberculosis, septic conditions, etc.); and
- bring the patient back to a normal, fully functional life.

Substitution treatment (ST) is the practice of prescribing a substitute medication to comprehensively treat dependence syndrome resulting from opioid use. The substitute medication improves the patient's condition, prevents the onset of withdrawal syndrome, reduces the cravings for illicit drugs, creates the possibility of rehabilitation and reduces the probability of risk behaviours (related to HIV and other sexually transmitted infections (STIs) transmitted through blood). A substitute medication may be prescribed for a period that varies from several weeks (detoxification) to several years.

Medicines used in substitution therapy can be prescribed either in decreasing doses over short periods of time (usually less than one month) for the treatment of withdrawal or for detoxification, or in relatively stable doses over a long period of time (usually more than six months) for SMT. This allows brain functions to stabilise and prevents cravings and withdrawal. The term 'substitution therapy' is often used as an equivalent to 'substitution maintenance therapy'.

SMT stands as one of the most effective types of pharmacological therapies to treat opioid dependence. Consistent evidence from numerous controlled trials, large longitudinal studies and programme evaluations demonstrate that SMT for opioid dependence is associated with substantial reductions in illicit opioid use, criminal activity, deaths due to overdose and behaviours associated with HIV transmission.

In addition, SMT for opioid dependence represents an important component of community-based approaches whereby treatment can be provided on an outpatient basis to achieve high rates of retention in

treatment. Furthermore, SMT may extend the time and expand opportunities for individuals to tackle major health, psychological, family, housing, employment, financial and legal issues whilst in contact with treatment services.

The prescription for ST and the administration of opioid agonists to individuals dependent upon opioids — within the framework of recognised medical practice approved by competent authorities — is in line with the 1961 and 1971 Conventions on Narcotic Drugs and Psychotropic Substances.

Pharmacological agents for SMT include the following:

- Methadone,
- Buprenorphine,
- Levo-alpha acetyl methadol (LAAM),
- Dihydrocodeine,
- Diacetylmorphine (heroin) and
- Tincture of opium (laudanum).

The objectives of SMT include:

1. Reducing the use of illegal opioids (first of all, by injection).
2. Stabilising and improving the physical and mental condition of patients with opioid dependence.
3. Reducing criminal activity amongst PWUD.
4. Reducing risky behaviour associated with the spread of HIV, hepatitis B and C, as well as other infections transmitted through blood (first, by rejecting the injection of mind-altering substances).
5. Involving PWUD in cooperation amongst concerned social agencies and creating the necessary conditions for the social rehabilitation and reintegration of patients. These are achieved by helping to restore the patient's relations with their families and inner circle of friends, and by providing assistance with finding employment among other issues.
6. Creating the necessary conditions for the effective treatment of HIV, TB, and associated illnesses among injecting drug users (e.g., systemic infections, purulent inflammation (infections), hepatitis B and C, ischemic ulcers and phlebitis.)
7. Creating the necessary conditions to provide quality healthcare for pregnant drug users.

We should mention that, due to many international standards, drug treatment is perceived as a comprehensive package of medical, psychological and social services. For instance, in the United Kingdom, the National Clinical Practice Guideline on Opioid Detoxification includes sections not only on pharmacological and physical interventions in opioid detoxification, but also psychosocial interventions with detailed descriptions of rehabilitation models.\

5_CLASSIFICATION OF DRUG USE DISORDERS

CLASSIFICATION BASED ON AN ORGANISATIONAL PRINCIPLE

Another approach to classifying treatment models uses an organisational principle and provides three main groups: a service organisation pyramid, a one-stop shop and, finally, community-based drug dependence treatment and care (UNODC-WHO International Standards for the Treatment of Drug Use Disorders. Draft for field testing. 2016).

Service organisation pyramid

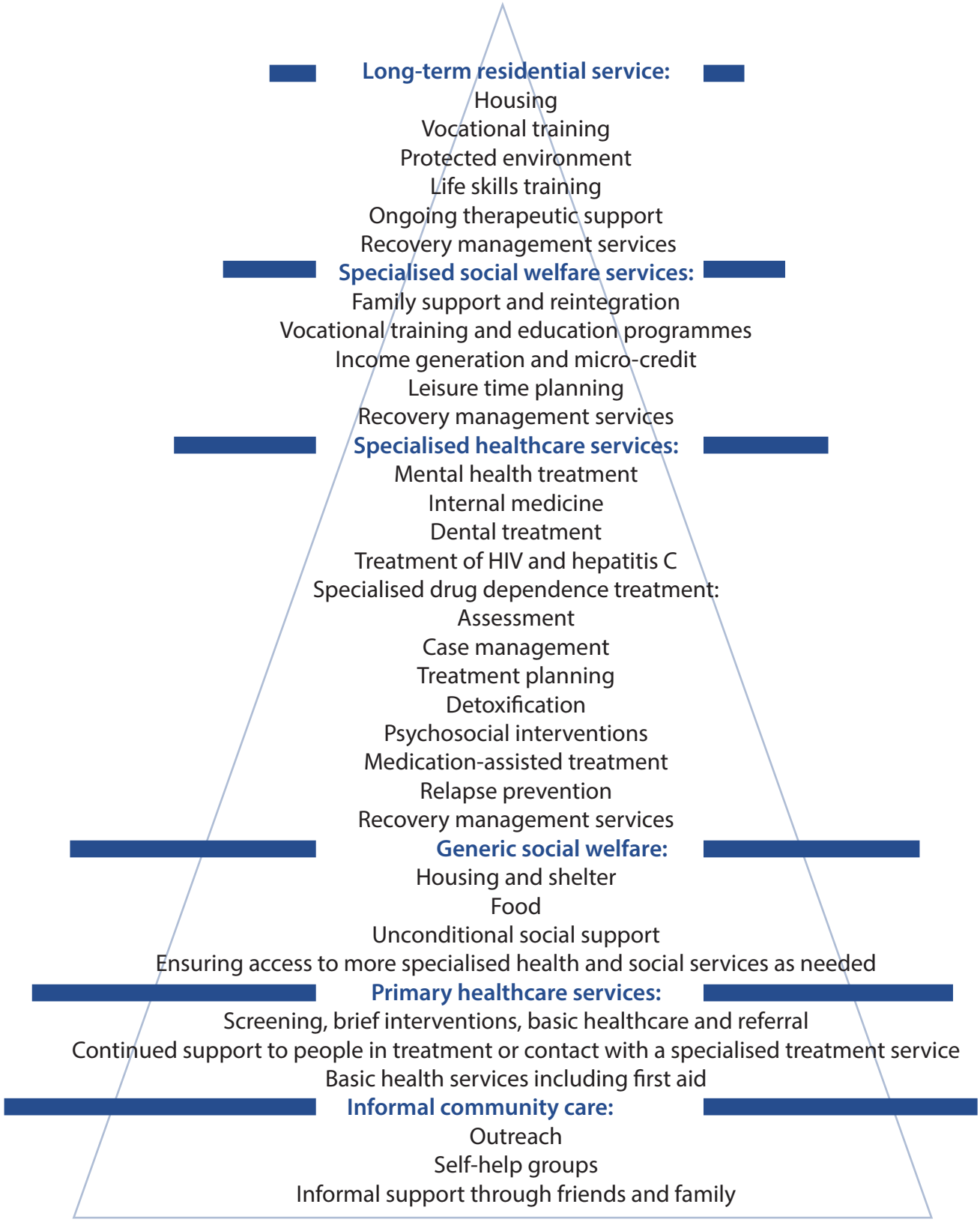
As captured in the service organisation pyramid (see Figure 1), most services are required at the levels of lower intensity and if implemented can prevent individuals from developing more complex drug use disorders. Whilst more services are required at the less intensive spectrum of the pyramid, these services are typically also less specialised and less costly, rendering the treatment system designed aligned with the service delivery pyramid more cost-effective, provided that the actual services offered are implemented based on the available evidence.

However, in reality investments are directed at highly intensive and highly costly treatment services at the top of the pyramid. This may lead to a situation whereby individuals with a low severity of dependence receive highly intensive services. This represents an inefficient investment of public funds rather than matching the severity of the disorder with the intensity of treatment, thereby maximising outcomes and more efficiently distributing resources.

World Drug Report (UNODC, 2015) data show that globally a substantial gap exists between the number of people who want or might benefit from treatment for drug use disorders and the number of people who actually receive such services. The non-existence of services at the lower threshold and lower intensity (such as brief interventions at the primary healthcare level) may also lead to a situation whereby PWUD only come into contact with the healthcare system when they have already developed highly severe drug use disorders rather than by receiving less intensive (and less costly) support during the earlier stages of their disease.

5_CLASSIFICATION OF DRUG USE DISORDERS

Figure 1. Suggested interventions at different service levels



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TYPES OF TREATMENT PROGRAMMES

Type of specialised **inpatient or residential programmes**

- Hospital inpatient unit
- Therapeutic community (TC)
- Other

Types of specialised outpatient or non-residential programmes

- Hospital outpatient treatment centre
- Structured day-care centre or day hospital
- Local health or social service centre
- Low threshold, drop-in or street-level agency
- Other

General service-based programme

- Inpatient psychiatric hospital
- Outpatient mental healthcare centre
- Primary healthcare service
- Residential social care facility
- Non-residential social care facility
- Other non-specialised residential
- Other non-specialised non-residential

Treatment unit in prison

The types of treatment modalities

We often distinguish between various treatment modalities. These include:

- Detoxification or short-term reduction,
- Longer-term drug substitution,
- Medicament-free therapy or longer-term psychosocial treatment and
- Advice, counselling, short-term interventions or support.

The goal of treatment

Treatment goals include the following:

- Abstinence,
- Stabilisation, harm reduction or secondary prevention and
- Behavioural change.

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Planned duration of treatment

How long treatment lasts can fall into the following ranges:

- Short-term (<1 month),
- Medium-term (1–6 months) and
- Long-term (>6 months).

Accessibility of treatment

Issues related to the accessibility of treatment can be categorised as follows:

- Waiting lists (e.g., the average wait during the previous year),
- Insurance coverage (yes or no),
- Motivation required (e.g., the threshold at intake measured as low, moderate or high; abstinence required),
- Planned total duration of treatment (short-, medium- or long-term) and
- Geographical location (urban, suburban or rural).

The type of ownership

The type of ownership indicates the type of entity responsible for operating a residential facility. These consist of the following:

- Government, broken down as
- State or federal
- Local or regional
- Private, for-profit (commercial)
- Private, non-profit.

Due to the aims of our assessments, in what follows we focus on the description of inpatient and outpatient treatment programmes, as well as drug treatment in prison settings.

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Inpatient, residential treatment programmes

Residential treatment comprises the provision of a range of treatment delivery models or programmes of therapeutic (and other) activities for drug users within the context of residential accommodation in either the community or a hospital setting (Residential treatment for drug use in Europe (EMCDDA)).

Most individuals receiving treatment for drug use–related issues may not need to access residential treatment. Their needs can be met appropriately by community drug treatment services, which have increased in availability and effectiveness over the past decade. However, outpatient treatment and rehabilitation may not always be the most appropriate option, particularly for a select group of drug-dependent clients who need the safety and structure that residential treatment provides. Hence, residential drug treatment represents a sizeable and necessary element within the range of treatment options available to people who use drugs.

A wide range of different types of residential treatment options exist, and residential treatment is advancing and currently developing its evidence base. To aid comparisons, it is important to establish common factors and models amongst this variety. Traditionally, residential programmes have been delivered over a number of months up to a year to allow successful achievement of treatment goals. In the current unfavourable economic conditions, it is particularly relevant to examine whether and how the pattern of residential treatment provision is changing and how providers are responding to new demands and opportunities — in terms not only of treatment duration, but also of programme content and intensity.

Furthermore, it is important to note that residence can occur within a range of settings. These include community-residential, hospital and prison environments.

Residential treatment programmes generally seek to prevent a return to active drug use, to provide individuals with healthy alternatives to drug use and to assist drug users to understand and address the underlying factors supporting drug use and make healthier decisions (NTA, 2006). Inpatient programmes help individuals to attain control over drug use, to achieve recovery from drug problems, to improve their health and well-being and to change their lifestyle, including family and social relationships, education, voluntary activities and employment.

Residential programmes thus potentially offer a number of benefits through a comprehensive package that removes individuals from their drug-using environments and provide a safe and supportive place to learn skills conducive to living a sober and rewarding life.
The main therapeutic approaches used include the 12-step or Minnesota model, the therapeutic community (TC) and cognitive behavioural (or other) therapy–based interventions. (You can find a detailed description of the most popular approaches used in Europe within residential and non-residential treatment programmes in the annexes.)

Inpatient residential facilities are divided into two broad categories based on the setting — community-residential or hospital — for service delivery:

1. Community-residential facilities include residential facilities within the community for the treatment of clients with drug-use problems.

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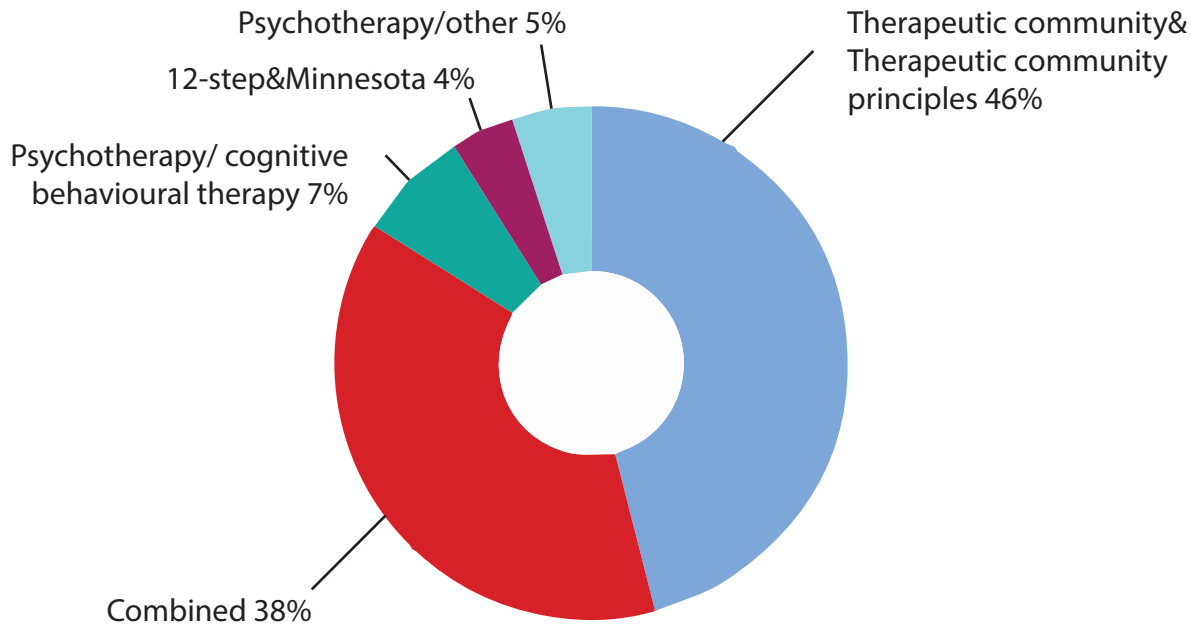
2. Hospital-based facilities provide beds for the treatment of clients with drug-use problems in a hospital environment. These take the form of either stand-alone facilities used for nothing other than the treatment of clients with drug-use problems or wards within psychiatric or general medical facilities theoretically available for drug users, but in practice could be and are occupied by general or medical psychiatric clients.

Figure 2. Distribution of various therapeutic approaches within residential treatment in Europe (Residential treatment for drug use in Europe (EMCDDA, 2014)):



Residential treatment is typically medium- to long-term in duration with the length varying depending upon an individual's needs. However, in recent years, studies suggest that the planned length of time in residential treatment facilities has decreased in some European countries through the evolution of treatment, but also in response to financial pressures.

Outpatient or non-residential treatment programmes

The outpatient treatment setting consists of treatment and care for individuals who do not reside at the treatment facility. Whilst the treatment facility may have the capacity for overnight care (i.e., as a hospital), outpatients live at home and visit the treatment facility for their care.

Outpatient services vary considerably in terms of their components and intensity. They can range from health education efforts to treatment centres providing continuous care and recovery management.

In addition, outpatient treatment is most appropriate for individuals who possess sufficient social support and resources at home and in the community to participate in ambulatory care. Outpatient treatment is an ideal

setting for providing long-term maintenance care for patients with substance use disorders, since the majority of substance use–related issues can be managed on an outpatient basis where both psychosocial and pharmacological interventions can be offered. The specific target population will depend on the specific outpatient intervention.

Outpatient treatment primarily seeks to help patients to stop or reduce drug use; to minimise the medical, psychiatric and social complications associated with drug use; to reduce the risk of relapse drug use; and to improve their personal and social functioning as part of the long-term recovery process. Another important goal of outpatient treatment is to increase access to treatment and healthcare for individuals severely affected by their condition who do not wish to accept hospitalisation or residential treatment as the initial intervention.

Outpatient treatment programmes for individuals with drug use disorders may take quite different forms depending on the level of intensity such services offer.

High-intensity interventions

High-intensity programmes may consist of intensive day treatment possibly requiring frequent interactions with patients (i.e., daily or several hours on one or more days).

Low- to medium-intensity interventions

Lower intensity interventions may involve weekly group support sessions, individual counselling or health and drug education. During outpatient treatment, associated healthcare professionals may administer regular assessments of drug and alcohol use, and check the physical and mental health status of patients. Routine cooperation with allied care services is essential. These include the integration of outpatient treatment with infectious disease services for HIV, viral hepatitis, tuberculosis (TB) and STIs. This coordination should also enable the patient or client to navigate services at relevant psychiatric hospitals if inpatient care becomes necessary, such as in cases of psychosis, suicidality or detoxification.

For low- to medium-intensity interventions, the treatment objectives can be best accomplished using a combination of pharmacological and psychosocial interventions. Ideally, outpatient treatment programmes for drug use disorders offer a comprehensive range of services to manage various problems affecting patients and clients across several life domains.

Currently, no definitive research exists which prescribes a specific approach to treat individuals experiencing a drug use disorder. Care components must be tailored to meet the needs of each patient or client. The scientific literature supports the effectiveness of cognitive behavioural therapy (CBT), motivational interviewing and motivational enhancement therapy, family therapy modalities, contingency management, drug counselling and 12-step group facilitation amongst others.

Drug treatment in prison

In general, prisoners are entitled to the same level of medical care as persons living in the community. Furthermore, prison health services should be able to provide drug-related treatment and care comparable to

that enjoyed by patients outside prison walls (Prisons and drugs in Europe: the problem and responses (EMCDDA, 2012)).

In the majority of European countries, drug treatment in prisons is provided by staff employed by the prison administration. However, it is also common for prison administrations to collaborate with a range of community-based providers, public health services or NGOs to deliver drug treatment services to those in detention.

Drug treatment services in prisons have the following components:

- Prison entry (assessment of drug use problems and suicide risks),
- Treatment of drug dependence (prevention of drug-related infectious diseases in prison settings, needle and syringe programmes and treatment of hepatitis C in prison) and
- Release preparation and throughcare.

Prison Entry

Medical examination of all those remanded into custody or entering prison following conviction is a widely accepted standard of prison healthcare. The aim here is to diagnose any physical or mental illnesses that might be present and to take the necessary treatment measures, such as ensuring the continuation of existing medical treatment.

Assessment of drug problems

In many countries, new inmates are routinely assessed for drug use and drug-related problems. The common approach includes a clinical assessment carried out by a medical doctor, psychiatrist or psychologist in order to ascertain a diagnosis of drug dependence and mental health problems. In some countries, standardised tests, questionnaires and interviews are used for this purpose.
The medical consultation upon prison entry is also used as an initial opportunity to inform prisoners about treatment and prevention, raise risk awareness, distribute prevention materials including hygiene kits and condoms and make referrals to specialised drug treatment and care.

Assessment of suicide risk

Early identification of drug-using prisoners at risk for suicide and referring them for adequate treatment should become a part of care in prisons. As England's experience shows, the integration of suicide risk assessment into the treatment system in all prisons led to a dramatic reduction in suicides amongst women prisoners, from a total of 36 in the preceding three full years (2002–04) to 15 in the three years following the initiation of the programme (2005–08) (Marteau et al., 2010).

Treatment of drug dependence

Treatment for drug dependence is aimed at both improving the health of detainees and reducing the often high levels of illicit drug use in prisons. Treatment options for drug users in European prisons cover a range of modalities, which, in the absence of a standard nomenclature, are broadly categorised into three types:

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1. 'Low-intensity drug treatment' covers counselling interventions as well as short-term treatment conducted in an outpatient regime within the prison setting.
2. 'Medium- or high-intensity drug-free treatment' includes inpatient wards for the delivery of drug treatment in a residential setting, such as therapeutic communities in prisons.
3. 'Medium- or long-term opioid substitution treatment' covers methadone or buprenorphine substitution programmes.

Various treatment models may be offered, including cognitive, behavioural, 12-step programmes and substitution treatment. The UNODC Treatment Project describes the different types of residential drug-free treatment approaches available in prisons (UNODC, 2008a).

Cognitive-behavioural therapy (CBT) is structured psychological interventions that help a prisoner to develop the skills necessary to remain drug free. Strategies include relapse prevention such as coping strategies, identification of high-risk situations and triggers to drug use and identifying dysfunctional thinking patterns, managing emotions and problem solving.

Prisons also rely on **the 12-step residential approach**, based on the Alcoholics Anonymous model, which assumes a biological or psychological vulnerability to dependency. The treatment goal is abstinence, and prisoners usually work their way through the first 5 steps of the 12-step programme. Programme graduates are expected to attend self-help groups in prison and in the community upon release.

Therapeutic communities (TCs) are a special form of long-term, participatory, group-based residential treatment drug addiction programmes, where milieu therapy principles are applied. As such, clients are encouraged to take responsibility for themselves and for others.

Research and evaluation of prison-based treatment programmes remain lacking and little is known about their effectiveness. However, two randomised trials conducted in prisons were included in a review of the effectiveness of TCs versus other treatment types for substance dependents (Smith et al., 2006). While the authors found little evidence that TCs offer significant benefits in comparison with other residential treatment provided in community settings, inmates in prison-based TCs were less likely to return to prison within the first 12 months compared with prison inmates receiving no treatment or assigned to alternative services. Thus, prison-based TCs may be better than prison on its own. However, a number of methodological limitations are mentioned by the authors, preventing them from drawing firm conclusions. The fact that both trials were conducted in US prisons may limit the transferability of the results to Europe.

Opioid substitution treatment (OST) is the main approach in the treatment of opioid dependence in the European Union. A systematic review of the effectiveness of OST in prison (Hedrich et al., 2012) analysed data from 21 studies, including 6 experimental studies. The authors concluded that the benefits of treatment in prison are similar to benefits in community settings; namely, OST provides an opportunity to recruit problem opioid users into treatment, to reduce illicit opioid use and risk behaviours in prison and potentially minimise overdose risk upon release. Positive outcomes depended on the quality of treatment. The review highlights the importance of establishing a liaison between prison and community-based programmes in order to achieve a continuity of treatment and longer-term benefits. The data also show that disruptions in the continuity of treatment, especially owing to short periods of detention, are associated with very significant increases in hepatitis C incidence.

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In the countries included in this assessment, the availability of substitution treatment varies. OST in prisons is available in Georgia (although used as a detoxification method) and the Kyrgyz Republic. In Ukraine access to OST in prisons is not available (only patients who initiated OST before imprisonment can receive medication in detention centres). In the Russian Federation, OST remains completely unavailable.

Release preparation and throughcare

Most social care, rehabilitation strategies and procedures for those leaving prison are directed at the prisoner population. However, some pre-release measures are particularly important for those who use or have used drugs.

Of particular importance for drug users during the phase immediately preceding prison release — but ideally a process throughout the entire sentence — is cooperation between services inside the prison and health and social services outside. This cooperation ensures a seamless transition into community treatment. The term 'throughcare' refers to arrangements for managing the continuity of care before, during and immediately after detainment . Throughcare and referral to external service providers is a general duty of prison or probation services, and can be crucial in preventing relapse.

The *AFEW Network* has promoted transitional case management in prisons in EECA since 2005. As such, a number of projects have been implemented in order to support inmates during the process of release from prison and reintegration into society. Since 2012, transitional case management has been provided for adolescents in prisons in Ukraine.

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No one single document provides the definitive standards of treatment to apply across all countries. All international standards and guidelines exist as recommendations and should be adapted to the local context in each region. Yet, general principles have been outlined which form the basis of any standards developed to address drug use disorders.

The *International Standards* for the *Treatment of Drug Use Disorders* (UNODC-WHO, 2016) were prepared to support Member States in the development and expansion of treatment services offering effective and ethical treatment. The goal of such treatment is to reverse the negative impact persistent drug use disorders have on the individual and to help the individual achieve full recovery from the disorder as much as possible and to become a productive member of their society.

KEY PRINCIPLES AND STANDARDS FOR THE TREATMENT OF DRUG USE DISORDERS

Drug use disorders can be effectively treated using a range of pharmacological and psychosocial interventions. These interventions have been developed backed by scientific evidence, and their effectiveness has been analysed using scientific methods applied in the development of treatment for other medical disorders. The goals of treatment are 1) to reduce the intensity of the drug use desire and drug use itself, 2) to improve the functioning and well-being of the affected individual and 3) to prevent future harms by decreasing the risk of complications and reoccurrence.

Many interventions commonly used when working with affected individuals do not meet the standards of effective evidence-based treatment. Such interventions are ineffective and can be harmful. This distinction between effective and ineffective interventions carries important financial implications. In many countries, the resources available to work with affected individuals remain limited, and prioritising resource allocation must be carefully considered. The scientific standard can be used to make an important differentiation between interventions worth supporting and those that are not. Thus, determining which activities to develop and prioritise vis-à-vis funding from public resources versus those activities that should not be funded because they do not meet the minimum standard for effective treatment becomes more important.

The International Standards on the Treatment of Drug Use Disorders defines a set of requirements and attributes (that is, standards) that must be in place to initiate any form of outreach, treatment, rehabilitation or recovery service regardless of the treatment philosophy used and the setting in which it occurs. This is critically important, since individuals with drug use disorders deserve nothing less than ethical and science-based standards of care similar to the standards applied to treat other chronic diseases.

Principle 1. Treatment must be available, accessible, attractive and appropriate to the needs

Drug use disorders can be treated effectively in the majority of cases if individuals may access a wide-range of services covering the continuum of needs patients may have. Treatment services must match the needs of the individual patient at the specific phase of their disorder to include outreach, screening, inpatient and outpatient treatment, long-term residential treatment, rehabilitation and recovery-support services.

These services should be affordable, attractive, available in both urban and rural settings and accessible via extensive opening hours and a minimal wait time. All barriers limiting the accessibility to appropriate treatment services should be minimised. Services should not only offer dependency treatment, but also provide social support and protection as well as general medical care. In addition, the legal framework should

not discourage individuals affected from attending treatment programmes. The treatment environment should be friendly, culturally sensitive and focus on the specific needs and level of preparedness of each patient. This environment should encourage rather than deter individuals from attending a programme.

Principle 2: Ensuring ethical standards in treatment services

Treating drug use disorders should be based on the universal ethical standards — that is, respect for human rights and dignity. This includes responding to one's right to enjoy the highest attainable standard of health and well-being, ensuring non-discrimination and removing stigma. The choice to start treatment should be left to the individual. As such, treatment should not be forced upon or initiated against the will and autonomy of the patient. The consent of the patient should be obtained before any treatment intervention. Accurate and up-to-date medical records should be maintained and the confidentiality of treatment records should be guaranteed. Furthermore, registering patients entering treatment outside health records should not be permitted, whilst punitive, humiliating or degrading interventions should be avoided. The individual affected should be recognised as a person suffering from a health problem and deserving of treatment similar to patients with other psychiatric or medical issues.

Principle 3: Promoting treatment of drug use disorders through the effective coordination between the criminal justice system and health and social services

Drug use disorders should be seen primarily as health problems rather than criminal behaviour. In turn, wherever possible, drug users should be treated within the healthcare system rather than in the criminal justice system. Whilst individuals with drug use disorders may commit crimes, these are typically low-level crimes used to finance drug purchases, behaviour which ceases following effective treatment of the drug use disorder.

As such, the criminal justice system should collaborate closely with the health and social system offering the choice to enter treatment as an alternative to criminal prosecution or imprisonment. Law enforcement and court professionals alongside penitentiary system officers should be appropriately trained to effectively engage with treatment and rehabilitation efforts. If prison is warranted, treatment should also be offered to prisoners with drug use disorders during their incarceration and following their release since effective treatment will decrease the risk of reoffending. Continuity of care following release is of vital importance and should be assured or facilitated. In all justice-related cases, individuals should be provided treatment and care of equal standards to the treatment offered to those in the general population.

Principle 4: Treatment must be evidence-based and respond to the specific needs of individuals with drug use disorders

Evidence-based practices and accumulated scientific knowledge on the nature of drug use disorders should guide interventions and investments in treatment. The same high-quality standards required for the approval and implementation of pharmacological or psychosocial interventions in other fields of medicine should be applied to the treatment of drug use disorders. To the extent possible, only the pharmacological and psychosocial methods demonstrated as effective by science or agreed upon by an international body of experts should be implemented. The duration and intensity (dose) of an intervention should be aligned with evidence-based guidelines. In addition, multidisciplinary teams should integrate various interventions

tailored to each patient. Organising treatment for drug use disorders should be based on a chronic care philosophy rather than acute care interventions. Severe drug use disorder is quite similar in terms of the course and prognosis of other chronic diseases such as diabetes, HIV, cancer, or hypertension. Thus, a long-term model of treatment and care will most likely promote life-long recovery, a sustained cessation of drug use, the absence of drug-related problems and an enhanced physical, psychological, interpersonal, occupational and spiritual health status.

Principle 5: Responding to the needs of special subgroups and conditions

Several subgroups within the larger population of individuals affected by drug use disorders require special consideration and often specialised care. Groups with specific needs include but are not limited to adolescents, the elderly, women, pregnant women, sex workers, sexual and gender minorities, ethnic and religious minorities, individuals involved with the criminal justice system and socially marginalised individuals. Working with those special groups requires differentiated and individualised treatment planning that considers their unique vulnerabilities and needs. For some of these subgroups, special considerations will need to be addressed directly within every setting along the treatment continuum. In particular, children and adolescents should not be treated in the same setting as adult patients and should be treated in a facility able to manage other issues these patients face. Their care should encompass broader health, learning and social welfare contexts in collaboration with family, education and social services. Similarly, women entering treatment should have access to special protections and services. Women are vulnerable to the risk for domestic violence and sexual abuse, and their children may be at risk for abuse. Therefore, a liaison with social agencies protecting children and women are helpful. Women may require women-focused treatment in a safe single-sex setting to obtain the maximum benefit. Treatment programmes should be able to accommodate children's needs to allow parents caring for their children to receive treatment and support good parenting and child care practices. In addition, women may need training and support on issues such as sexual health and contraception.

Principle 6: Ensuring good clinical governance of treatment services and programmes for drug use disorders

Good quality and efficient treatment services for drug use disorders require an accountable and effective method of clinical governance that facilitates achieving treatment goals and objectives. Treatment policies, programmes, procedures and coordination mechanisms should be defined in advance and clarified to all therapeutic team members, administrators and target populations. Thus, service organisations need to reflect current evidence and be responsive to service user needs. Treating people with drug use disorders who often have multiple psychosocial and sometimes physical impairments remains challenging, both to individual staff and organisations. Staff attrition in this field is recognised and organisations need to have in place a variety of measures to support their staff and encourage the provision of quality services.

Principle 7. Integrated treatment policies, services, procedures, approaches and linkages must be constantly monitored and evaluated

As a response to a complex and multifaceted health issue, comprehensive systems must be engaged to facilitate the effective treatment of drug use disorders. A variety of services should be integrated in the case management of these patients, including mainstreaming primary healthcare delivery and multidisciplinary activities. A coordinating team should include psychiatric and psychological care, municipality-level social

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services support, support for housing and job skills or employment, legal assistance and specialist healthcare services (e.g., HIV, viral hepatitis and other infections). The treatment system must be constantly monitored, evaluated and adapted. This requires the planning and implementation of services in a logical, step-by-step sequence ensuring the strength of links between (a) policy, (b) needs assessment, (c) treatment planning, (d) the implementation of services, (e) the monitoring of services, (f) the evaluation of outcomes and (g) quality improvements.

The *AFEW Network* follows an additional important principle — that is, the meaningful involvement of the community. The participation of people who use drugs in the planning, monitoring and evaluation of the quality of services can significantly improve treatment and rehabilitation effectiveness.

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TREATMENT WITH A SPECIAL FOCUS ON ADOLESCENTS AND INMATE POPULATIONS

Among all populations, children and inmates represent the most vulnerable. Due to various limitations, these two groups typically experience inadequate access to drug use disorder treatment and cannot easily protect their rights. Thus, special attention should be paid to children and inmates within all standards and protocols.

Children and adolescents

Substance use disorders are critical paediatric illnesses. The earlier substance use begins, the greater the risk for more rapid progression to heavy use and use-related disorders. Experiencing drug dependence in childhood affects all areas of life causing long-term and sometimes irreversible negative consequences. Drug treatment for young people and children renders the need more acute, more urgent and more intensive. Children who use substances are unlikely to understand it as a problem for themselves or others in their lives; however, substance use — both licit and illicit — can harm a child's development. Moreover, such children will very likely need substance use and mental health services in future. Furthermore, children may reside with their families, or live on the streets as orphans or rejected from their family, may be conscripted into the military or live in correction system institutions. As a result, treatment circumstances and settings for these latter two groups of children may be quite different than traditional outpatient or residential treatment facilities, and may involve more outreach and drop-in centres than typical in the treatment of substance use disorders amongst adults.

Research on treatment for children and adolescents remains limited. Although encouraging evidence regarding the effectiveness of psychosocial treatment exists amongst older children, guidance regarding treatment for children often relies on research findings from treatment provided to adults or adolescents. However, such an approach to treating children with substance use disorders may present unanticipated problems including a different response to medications amongst children compared to adults. Finally, many psychosocial treatment options used amongst children must be tailored to their cognitive development and life experiences.

Other issues to consider when providing treatment for substance use disorders in children and adolescents include the following:

- Children and adolescent drug users have unique treatment needs related to their immature brains and cognitive functioning, as well as their limited coping skills related to their incomplete psychosocial development.
- Adolescents exhibit high levels of risk-taking and novelty-seeking behaviours and are quite responsive to peer pressure.
- Adolescents with drug use problems have a high prevalence of comorbid psychiatric disorders and family dysfunctions upon which treatment must focus.
- Children and adolescents may be less likely compared to adults to see the value in discussing their problems. Young people are more concrete in their thinking, less developed in their language skills and may be less introspective than adults.
- Behavioural treatment interventions must be adapted taking into account the limited cognitive abilities of children and adolescents.
- Children and adolescents may have different motivations than adults to participate in treatment and share treatment goals with a treatment provider.

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Given the onset of sexual activities and higher rates of sexual abuse amongst adolescents with drug dependence, testing adolescents for STIs such HIV, as well as hepatitis B and C, is an important part of drug treatment. Treatment should also include strategies such as social skills training, vocational training, family-based interventions and sexual health interventions including preventing unwanted pregnancies and STIs.

In addition, treatment should attempt to integrate other areas of socially involving adolescents such as through school, sports and hobbies and recognise the importance of positive peer relationships. Finally, treatment for adolescents should promote positive parental involvement where appropriate, and access to child welfare agencies must be available.

Inmates

More than 10 million people are incarcerated worldwide (approximately 146 per 100 000) and, in most instances, the majority of these individuals have a history of problematic drug use. In addition, a large percentage of individuals with problematic drug use not currently incarcerated report having been incarcerated at least once. In confined settings, such as in jails and prisons, the criminal justice system has a 'captive' audience that can benefit from the provision of effective treatment services. For those not confined, treatment services can be provided under a variety of conditions, such as through probation or parole, diversion and drug court programmes and, when appropriate, police referral to treatment rather than arrest. By ensuring that those who need treatment services receive them, significant decreases in drug use and criminal activity are likely and public health outcomes will improve (e.g., the decreased spread of hepatitis C, HIV, etc.). Left untreated, individuals with an extensive drug use and criminal history will most likely continue using and committing crimes, and pose a serious ongoing public health threat.

Providing drug treatment and rehabilitation services in the context of the criminal justice system must be based on the same principles of evidence-based treatment in any other field of medicine.

Women who use drugs represent another group requiring special attention. In most countries of EECA, women face a double stigma with less access to services. As such, this community requires special approaches and facilities reflecting their specific needs and which contribute to changing stigmatising attitudes.

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EVALUATING THE QUALITY AND EFFECTIVENESS OF DRUG TREATMENT

Many studies have indicated that treatment 'works' for a considerable number of clients. Roughly speaking, the 'rule of thirds' (Miller and Sanchez-Craig, 1996) seems to apply to treatment outcomes for both alcoholism and illicit drug use: about one-third of clients become abstinent; one-third improve but are not abstinent; and one-third do not improve following treatment.

Treatment interventions in the drug use field vary widely across as well as within countries. Often, these interventions are selected more for political or administrative reasons than because of their actual effectiveness. In addition, concrete evidence regarding the benefits of applying different approaches to different groups remains lacking. In an attempt to address this imbalance and to raise awareness of the effects of various treatment approaches, researchers have attempted to standardise the way information used in treatment-evaluation studies is collected and recorded. The two most commonly used techniques in evaluation research are retrospective, often naturalistic analyses, and prospective studies such as controlled clinical trials or randomised clinical trials. A third, less commonly used method is modelling.

Whilst cumulative evidence exists that treatment does 'work', it is also clear that most evidence comes from naturalistic studies that have used a wide variety of methods to evaluate treatment outcomes.

From the scientific perspective, four major obstacles limit the evaluation of treatment programmes:

- the non-comparability of research findings,
- disagreement about what constitutes a successful treatment outcome,
- the various measures used specifically related to drug use and
- the general absence of control groups.

Reaching consensus on what constitutes a successful treatment outcome remains one of the major problems. The majority of the literature views a successful outcome as the achievement of total abstinence from drug use. As such, many studies use the rate of total abstinence as the primary — and sometimes only — criterion for evaluating treatment as 'successful'. Other studies similarly report the frequency of substance use, while others record the time span involved and rates of relapse. In addition to abstinence and substance use, the employment and socio-psychological condition of clients may also be examined.

Another challenge lies in the evaluation of cost-effectiveness. This includes assessing users' needs and evaluating the costs and effectiveness in a systematic way to create clear policies on allocating available resources. Evaluating treatment approaches is now viewed as an integral part of programme management rather than as a purely scientific function, a tendency with historical precedent. Cost-effectiveness evaluations may be undertaken for one of two reasons: accountability or improving quality.

Substance-use services can be evaluated on many levels, including treatment activities and components, treatment services, treatment programmes and agencies and treatment systems (WHO, 1997). In terms of accountability, treatment programmes are evaluated to demonstrate their effectiveness to those who fund them. Accurate evaluations are required in order to allow for the differentiation of programmes and to advise policymakers on the quality of different interventions. Programme designers and managers face growing pressure to balance service delivery costs with results. Cost-effectiveness is thus often viewed as auditing, rather than as process evaluation. In most countries, economic evaluation is intended to maximise healthcare

using the available and often limited resources. A genuine economic evaluation requires two key elements:

- It must compare inputs or costs and outputs or effects.
- It must compare alternative treatment options.

The quality of treatment across European countries is ensured by applying evidence-based guidelines and finding consensus on standards. Quality typically includes:

- the availability of and adherence to guidelines;
- service standards, staffing levels and minimum requirements for staff qualifications;
- programme outcome documentation and evaluation; and
- links between financing and quality assurance.

For multiple reasons, this type of quality assessment represents an ineffective way of looking at drug treatment: good quality and user friendly drug treatment is a need expressed by PWUD globally, whilst in many countries drug treatment remains lacking, scarce or inaccessible.

Apart from this widely expressed need, it also remains clear that the objectives of drug treatment (breaking the cycle from addiction to greater control over their drug use leading to less harmful and risky ways of using and even to abstinence) vis-à-vis HIV prevention stands as one of the simplest ways to prevent HIV. Furthermore, in many countries HIV-positive PWUD will only be accepted for antiretroviral therapy (ART) when they are abstinent. Drug treatment can function as a way to initiate ART and with specialised support adherence rates appear rather promising. For instance, based on a model provided by an ART adherence unit in Pakistan within the 'Bridging the Gaps' programme, an inpatient facility exists where HIV-positive PWUD can enter for detox, initiate ART, learn about treatment adherence and receive follow-up support through service points across the country.

In general, the quality of rehabilitation is measured by indicating how many individuals remain abstinent, although this represents a narrow viewpoint. Rehabilitation can serve many more functions: it may lead to total abstinence, although it can also support an individual to self-control their drug use. A period of rehabilitation may also prepare individuals for safer and less harmful drug use by informing, educating and supporting safer injecting practices, preventing overdose and encouraging health check-ups, HIV testing and initiating ART when required. Thus, rehabilitation can improve the quality of life of the individual. Unfortunately, little evidence can be found on the effectiveness of rehabilitation vis-à-vis risks for HIV or other indicators beyond simple drug abstinence.

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I_GEORGIA

SUMMARY

According to a survey conducted in 2016, the estimated number of PWID in Georgia totalled 52 500 (50 000–56 000). National prevalence estimates for injecting drug use stands at 2.24% (2.13–2.39%) amongst adults aged 18 to 64 years and 1.41% (1.34–1.51%) amongst the general population.

The most popular drugs injected includes of suboxone (Subutex plus naloxone), 'conifer vint' (a home-made ephedra herb prepared to create an injectable amphetamine-like stimulant) and heroin including the coarse 'street-heroin' form known as 'sirets'. Multi-drug use is common. Dependency treatment in Georgia is regulated by the **'Law of Georgia on Drugs, Psychotropic Substances, Precursors and Narcological Aid'.** This law determines the source of funding for treatment and rehabilitation programmes covering drug users, including the corresponding rules as well as the voluntary character of assistance and conditions ensuring confidentiality.

Treatment for individuals suffering from drug dependency is provided by public, private and non-governmental organisations. Government funding covers OST (involving up to 5000 patients) and inpatient and outpatient detoxification (for opioid and non-opioid substances) followed by short-term primary rehabilitation services including consultations with a narcologist, medication and a course of psychotherapy. However, the funds allocated for detoxification and primary rehabilitation remain insufficient, such that services are not easily accessible and waiting lists are common.

Detoxification and substitution therapy (suboxone) are also available privately. Detoxification is only available in Tbilisi, whilst suboxone is available only in Tbilisi, Kutaisi, Batumi and Gori.

OST including both methadone and suboxone and opioid detoxification are regulated by guidelines from the Ministry of Labour, Health and Social Affairs of Georgia. Methods of non-opioid detoxification have been applied since the Soviet era, although no protocols have yet to be introduced.

Only one state-run facility provides detoxification and substitution treatment primarily through short-term **rehabilitation**. No long-term state residential rehabilitation services are available. Psychosocial rehabilitation is provided by three NGOs (two in Tbilisi and one in East Georgia). A range of methodologies are employed by these centres (Biblical, 12-step programmes, contingency management, cognitive behavioural therapy [CBT], art therapy and occupational therapy), but no uniform guidelines or effectiveness evaluation system for rehabilitation services have yet been developed in the country. Furthermore, NGO-based rehabilitation programmes largely depend on donor funding, potentially affecting their sustainability. In addition, the self-support movement is developing very slowly.

In general, **limited access** characterises the state of comprehensive drug treatment and rehabilitation services in Georgia, particularly outside the capital. The government does not support the full cycle of drug-addiction treatment (that is, long-term rehabilitation and resocialisation), thus affecting the effectiveness of treatment available. In addition, problems persist vis-à-vis access to services for women and youth due to a lack of gender-sensitive and age-specific programmes.

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NATIONAL DRUG POLICYREGULATORY FRAMEWORK FOR THE TREATMENT AND REHABILITATION OF PEOPLE WHO USE DRUGS

The legal circulation of drugs in Georgia is regulated by the ***Georgian Law on Drugs, Psychotropic Substances, Precursors and Narcological Aids*** (so-called Framework Law, adopted by the Parliament of Georgia in 2002 and amended in 2012). By contrast, the illegal circulation of drugs is regulated by the ***Administrative Offences Code of Georgia*** and the ***Criminal Code of Georgia***. The use of illicit substances is considered a violation of both codes.

Article 45 of the ***Administrative Offences Code*** states that illegal drug use without a doctor's prescription in the first instance during a year or the possession of a small amount of drugs for personal use only carry a fine of 500 Georgian Lari (GEL) (€170). In exceptional cases, the code provides for administrative imprisonment for up to 15 days. The same offences committed in the same year are considered a crime and are punishable under ***Article 273 of the Criminal Code***.

Under the ***Law on Combating Drug Crime*** adopted in 2007, the person who has committed a crime under Article 273 of the Criminal Code is deprived of a number of rights including their driving licence, working as a doctor or lawyer and being employed by public or local governance bodies amongst others. These measures are enforced through court resolution and are implemented for three or more years.

According to the ***Criminal Code of Georgia the following cases are considered crimes and should be punished*:** the illegal trade of drugs and/or psychotropic substances as well as the illegal manufacture, storage, production, selling, importation and export of psychotropic substances (for more detailed information, see the Criminal Code of Georgia, Chapter XXXIII: Drug-related crime).

The severity of punishment for drug-related crimes depends on aggravating factors such as the amount of drugs seized. Controlled amounts are regulated by the ***Framework Law*** which defines small, large or extremely large amounts for more than 200 narcotic substances and 67 psychotropic substances. For a number of substances commonly used in the country such as amphetamines, methamphetamine and desomorphine, small amounts are not defined by the law whereby any amount is considered a large amount. In response to the use of home-made desomorphine, the Framework Law on the joint initiative of the Ministry of Internal Affairs and the Ministry of Labour Health and Social Affairs was amended. These amendments outline the criminal liability for selling medications containing codeine, ephedrine, norephedrine and pseudoephedrine.
In response to the illegal circulation of new psychoactive substances, the ***Law on New Psychoactive Substances*** was enacted in 2014. New regulations were added to the Criminal Code, on the basis of which the manufacturing, purchase, storage and trafficking amongst others of new psychoactive substances (NSPes), including nine different classes of NPSes based on their chemical structure and a list of 20 substances, were criminalised.

Street drug testing for drug intoxication became an established practice in Georgia beginning in 2006. This practice is regulated through a joint order of the Ministry of Internal Affairs and the Ministry of Labour, Health and Social Affairs (***Order no. 1244-278/n***) issued as Article 45 of the Administrative Offences Code of Georgia. According to this order, the police are authorised to stop citizens in the street to perform a drug intoxication test if 'sufficient grounds for assuming drug intoxication' exist. Prior to 2013, 'reasonable suspicion' was sufficient to warrant such testing, but the ambiguity of this formulation made various interpretations possible. The existing punitive legal framework in Georgia does not allow for the implementation of a balanced drug-related strategy. Traditionally, the drug strategy in the country was more oriented towards the reduction in supply and punishment rather than on the reduction of demand and care.

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Currently, treatment and harm reduction service protocols are being elaborated.

Methadone substitution was introduced in Georgia in 2005 and is regulated by the Ministry of Labour, Health and Social Affairs of Georgia Order No. 302/n on ***'Approving methodology for implementing pilot programmes on substitution therapies for opioid drug addiction',*** dated 8 December 2005. Meanwhile, certain amendments were subsequently introduced.

A suboxone substitution therapy protocol was accepted in 2016, and subsequently approved by the Minister's order (approved by the Ministry of Labour, Health and Social Affairs of Georgia Order No. 01-139/o, dated 20 June 2016).

In addition, a special order was issued to regulate opioid substitution therapy in prisons (joint Ministry of Labour, Health and Social Affairs of Georgia and Ministry of Justice Order Nos. 266/n and 298, '***Implementation rules for substitution therapy programmes for opioid addiction within penitentiary institutions***').

The National Strategy for Combating Drug Addiction and the Action Plan for 2013 to 2017, developed on the basis of the strategy, were approved in 2013 by the Inter-Agency Coordination Council for Combating Drug Addiction within the Ministry of Justice. This is the main coordinating body for drug use–specific measures in Georgia. However, a large portion of the action plan (such as the development of institutional prevention mechanisms within the education system) is not supported by budgetary resources and cannot be implemented for various reasons. In addition, the implementation of the ***Action Plan*** is not monitored by government or non-governmental bodies. Thus, no evidence exists to evaluate its impact on the drug-use situation in the country.

The National Drug Policy Platform recently submitted a draft bill to the parliament of Georgia, which is expected to result in discussions during the 2018 spring session. The primary goal of this bill is to decriminalise drug use and the possession of small amounts of drugs by increasing the doses of all drugs for personal consumption. The proposed model envisions the introduction of four main components into the system of illegal drug use: 1) the prevention of drug use; 2) the establishment of commissions responsible for assessing client needs for services and creating mechanisms for referring drug users to appropriate programmes; 3) the enhancement of consulting and treatment services; and 4) the establishment of a social and psychosocial rehabilitation system.

In Georgia, treatment and harm reduction protocols are currently being drafted. Hence, if the above-mentioned bill is accepted, certain courses of action will require specific support, including the expansion of treatment and rehabilitation options, as well as establishing evaluation systems to measure the effectiveness of treatment, rehabilitation and other related services. Developing and updating manuals and programmes for professional development are essential, alongside identifying opportunities for specialists to acknowledge well-established (and, therefore, successful) treatment and rehabilitation programmes.

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CHARACTERISTICS OF THE DRUG USE SITUATION IN THE COUNTRY

A survey aimed at determining the size of the injecting drug user population was conducted in Georgia on four occasions using different methods, specifically the capture–recapture methodology, network size estimation and the multiplier-benchmark method. The expert consensus method was applied to the results from each survey to determine the size of the injecting drug user population. According to the most recent expert consensus, the estimated number of PWID stood at 52 500 (50 000–56 000), with a prevalence rate of 2.24% (2.13–2.39%) amongst adults aged 18 to 64 and 1.41% (1.34–1.51%) amongst the general population.

According to the National Centre for Disease Control and Public Health, in 2015, 170 women and 547 men were identified as newly detected cases of HIV in Georgia (NCDC 2015b). The incidence rate was 19.3 per 100 000 population. Before 2010, the main route for HIV transmission was injecting drug use. Later, heterosexual contact emerged as the primary transmission route. By 2015, the share of injecting drug use had dropped to 28.5%, whereas the share of heterosexual contacts increased to 50.2% of newly identified cases of HIV. The share of same-sex sexual cases has also increased (to 19.8%). From 18 811 HIV tests performed amongst PWID in 2015 under a state programme, 38 positive results were detected. The HIV detection rate was, thus, 0.2%.

According to the Bio-Behavioural Surveillance Survey conducted in seven Georgian cities (2015), the median age of initiating non-injecting drug consumption and injecting drug use has not changed since 2012, standing at 15 to 16 years and 18 to 20 years, respectively. This study identified various types of drugs consumed or injected by PWID during the month preceding the survey. In the combined sample, researchers found that 72.5% (n = 1476) had consumed drugs via non-injecting consumption during the previous month. Central nervous system depressants and hallucinogens were reported as the most popular non-injecting drugs. In addition, central nervous system depressants such as Baclophen, Gabapentin and Pregabalin amongst others were consumed by 69% of those who had taken drugs via non-injecting routes. More than half of this sub-sample reported taking hallucinogens. About 10% of non-injecting drug users mentioned the consumption of new psychoactive drugs, such as 'bio cannabis', 'crystal' or 'bath salt'. The use of these substances was more prevalent among younger drug users (<25 years) compared to their elder peers (23.6% vs. 8.5%).

The injecting drug use scene has significantly changed in recent years. Heroin stands as the most frequently used substance amongst drug users in Georgia, followed by buprenorphine. Yet, heroin use dropped in 2012, and then increased to the same level in 2015 (58.1%). Buprenorphine use also dropped in 2012, and increased up to 26% in 2014 and 2015. In comparison, a lower proportion of PWID reported using home-made opioid-type drugs such as desomorphine and amphetamine-type stimulants such as 'vint' or 'Jeff', compared to figures from 2012.

The majority of PWID have never attended drug treatment facilities. Only 6% underwent or were still receiving any kind of treatment. The number of PWID who survive an 'extreme need' without anyone's help reached at least in one in four respondents across cities. The coverage of preventive programmes (minimal coverage) has increased from 24% to 32.4% since 2012. Whilst awareness regarding syringe exchange programmes has improved in Telavi, Batumi and Zugdidi, in general, knowledge about such programmes remains low and requires improvement. Substitution therapy programmes are much better known amongst PWID. Furthermore, the prevalence of hepatitis C remains high among PWID, reaching 66.2% in all seven cities.

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'Marijuana is the most common option, but psychoactives (baclofen, gabapentine, diazepam from drugstores) have become more popular. Amongst injectable drugs, suboxone (Subutex plus naloxone), "conifer vint" (home-made preparation of an ephedra herb to obtain an injectable amphetamine-like stimulant) and heroin and its coarse "street-heroin" form, the so-called "sirec", are most common. Amongst youth, psychoactive "bios" are also common.'

'Multi-drug use is very common in our country depending upon availability. Desomorphine and "Jeff" use are down due to the restricted availability of their components, although ephedra harvesting in the Tbilisi surroundings for "vint", as well as club-based psychoactive substances, are up, particularly amongst the youth, leading to intoxication and lethal cases due to the consumption of unknown compounds.'

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AVAILABLE TREATMENT FORMATS (STATE-RUN, FAITH-BASED, COMMERCIAL AND NON -GOVERNMENTAL

Individuals suffering from drug dependency in Georgia may receive treatment from both public and private institutions, as well as from the non-governmental sector.

The types of treatment include: 1) abstinence oriented in- and outpatient treatment (detoxification) followed by short-term primary rehabilitation and short-term psychosocial rehabilitation and 2) substitution therapy. Through short-term primary rehabilitation, the patient can receive consultations from a narcologist, medication and a short course of psychotherapy.

One rehabilitation centre under state ownership — the Centre for Mental Health and the Prevention of Addiction in Tbilisi — currently operates in Georgia. Services provided by this centre consist of alcohol and drugs detoxification as well as primary rehabilitation. The centre also implements an MMT programme across the country. At present, 16 MMT sites in 10 cities of Georgia exist, and 2 MMT sites operate in 2 prisons.
The state provides vouchers to patients to cover the costs of two-week inpatient and two-week outpatient programmes. Under government order No. 308, dated 30 June 2015, the price of a 14-day treatment course shall not exceed 1600 Georgian Lari (GEL; €543), while the price of rehabilitation stands at GEL400 (€135).
The state also covers two weeks of methadone or suboxone detoxification in outpatient settings. Individual rehabilitation programmes extending for a longer period are available for a specific fee.
Since 1 July 2017, opioid substitution has been covered by the state budget, subsequently covering up to 5000 patients, whilst suboxone treatment programmes are offered by public and private organisations. Monthly payments for suboxone substitution treatment through for-profit clinics cost approximately GEL600 (€ 198).

Rehabilitation programmes are available from centres supported by donor organisations or via fee-for-services paid by patients. Yet, insurance policies do not cover any expenses related to such services.
In total, three non-governmental treatment or rehabilitation centres operate in Georgia: the Centre for Psychosocial Rehabilitation 'Kamara' (Tbilisi), the rehabilitation centre 'Tanadgoma' or the Centre for Information and Counselling on Reproductive Health (Kvareli municipality, in the village of Gremi) and Teen Challenge Georgia (Tbilisi). These centres are primarily financed by international donor organisations. Two of these offer their clients services for free; the cost of the third is GEL400 (€135) per month. 'Tanadgoma' and Teen Challenge Georgia offer inpatient care, whilst 'Kamara' operates as an outpatient facility. The duration of these programmes varies from 1 to 12 months.

In total, six private commercial clinics also operate in Georgia, all of which are situated in Tbilisi, the capital of Georgia. These clinics provide detoxification and primary rehabilitation services, which may last from 5 to 28 days. The cost for treatment varies from GEL200 to GEL4000 (€68–1357). One clinic, 'Uranti', also offers a suboxone programme.

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THE MOST COMMON APPROACHES TO TREATMENT AND REHABILITATION

The key basic treatment and rehabilitation methods established in Georgia include the following:

- Detoxification and primary rehabilitation (i.e., medical-psychological tool).
- Opioid substitution therapy (i.e., methadone and suboxone).
- Psychosocial rehabilitation (two inpatient centres, one outpatient centre) and self-help support groups.

The goal for detoxification is to relieve withdrawal syndrome manifestations. Both non-opioid approaches and opioid substitution (relying on methadone or suboxone) are well established in Georgia. The broad set of medications used for non-opioid detoxification include sedatives, painkillers, neuroleptics, anticonvulsant drugs, muscle relaxants, antidepressants and tranquilizers. The treatment regimen depends on the type of substances, doses and duration of use resulting in dependency as well as drug-use practices. Treatment lasts on average 10 to 14 days. Methods currently used have been applied since the Soviet period, although no protocols or evaluation systems are in place.

In Georgia, detoxification is followed by a short-term medical-psychological rehabilitation (two or more weeks), although long-term psychosocial rehabilitation remains problematic. Currently, no state residential rehabilitation services are available, and only a few outpatient or ambulatory initiatives exist. Therefore, relapses following detoxification remain statistically quite common.

For psychosocial rehabilitation, as mentioned above, two inpatient and one outpatient facilities operate in Georgia. Different methodologies are used, including Biblically-based, 12-step programmes, contingency management, CBT, art therapy and occupational therapy. The self-help support movement is developing extremely slowly. Furthermore, no evaluation systems measuring effectiveness have been established.
For OST, methadone and suboxone are both available.

Short-term OST in prisons is provided as a method of detoxification in two institutions, colony Nos. 2 and 8, as well as at medical facility No. 18, where OST is available for female inmates. No data on the effectiveness of this programme is available.

In addition, the 'Atlantis' programme is functioning in two penitentiary establishments: women's prison No. 5 and colony No. 2. Various NGOs periodically carry out different rehabilitation activities that facilitate the psychosocial rehabilitation of drug users. For example, the 'Tanadgoma' Centre for Information and Counselling on Reproductive Health has provided trainings on CBT and self-help groups for prison staff. These methods are used in prisons to support the psychosocial rehabilitation of prisoners who use drugs.

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ACCESS TO TREATMENT AND REHABILITATION SERVICES

Certain financial and geographical barriers to treatment accessibility persist in Georgia. Primarily, specialised clinics are mainly situated in the capital. The only public clinic is located in Batumi, although it is currently reorganising and may shift its inpatient status.

In recent years, access to treatment has improved. The state budget for treatment has increased from 0 to GEL5–6 million (€1.7–2 million). However, the funds allocated for detoxification and primary rehabilitation remain insufficient and inaccessible to all beneficiaries. As several experts stated during their interviews, waiting lists for treatment remain rather long. Access to specific treatment programmes (for example, suboxone) is rather limited. Furthermore, methadone is available only within the scope of state programmes, where it is administrated on a daily basis. No alternatives are available and, hence, suboxone remains expensive and, therefore, inaccessible to many patients.

Ideally, detoxification and primary rehabilitation should be followed by rehabilitation and resocialisation within both inpatient and outpatient settings. Facilities providing long-term behavioural changes are relatively unavailable. In total, only three centres provide such services, consisting of one inpatient and one outpatient centre, respectively, in Tbilisi, and one inpatient centre in eastern Georgia, for a total of approximately 20 inpatient posts across all centres. Furthermore, these centres are primarily supported by a donor organisation, rendering their sustainability at risk.

Substantial limitations are obvious vis-à-vis treatment options targeting women who use drugs, particularly as stipulated by the country-specific cultural context. Women who use drugs are stigmatised, so they often refrain from participating in treatment programmes and remain less involved.

Finally, access to services to younger (or underage) drug users is limited. Most private and non-governmental treatment and rehabilitation facilities do not accept patients under the age of 18. Some services, however, can be obtained by adolescents with the consent of their parents or guardians, including detoxification and medical diagnostics amongst other services.

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QUALITY OF SERVICES

In Georgia, no system exists to assess the quality and approved criteria related to the effectiveness of treatment and rehabilitation services. Currently, the protocol on the provision of harm reduction services is under development. Experts believe that the development of assessment tools and standards of rehabilitation services might significantly improve access to such services as well as their quality.

Within existing OST and harm reduction programmes, various evaluation indicators have been set including relapse, the involvement of clients in the programme and others. The manager of a facility oversees the quality of medical services and their compliance with job descriptions based on the facility's statutes, but no other activities or results are supervised on a regular basis.

Commercial clinics and non-governmental rehabilitation centres typically implement internal monitoring mechanisms according to their own procedures and can provide information upon request. When funding is provided by a donor organisation or the state, reporting is based on their requirements. If a facility is not engaged in state or donor programmes, reporting remains an internal procedure. Students of the state medical university who wish to become narcologists upon graduation enrol in a residency training programme in the field. In order to work as narcologists, they must also to take an exam in narcology and obtain a licence. Social workers and psychologists undergo a training course in narcology (mostly theoretical in content) while studying at the university. They do not need a special licence to work in the field.

The private university Iliauni offers a Master's course on addiction studies, focussing on research and situation analyses in particular (http://iliauni.edu.ge/en/iliauni/AcademicDepartments/mecnierebata-da-xelovnebis-fakulteti-269/programebi-303/mecnierebata-da-xelovnebis-fakulteti-samagistro-programebi/adiqciis-kvlevebi).

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RECOMMENDATIONS

The following recommendations were put forth by Georgian experts or result from an assessment of current legislation and practices in the country.

- **Improve access to treatment and comprehensive rehabilitation.**

'Improve and increase access to treatment and rehabilitation. Support post-treatment processes such as establishing a comprehensive socialisation programme.'

'Treatment effectiveness is substantially related to its duration – a minimum of three months is required (15 days inpatient and 75 days outpatient).'

'Outpatient care should be integrated into state funding (nowadays, it is set only for inpatient care).'

'Mechanisms for social rehabilitation, education and employment should be engaged by creating a network of rehabilitation units.'

- **Introduce scientifically based approaches to treatment and rehabilitation.**

'My recommendation to AFEW International is to introduce new, successful approaches to treatment and rehabilitation and to support the implementation of these approaches in Georgia.'

'Elaborate upon a long-term rehabilitation country-wide system.'

'Geographical extension of inpatient options.'

- ***Revise guidelines on OST administration.***

'Allow OST dose-outs (still prohibited by Ministry order, thus everyday admission is required to receive the dose) and implement a programme supporting substitution therapy inside the prison system.'

'Level up the single suboxone doses (general guideline overview).'

'Positive encouragement practices in OST for adherent patients are welcome.'

- **Improve the quality of care.**

'Unified criteria for evaluation and quality assurance, creating missing and updating or renewing existing protocols to improve the quality of care.'

'Human resources (physicians and other personnel) are subject to capacity-improving training and re-training.'

- **Develop guidelines for non-opioid detoxification.**

- **Introduce gender-sensitive and age-specific (for adolescents) programmes.**

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II_THE KYRGYZ REPUBLIC

SUMMARY

As of 1 January 1 2017, official statistics from the Kyrgyz Republic indicated that 8428 people were registered as drug dependent and 115 individuals were registered as dependent on psychoactive substances not classified as drugs.

An estimated 25 000 people inject drugs in the Kyrgyz Republic (based on sentinel surveillance data from 2015). The most commonly used drugs include anasha (cannabis), hashish and heroin. Young people often prefer using volatile solvents, such as 'carb', 'Moment' glue and gasoline. Synthetic drugs such as 'salt' and 'spice' are also becoming popular.

The state policy of the Kyrgyz Republic on drug control is implemented within the framework of the **Anti-Drug Programme** approved by Decree No. 54 of the Kyrgyz Government, dated 27 January 2014. This programme aims to coordinate anti-drug activities amongst state bodies, local authorities and civil society, as well as establish effective state and public control over the drug use situation in the country. In addition, the state programme specifies all types of drug prevention, whereby tertiary drug prevention is described as a set of measures aimed at relapse prevention, as well as the further rehabilitation of persons with drug dependence.
Drug treatment, including the rehabilitation of persons dependent upon psychoactive substances, is provided by state medical institutions run by the Ministry of Health, penitentiary system medical institutions, private narcologists and NGOs.

State drug treatment facilities offer the following types of treatment:

1. Detoxification carried out by inpatient and outpatient facilities in all state drug treatment institutions.
1. Methadone maintenance therapy (MMT, which, as of 1 October 2017, consisted of 32 MMT sites operated throughout the country with a total coverage of 1223 clients (including 105 women). This includes 450 individuals receiving services through the penitentiary system.
2. Inpatient medical and psychological rehabilitation and outpatient rehabilitation programmes.

Currently, rehabilitation services are provided at two state treatment facilities: a rehabilitation outpatient office at the Republican Narcological Centre in Bishkek and a rehabilitation ward with five beds at the Osh Interdepartmental Narcological Centre. Consultations with a narcologist and a psychologist are available at local drug treatment offices countrywide.

Drug addiction treatment in the penitentiary system

In total, nine MMT sites operate within the penitentiary system, including two at pretrial detention centres, six at closed correctional facilities and one in a settlement-type prison colony.

The rehabilitation programme in the penitentiary system relies on the 'Atlantis' programme, treatment for drug dependence based on the Minnesota model. Another programme called the 'Clean Zone' is available for those who successfully complete treatment via 'Atlantis'.

Drug dependency treatment through private clinics

In the Kyrgyz Republic, detoxification services are widely available through private clinics, although Dr. Nazaraliev's clinic is the only private rehabilitation-type clinic. The cost of rehabilitation in this clinic can be as high as €1695 per month, with an average duration of 35 to 40 days, reaching in some cases up to a year.

II_THE KYRGYZ REPUBLIC

Non-governmental organisations providing rehabilitation services

Currently, one non-governmental rehabilitation centre— Centre Plus — operates in the Kyrgyz Republic in Osh on a self-financing basis. This centre can accommodate up to 18 individuals and offers a rehabilitation programme lasting up to six months.

The Kyrgyz Republic has a large number of NGOs providing services to people who use psychoactive substances. These include:

- social institutions;
- drop-in centres which provide clients with information, medical and psychological services and social support;
- social housing providing clients with a place of residence;
- halfway houses providing clients with the opportunity to undergo a course of adaptation therapy, ensuring client participation in the drug dependence rehabilitation programme and further social adaptation; and
- a social bureau for people who inject drugs (PWID) and people living with HIV released from prisons.

Recently, due to insufficient funding, some NGOs closed.

The following rehabilitation models and approaches are most widespread in the country:

- those based on a therapeutic community (TC);
- those based on psychotherapeutic and rehabilitation self-help groups (Alcoholics Anonymous (AA) and Narcotics Anonymous (NA));
- faith-based organisations operating as TCs within a religious context; and
- those based on an outpatient rehabilitation model (individual work between a psychologist or psychiatrist and the client).

To assess the quality of treatment, the Kyrgyz healthcare system control functions are entrusted to the Obligatory Health Insurance Fund (OHIF), which also distributes financial resources. Quality control of services is carried out by the licencing department of the Ministry of Health in accordance with the approved standards of services and established treatment quality indicators.

The licencing of private medical activities and the private health sector is carried out in accordance with the regulations and orders of the Ministry of Health of the Kyrgyz Republic. This licencing applies only to narcology and psychiatry and is not required for social and psychological rehabilitation services. Monitoring and evaluation of the quality of services in the non-governmental sector depends on their specific activities and the requirements of the funding agencies.

All practicing physicians must undergo primary specialisation and take mandatory advance training courses every five years.

The Kyrgyz State Medical Institute for Retraining and Professional Development (KSMIRPD) within the Department of Neurology, Neurosurgery and Psychiatry provides training to narcologists and psychiatrists. This training includes rehabilitation-related issues, although only a few hours are allocated to these issues.

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KSMIRPD also provides online training on drug dependence and harm reduction for medical and non-medical professionals, with financial support from international organisations (via the learn.aids.gov.kg website and the KSMIRPD website). However, whilst appropriate curricula and programmes have already been developed for psychiatrists and narcologists, such programmes and manuals remain insufficient for specialists from related fields (i.e., psychologists, educators and social workers).

Access to detoxification and substitution therapy services may be considered satisfactory, although certain barriers persist, such as the cost of detoxification if a copayment is necessary or being officially registered as a drug-dependent patient when entering substitution treatment programmes. People who use drugs can receive consultations from a narcologist and a psychologist via local drug treatment clinics nationwide. Yet, the availability of inpatient rehabilitation programmes for people with drug dependence remains exceptionally low.

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NATIONAL DRUG POLICY

The Anti-Drug Programme approved by Decree No. 54 of the Government of the Kyrgyz Republic, dated 27 January 2014, describes the main types of drug use prevention.

The state policy of the Kyrgyz Republic in the area of drug control envisions the following strategic directions aimed at reducing:

- offers of illicit drugs,
- the demand for illicit drugs and
- harm related to drug use.

The main objectives of the state anti-drug programme are:

- to reduce the volume of illicit drug trafficking,
- to reduce drug use and the negative consequences associated with it and
- to ensure the availability of drugs and psychotropic substances to meet public health needs.

A number of strategic issues should be addressed for the successful implementation of the drug control programme. These include:

- developing a state system of primary, secondary and tertiary drug prevention focussing on primary prevention;
- combating drug crime and corruption particularly their organised forms;
- improving state control system over the legal turnover of narcotic drugs, psychotropic substances and their precursors;
- strengthening law enforcement to counter illicit drug trafficking;
- developing the narcological care system;
- reducing the harm associated with illegal drug use (e.g., HIV, viral hepatitis and other adverse consequences);
- enhancing organisational, regulatory and resource support for anti-drug activities;
- involving civil society in anti-drug prevention activities; and
- raising the level and effectiveness of international cooperation.

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CHARACTERISTICS OF THE DRUG USE SITUATION IN THE COUNTRY

Few assessments of the number of drug users in the country have been completed. Accordingly, UNODC carried out the first study on drug use prevalence in the Kyrgyz Republic in 2002. Based on that study, the estimated number of drug users in the Kyrgyz Republic reached 80 000 to 100 000 people (2.62% to 3.27% of the total population aged 16 to 64), amongst whom 54 000 (1.77% of the total population aged 16 to 64) reported injecting drug use.

Subsequently, a similar study was carried out with UNODC support in 2006, revealing that the number of problematic Kyrgyz drug users stood at 26 000 (495 per 100 000 general population), amongst whom 25 000 represented people who inject drugs (476 per 100 000 general population).
The most recent study, conducted in 2015, used sentinel epidemiological surveillance (SES) indicators, revealed a total of 25 000 people who inject drugs.

Official statistics maintained according to an order from the Ministry of Health of the Kyrgyz Republic, 'Compulsory accounting of persons with certain types of substance use disorders', registers individuals with a dependence on psychoactive substances, including alcohol, at narcological facilities. The following figures were recorded as of 1 January 2017:

- a total of 8428 people, including 501 women and 1 person under 18 with a drug addiction;
- a total of 115 people, including 7 women and 12 persons under 18 with a dependence on a psychoactive substance not classified as a drug; and
- a total of 33 562 people, including 3809 women and 0 persons under 18 with a dependence on alcohol.

The primary incidence rates for 2016 were as follows:

- a total of 354 people, including 16 women and 0 persons under 18 with a dependence on drugs;
- a total of 12 people, including 0 women and 7 persons under 18 with a dependence on a psychoactive substance not classified as a drug; and
- a total of 1697 people, including 199 women and 0 persons under 18 with a dependence on alcohol.

A downward trend is visible regarding the number of people registered under observation in narcological facilities with a dependence on psychoactive substances.

The following statements were made during the expert interviews regarding the drug use scene in the Kyrgyz Republic.

'Heroin (opium) and marijuana (cannabis) are popular in the country. Recently, synthetic drugs such as "spice" have become more common. Youth often use inhalable solvents, such as "carb", "Moment" glue and petrol".'

'I think hashish use is the most prevalent, followed by heroin.'

'Mostly, they use heroin, whilst new drugs such as "spice" are appearing now. But, it is young people who are more into it.'

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REGULATORY FRAMEWORK FOR THE TREATMENT AND REHABILITATION OF PEOPLE WHO USE DRUGS

The following primary regulatory documents govern the activities of narcological services:

Laws:

- The law ***'On Narcotic Drugs, Psychotropic Substances and Precursors',*** which establishes a unified procedure for the legal turnover of controlled substances and actions to combat illicit drug trafficking (1998).
- The law ***'On HIV/AIDS in the Kyrgyz Republic',*** which defines the procedures for the legislative regulation of HIV prevention in the territory of the Kyrgyz Republic.
- The law ***'On Medications'.*** This law focuses on narcotic drugs and psychotropic substances used in medicinally healthcare settings and subject to state control. The regulatory and legal framework of the country allows for the acquisition of syringes and needles through the pharmacy network at any time of day and imposes no ban on the implementation of needle and syringe exchange programmes.

Resolutions:

- Resolution of the Government of the Kyrgyz Republic ***'On the Procedure for Recording, Storing and Using Narcotic Drugs, Psychotropic Substances and Precursors in the Kyrgyz Republic'.***
- Decree of the Government of the Kyrgyz Republic ***'On Narcotic Drugs, Psychotropic Substances and Precursors Subject to Control in the Kyrgyz Republic'.***

Programmes:

- ***'State Programme on the HIV Epidemic Stabilisation in the Kyrgyz Republic for 2013–2016'.***
- ***'Anti-Drug Programme of the Government of the Kyrgyz Republic'.*** This programme aims to coordinate the anti-drug activities of state bodies, local governments and civil society by establishing effective state and public control over the drug use situation in the country. The programme also defines all types of drug prevention, where tertiary drug prevention is described as a set of measures aimed at preventing substance use disorder (SUD) relapse and complications, as well as additional rehabilitation services for dependent persons.

Orders and regulations:

- Clinical protocol ***'Treatment of opioid dependence on the basis of methadone maintenance therapy',*** dated 29 May 2015.
- ***'Clinical Guidelines for Methadone Substitution Maintenance Therapy in Patients with Opioid Dependence Syndrome'***, decree No. 49, dated 11 November 2010.
- Clinical manual ***'Diagnosis and treatment of mental and behavioural disorders caused by the use of opioids'***, decree No. 825, dated 25 December 2012.
- Clinical protocol ***'Assistance in cases of opioid overdose',*** dated 2013.
- ***'Standards for the provision of medical services for injecting drug users',*** approved by Order No. 494, dated 8 October 2010. This includes the standards of detoxification for opioid withdrawal in the inpatient unit of the Republican Narcology Centre, the standards for naloxone prevention of opioid overdoses and the standards of rehabilitation of persons with opioid dependence.
- ***'Regulations for the Narcological Rehabilitation Centre'***, approved by Order No. 65 of the Ministry of Health of the Kyrgyz Republic, dated 12 February 2004. This document from the Ministry of Health regulates the activities of the rehabilitation centre, its goals, primary tasks, functions and the main activities of the centre.
- ***The Computerised Adaptation and Training Tool (ICATT)*** video modules (basic and advanced) for the provision of narcological assistance to groups with special needs (patients with comorbid psychiatric

disorders, minors and women including pregnant women). These training modules include access to a variety of educational materials, scientific reviews and videos and testing before and after training. These modules are only available to those completing training at KSMIRPD.

- Clinical protocols ***'Neonatal abstinence syndrome'*** and ***'Application of the ASSIST questionnaire in primary healthcare'*** for the management and provision of comprehensive care for pregnant women who use psychoactive substances, in particular, opiates, and withdrawal syndrome management in the newborns of mothers who use psychoactive substances.

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AVAILABLE TREATMENT FORMATS (STATE-RUN, FAITH-BASED, COMMERCIAL AND NON -GOVERNMENTAL

Drug treatment, including the rehabilitation of people dependent on psychoactive substances, is provided in Ministry of Health state-run medical facilities, penitentiary system medical facilities and from private narcologists and NGOs.

Types of treatment in public institutions

1. Detoxification

Detoxification is provided through inpatient and outpatient services via all state drug treatment facilities. These facilities include 39 narcological cabinets within district family medicine centres in 3 institutions in Bishkek (the Republican Narcological Centre with an inpatient department consisting of 180 beds), Osh (Osh Interdepartmental Narcological Centre with a 50-bed hospital, 5 situated in the rehabilitation department), Zhalalabat (the drug treatment department consisting of 30 beds in the Zhalalabat Mental Health Centre), as well as five locations merged with oblast-level hospitals (a number of beds allocated for SUD treatment within the mental health and narcological departments of regional unified hospitals with a total capacity of 45 beds in the oblasts of Naryn (5), Issyk-Kul (12), Talas (10), Zhalalabat (5) and Batken (13)).

Patients pay 330 to 2980 Kyrgyzstani Som (KGS) (€4–37) for 7 to 14 days of detoxification. The amount depends on the client category (e.g., recipient of social benefits, insured persons, etc.).

2. Methadone maintenance therapy (MMT)

Methadone maintenance therapy (MMT) for opioid dependence syndrome is available only in state treatment and prevention facilities. MMT was introduced in the Kyrgyz Republic in 2002 with support from the Soros Foundation-Kyrgyzstan and the United Nations Development Programme (UNDP). Beginning in 2005 and continuing to today, MMT offices operate through funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and this substitution therapy programme remains free-of-charge for clients. Detoxification from polydrug use is also free-of-charge for programme participants.

MMT in the Kyrgyz Republic is provided in accordance with the clinical protocol ***'Treatment of opioid dependence on the basis of methadone maintenance therapy',*** dated 30 June 2015, and ***'The Clinical guidelines for methadone maintenance therapy in opioid dependence syndrome',*** dated 11 August 2010.

MMT was included in a previous version and the newly revised ***'National HIV Programme in the Kyrgyz Republic for 2017–2021'***. All MMT offices in the Kyrgyz Republic are included in the Register of Legal Drug Turnover Entities subject to state regulation and control in accordance with the law of the Kyrgyz Republic ***'On Rules for the Storage, Accounting, Reporting of Narcotic Drugs'.*** Methadone in the Kyrgyz Republic is included in the schedule I list of narcotic drugs subject to national control, and has been included in the list of essential medicines of the Kyrgyz Republic since 2006.

The development and expansion of MMT represents a strategy for secondary drug prevention in the Anti-Drug Programme of the Government of the Kyrgyz Republic by degree No. 54, dated 27 January 2014.

The methadone maintenance therapy programme (MMTP) is implemented in 32 sites of the Kyrgyz Republic, including within the penitentiary system as of 1 January 2017, amongst which 30 sites currently offer MMT. The programme covers 1223 individuals, including 105 women, amongst whom 450 individuals including 19 women receive MMT through the penitentiary system. Methadone is administered to patients in liquid form.

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A total of 21 MMTP sites are situated in healthcare organisations in the Kyrgyz Republic (five sites in Bishkek, seven in the Chuya oblast, four in Osh, three in the Osh oblast, and one each in the Zhalalabat oblast and the Batken oblast). The penitentiary system operates nine MMTP sites, including two at pretrial detention centres, six in correctional colonies and one at a prison colony settlement. The site at correctional colony No. 27 does not currently function due to the absence of inmates who inject drugs, and the site at Zhalalabat correctional facility No. 10 was suspended in July 2017. A total of ten sites provide 'one-stop shop' services, including TB and infectious disease services.

Detoxification and the prevention of mother-to-child HIV transmission (PMTCT) are accompanied by counselling aimed at motivating patients to receive and continue treatment, as well as preventing relapse and overdose. Naloxone prevention for overdose is now included in the overall package of harm reduction programmes (via syringe exchange points).

3. Medical and psychological rehabilitation

3.1. Rehabilitation in state healthcare facilities

A state-run rehabilitation programme has been implemented since December 2003 in the Republican Narcological Centre within the framework of the UNODC regional project 'Expansion of prevention, treatment and rehabilitation services for injecting drug users in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan'. In the Kyrgyz Republic, this entailed implementing the subproject, 'Creation of a system of medical, psychological and psychosocial rehabilitation of persons with drug use disorders in Bishkek'.

Until recently, the Narcological Rehabilitation Centre (also referred to as 'rehabilitation department') within the Republican Narcological Centre offered the initial stage of rehabilitation services for people with psychoactive SUDs. All rehabilitation centre employees received training on various levels of the rehabilitation process at the Republican Scientific and Practical Centre for Medical and Social Problems of Drug Addiction in Pavlodar City, in the Republic of Kazakhstan.

The fundamental legislative framework was developed, whereby the rehabilitation process is understood as a complex of medical, social and psychological activities aimed at preventing dependence progression, achieving recovery or the acquisition of proficient life skills and reintegration into society.

The rehabilitation centre at the Republican Narcological Centre successfully operated with support from international organisations and achieved a good indicator of success via the number of relapses. However, following the termination of financing from international organisations and a transition to a copayment system, many of the trained specialists left the rehabilitation centre. This weakened its operations, leading to a restructuring of the outpatient department for psychological assistance to persons with SUDs.

In accordance with existing regulatory documents, the Narcological Rehabilitation Centre is a healthcare facility or a subdivision of a healthcare facility specialising in addiction treatment providing specialised rehabilitation assistance to persons with drug-related disorders. The Rehabilitation Department is a structural unit of the Republican Narcological Centre of the Ministry of Health.

The main tasks of the rehabilitation centre are as follows:

1. The development and implementation of medical and social rehabilitation programmes for patients aimed at forming resilient attitudes to achieve abstinence.
2. The strengthening of the patient's independence, fostering self-discipline and a readiness for mutual assistance.

3. The formation and training of healthy lifestyle habits in real-life situations of self-service, communication, work and leisure.
4. Supporting the formation of harmonious interpersonal relationships within the microgroup of patients, in particular, the family, involving family members in rehabilitation and relapse prevention programmes and training in methods to overcome conflicts and stressful situations.
5. Participation in establishing public psychotherapeutic and rehabilitation self-help groups outside the rehabilitation centre (such as AA, NA, etc.).

Currently, rehabilitation services in the Kyrgyz Republic are available via two drug treatment facilities: in an outpatient rehabilitation office at the Republican Narcological Centre in Bishkek and a rehabilitation department with five beds in Osh in the Osh interdepartmental centre of narcology. Consultations with a narcologist and a psychologist are also available in local drug treatment offices. Inpatient rehabilitation can last up to 30 days, whilst outpatient services vary in duration depending on the needs of the patient. On average, outpatient services last about a month.

The main conditions for admission to rehabilitation programmes consist of a preliminary detoxification therapy and a high level of patient motivation for treatment, along with the absence of exacerbating somatic, neurological and mental illnesses.

3.2 Rehabilitation programmes within the penitentiary narcological service

Republican legislation distinguishes between voluntary and compulsory treatment. Voluntary treatment of dependence on psychotropic substances is provided via public and private medical institutions, as well as by a number of NGOs. In penitentiary system medical institutions, compulsory treatment is provided upon a court verdict imposing such, whilst voluntary treatment in rehabilitation centres is also available.

Rehabilitation in the penitentiary system relies on the 'Atlantis' programme, based on the Minnesota model to treat of persons with SUDs.

During the development and implementation of this programme in the penitentiary system of the Kyrgyz Republic, the long-term experiences of Atlantis in Poland and the Kyrgyz AA and NA communities were applied.

'Atlantis' rehabilitation centres have been functioning within the penitentiary system of the Kyrgyz Republic since March 2004 in prison Nos. 3 and 47, and since 2007 in prison Nos. 2, 10, 27 and 31.

The goals of the rehabilitation programme are as follows: to provide patients with objective information about substance dependence; to create the conditions necessary to identify the disease and recognise that the patient has lost control over their use of alcohol and drugs; to assist with understanding the psychological mechanism of chemical dependence; and to explain to the patient the possibility for the constructive manifestation of their emotions.

In the penitentiary system, the 'Clean Zone' programme also operates, which is available following successful treatment through 'Atlantis'. 'Clean Zone' operates only within the penitentiary system, in a special isolated area inside a prison. It imposes certain rules, without the typical lattices on windows and clean bunks instead of prison beds. In addition, study and living quarters, a dining room and a gym are available. The 'Clean Zone' is available only to prisoners who completely reject drug use, and the programme offers treatment specifically based on stress therapy. Initially, withdrawal syndrome is managed by completely abstaining from all psychoactive substances, and inmates practice psychological exercises. Prisoners in the 'Clean Zone' receive

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therapeutic and psychological courses, as well as professional training, for instance, as carpenters or hairdressers. They are also granted the opportunity to 'communicate' with the outside world via the internet.
Furthermore, NGOs can also provide psychological and social support to prisoners who participate in the 'Atlantis' programme as well as those who leave prisons.

'There is an "alternative in narcology" initiative. They arrive every Friday to correction facility No. 31. They carry out mini-sessions and peer-to-peer counselling. Moreover, through a social worker from this facility, they work with those prisoners nearing release. That is, they help with accommodation and restoring documents.'

Narcological care in private clinics

Private clinics providing detoxification to people who use psychoactive substances are widespread in the Kyrgyz Republic, although Dr. Nazaraliev's clinic is the only private clinic offering rehabilitation type services.

The cost of detoxification services stands at KGS1300 to KGS1500 (€16–19) per day, with rehabilitation starting at €1695 per month. The average duration of rehabilitation is 35 to 40 days; however, in some cases, it may last as long as one year.

In Dr. Nazaraliev's clinic, after detoxification and the normalisation of metabolism, the patient proceeds to the second stage of rehabilitation, namely, psychotherapy aimed at stabilising the psychological state, reconstructing the personality and resocialising.

Physicians provide patients with personality-oriented therapy, the main task of which is to develop healthy motivations, resistance to stress and the prolongation of psychological remission. Patients go to the Ak-Tengir ('Light Space') resort area located on the southern shore of the Issyk-Kul mountain lake for seven to ten days. During this time, they master psychoenergetic transformation sessions based on Dr. Nazaraliev's programme called 'mindcrafting'.

The programme includes Absolutus breathing training, Sri Aurobindo's integral yoga system, Dervish dancing, the AUM sound system training (sound tonograph for 'body wave tuning'), lapidopsychotherapy (meditation with stones) and Shavasan relaxation training. Therapeutic trainings were developed by Dr. Nazaraliev to encompass the spiritual practices of the East and the pragmatic approach of the West. These practices allow a person to control their dependence with the help of breathing, by activating their creativity and imagination, moving away from their problems and shrugging off any psychological burden, bad memories and negative emotions. Patients are directed to place them onto a stone in order to throw it literally and figuratively 'out of the soul', hurling it from the top of Tashtar-Ata (Salvation Mountain). In combination, the training complex allows patients to psychologically improve their personality and reinforce their motivation to adopt a healthy lifestyle.

During the final stage of Dr. Nazaraliev's rehabilitation, the patient can choose a 280-km long pilgrimage to the Tashtar-Ata (Salvation Mountain) or stress-energy psychotherapy (defined as an imperative suggestion for the motivation to abandon drugs). On the last day, the patient is brought to Tashtar-Ata, where they throw their stones on a man-made barrow, burn an object reminiscent of their past and tie a ribbon to a hawthorn bush. This is how the new attitudes and values of a person free from addiction are 'anchored'.

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Non-governmental organisations (NGOs) providing rehabilitation services

Until 2006, the rehabilitation centre 'Chance' operated in the republic, where following the initial stage of rehabilitation via the rehabilitation department of the Republican Narcological Centre patients proceeded to the second phase vis-à-vis reintegration into society. Clients received treatment through 'Chance' for no more than six months, where they engaged in occupational therapy and breathing techniques, and the clients themselves baked bread for their fellow clients. The centre, however, closed due to a lack of funding.

Currently, only one non-governmental rehabilitation centre exists in the Kyrgyz Republic — 'Centre Plus', operating in Osh via self-financing. As a separate house with a subsidiary farm and a car, clients breed rabbits and cows. Up to 18 individuals can simultaneously live at the centre, completing a programme lasting up to six months.

The Kyrgyz Republic has a large number of NGOs providing services to people who use psychoactive substances, consisting of:

- social institutions;
- drop-in centres, which provide clients with information, medical and psychological services and social support;
- social housing, providing clients with a place to live;
- halfway houses, providing clients with the opportunity to undergo adaptation therapy, ensuring participation in rehabilitation programmes on drug dependence and further social adaptation; and
- a social bureau for released prisoners who inject drugs or HIV-positive prisoners.

NGO programmes, as a rule, are low threshold and available to all applicants. Of course, certain requirements and rules must be met, depending on the format NGO's work.

'We have very low-threshold criteria for entry, the key condition is the patient's willingness and the absence of an acute mental disorder, if the person has a mental disorder, or active TB, etc. They need time to improve their condition so that we can work with them. But, this doesn't mean we reject them. We can discuss treatment with a mental health patient during lucid intervals or with a recovering TB patient.'

'… compliance with recommendations. We tell clients that we accept them, but we have very simple requirements — to attend, not to skip sessions, and pass some analyses.'

Recently, some NGOs closed due to a lack of funding.

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THE MOST COMMON APPROACHES TO TREATMENT AND REHABILITATION

Treatment for individuals with drug dependencies may be divided into three phases:

- Detoxification and the relief of withdrawal symptoms to normalise somatic and neurological disorders and correct psychopathic disorders.
- Recovery of metabolic disorders, behavioural disorders and the normalisation of the mental condition (including sleep).
- Defining the conditions preceding relapse and prescribing an anti-relapse treatment. Particular attention is paid to any internal and external factors leading to a spontaneous surge in a craving for psychoactive substances.

Specific treatment approaches and methods used in the Kyrgyz Republic include the following:

- Emergency care and intensive detoxification for acute and chronic poisoning from psychoactive substances.
- Treatment of withdrawal syndrome when problematic drug use that caused physical dependence is interrupted. In opioid dependence, both the α-2 opioid receptor blocker (clonidine) and the opiate receptor agonist (methadone) are used.
- Treatment of complications caused by the prolonged misuse of psychoactive substances.
- Treatment of comorbid conditions such as depression and anxiety among others.
- Suppression of cravings and elimination of dependence.
- Anti-relapse treatment.
- Harm reduction programmes, including long-term MMT for opioid dependence and syringe exchange points among others.
- Treatment of comorbidities including HIV, TB and hepatitis.
- Programmes relying on naloxone for the prevention of overdoses.
- Rehabilitation and resocialisation.

In the sections that follow, we describe the rehabilitation approaches used in the Kyrgyz Republic.

Rehabilitation based on a therapeutic community (TC)

Until recently, principles of therapeutic communities (TCs) were applied to work in the Narcological Rehabilitation Department. As such, services were provided by qualified specialists in accordance with the developed standards. The Narcological Rehabilitation Department functioned as a 24-hour inpatient facility. The rehabilitation process allowed patients to maintain contacts with the outside world.

TCs served as a part of a comprehensive rehabilitation programme, which, alongside TC principles, relied on an approach called 'integrative-developing, two-level group psychotherapy of drug addicts by A. L. Katkov' combined with environmental therapy, occupational therapy, trainings on assertiveness and conflict resolution. At present, some elements of this rehabilitation process remain, such as individual work with a client and their family.

Rehabilitation based public psychotherapy and self-help rehabilitation groups

These approaches to rehabilitation include self-help groups such as AA and NA. As a rule, self-help and support groups operate via an outpatient mode applying a 12-step approach.

The Minnesota model (or its Hazelden variant) is initially an inpatient programme, and then an outpatient 12-step rehabilitation programme based on basic principles such as voluntariness, honesty and the total refusal to use alcohol and drugs.

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AA was introduced in the Kyrgyz Republic in 1996, with NA following in 1998. The group 'Adult Children of Alcoholics' or Al-Anon is also active.

Faith-based approaches to rehabilitation

Faith-based approaches to rehabilitation consist of treatment provision via a religious context. In the Kyrgyz Republic, the G. Shichko method is used, which consists of classes that take into account the psycholinguistic patterns that shape concepts reorienting the personality of individuals who suffer from uncontrolled harmful habits and inclinations. Every day for ten days, classes in the form of lectures and home lessons take place, and then meetings are held twice a week. Religious communities hold meetings twice a week, where the 'leader' of the community holds group sessions similar to self-help communities such as AA.

Rehabilitation based on an outpatient model

The outpatient rehabilitation model focuses on the individual work of a psychologist and a psychiatrist with a client. Individual work with the client is carried out as follows:

- Treatment through intensive work consisting of tackling a physical dependence, aimed at overcoming it and stabilising the physical symptoms.
- Rehabilitation through intensive work on personal and interpersonal issues to sort out and comprehend emotional problems and address inadequate protective mechanisms.
- Preparation for life outside the rehabilitation institution represents the most intensive work done to prevent relapses. This consists of training towards improved social skills and abilities, interpersonal and communication competence, counteracting the pressure of the social environment and avoiding and resisting the temptation of the anaesthesia of substance use.
- Regular individual meetings with the patient lasting at least one to two hours. These meetings are clearly planned together with the patient depending on their purpose and objective. Over time, the intervals between meetings increase. During this period, patients may join self-help groups such as AA or NA.

The outpatient model of rehabilitation is quite common in the Kyrgyz Republic, both in the public sector of the narcological service and private drug treatment clinics.

We should note that, whilst some sources describe the outpatient model of rehabilitation as a separate approach, we found it is rather a description of the form of service provision.

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ACCESS TO TREATMENT AND REHABILITATION SERVICES

As experts noted during interviews, access to detoxification and substitution therapy services are generally satisfactory. Yet, some barriers exist, such as the cost of detoxification (if a copayment is required) or compulsory narcological registration when enrolling for substitution therapy programmes.

'There is no problem with "entering" the methadone programme. Detox, however, is too expensive for drug users. Moreover, drug users are afraid of entering the OST programme because they are immediately registered [as a drug user]. This is embarrassing for them because of problems with their rights and the police, amongst others.'

'Anyway, the demand for rehabilitation is very low. All this (rehabilitation in a state facility) is on a paid basis. Even a small copayment is quite burdensome for people requiring rehabilitation.'

According to Kyrgyz experts, cultural and family traditions significantly impact service-seeking behaviour.

'I noticed that further from big cities families are more likely to try to conceal drug use. They rarely seek medical assistance.'

'It's a matter of upbringing. Surely, the parents are very ashamed of this. If their son or daughter is drug-dependent, they are uncomfortable about seeking help or entering a methadone programme; they are against this. God forbid relatives learn about it, because religion and upbringing considerably influence such things.'

Access to inpatient rehabilitation programmes for individuals dependent on psychoactive substances is currently low in the Kyrgyz Republic. Thus, an inpatient rehabilitation department with five beds is available only in the city of Osh in the Osh Interdepartmental Narcological Centre.

In district-level state medical institutions, including psycho-narcological and narcological offices and departments, consultations with a narcologist and psychologist are provided. In addition to outpatient rehabilitation work with a psychiatrist or narcologist, the population can apply for specialist care, where, depending on existing requests, they can be referred to social services, AA and NA, all of which work with PWID.

In Bishkek, the narcological department shifted to an outpatient psycho-correctional care unit for individuals with SUD, including minors. This department provides outpatient counselling, diagnosis, medical and physiotherapeutic care for patients; psychotherapy with individual, group and family sessions covering a wide range of subjects, problems and needs; educational sessions on health where special attention is paid to personal hygiene, personal and moral growth and strengthening one's well-being; prevention of relapse; counselling and assistance in matters of career guidance and employment; referrals for assistance with human rights and legal issues; family counselling; and psychotherapy.

Many private clinics provide individual or family psycho-correctional services as well. Such clinics are located primarily in Bishkek and Osh.

Some NGOs, in addition to the standard package (e.g., household, information and consulting services), also provide psychological, social and rehabilitation assistance. But, such organisations remain extremely rare. In addition, weekly meetings similar to self-help groups like NA and AA are available in some mosques and churches.

II_THE KYRGYZ REPUBLIC

QUALITY OF SERVICES

The monitoring and evaluation of the quality of treatment within the healthcare system of the Kyrgyz Republic falls under OHIF, which distributes financial resources. The quality control of services is also carried out by the licencing department of the Ministry of Health in accordance with the approved standards of service and established indicators for the quality of the treatment process.

The joint order of OHIF No. 361, dated 23 December 2016, and No. 912 of the Ministry of Health of the Kyrgyz Republic, dated 23 December 2012, 'On the Improvement of the Quality Management System for Medical, Preventive and Pharmaceutical Services in the Single Payer System', approved the following:

- The regulation of the quality management of medical, preventive and pharmaceutical services within the single payer system.
- The methodology for conducting an examination of the quality of medical services and monitoring the performance of contracts within the single payer system.
- The methodology for analysing the database of treated cases in hospitals working within the single payer system.
- The accounting forms for the examination of the quality of medical services within the single payer system.
- The reporting forms for the examination of the quality of medical services within the single payer system.
- Instructions for the preparation of the reporting forms for the examination of the quality of medical services within the single payer system.

According to the above-mentioned order, the quality management of medical and preventive services is conducted on the basis of a contract signed with the provider of medical, preventive and medicinal assistance in accordance with the laws of the Kyrgyz Republic. The following methods are used to determine the quality:

- A quality assessment (quality control) related to medical, preventive care and drug provision.
- Monitoring, analysis and evaluation of the quality of medical and prevention services as well as drug provision on the basis of the agreed indicators.
- A study of patients' opinions on the quality of medical, preventive and pharmacological care, and the conditions for their provision.

Appraisal of the quality of medical, preventive and pharmaceutical services is carried out by medical experts from OHIF or by involving freelance experts. The scheduled quality examination is carried out in accordance with the plan approved annually by OHIF. An extraordinary quality examination may be conducted on the basis of citizens' applications, as well as on behalf of the Ministry of Health of the Kyrgyz Republic.

Moreover, in each healthcare facility the Quality Commission coordinates the measurement assessing the quality of services according to the standard provision 'On the Committee for the Quality and Safety of Medical Care in the Organisation of Public Health Care,' approved by Order No. 146 of the Ministry of Health of the Kyrgyz Republic, dated 27 March 2006. This commission can offer a quality improvement and modification plan.

'First, OHIF itself has the right to check our performance — that is, the audit process is ongoing. The performance of our centre has such indicators as the frequency of repeated hospitalisations and relapses after treatment. A relapse after six months is considered a successful case, a relapse in a year is also a good result.

Quarterly, we submit reports on treated cases. A treated case is one of the performance indicators. We carry out monitoring through feedback from each patient.'

In addition, in state institutions, including substitution therapy programmes, internal monitoring and assessment of the quality of service delivery is ongoing.

'As for the quality of services, our centre has the commission on quality assessment of the provided services. This is a very serious commission. They investigate every lethal case and complicated clinical cases. As for the quality, each department also has a log of complaints and suggestions, which is analysed from time to time. That is, department chiefs analyse these logs and make improvements if that falls within their terms of reference. If we are undergoing an inspection by any commission, following any internal and external audits, we analyse the penalties, if any are imposed upon us, jointly with the administration. As for performance, I can say that such a check took place for the substitution programme in the penitentiary system as well. There were a number of assessments completed by international experts.'

'Our programmes have performance criteria. In addition, the substitution maintenance therapy programme was subject to performance evaluation several times. Moreover, we submit quarterly reports on various indicators, such as retention in the programme for more than six months or the number of clients on ART.'

In NGOs, depending on the type of activity and requirements of the donor, a system of monitoring and evaluation of their performance is typically in place.

'NGOs have quarterly monitoring and annual reports, and then the donor issues annual reports about their activities and the activities of their recipients.'

'We also have focus groups. We have a quality assessment grid with special questions on accessibility, location, business hours and satisfaction with the conditions.'

'…they look at how the person changes during the course of treatment. We have questionnaires to be completed before and after treatment.'

'We use a treatment index, showing if the patient is still using drugs, is resocialised, has returned to work, decreased family conflicts and began to restore their social cohesions.'

Certification

The medical and pharmaceutical activities within the territory of the Kyrgyz Republic may be carried out by individuals and legal entities only upon receipt of a special permit (licence). The licencing of medical and pharmaceutical activities is carried out in accordance with the procedure established by legislation of the Kyrgyz Republic (Law of the Kyrgyz Republic 'On the Protection of the Health of Citizens in the Kyrgyz Republic' with amendments and additions dated 17 April 2009, adopted by the Legislative Assembly of the Zhogorku Kenesh of the Kyrgyz Republic, dated 11 November 2004, Article 5. Licensing of medical and pharmaceutical activities). The accreditation procedure is defined by the authorised state body of the Kyrgyz Republic in the field of health (Article 6. Accreditation of individuals and legal entities engaged in medical activities).

The types of licences, issuing authorities and the necessary documents as well as the terms for issuing licences are regulated by the Law of the Kyrgyz Republic 'On Licencing (with amendments and additions dated 13 October 2009)', adopted by the Legislative Assembly of the Zhogorku Kenesh of the Kyrgyz Republic, dated 24 February 2013.

Furthermore, healthcare organisations are subject to licencing and accreditation in cases and in accordance with the procedure provided by the legislation of the Kyrgyz Republic (Law of the Kyrgyz Republic 'On Healthcare Organisations in the Kyrgyz Republic' adopted by the Legislative Assembly of the Zhogorku Kenesh of the Kyrgyz Republic, dated 23 June 2004, Article 21. Licencing and accreditation of health organisations).

The provision of private narcological services (such as narcology and psychotherapy) requires compulsory licencing according to the regulation 'On the Licencing of Certain Types of Activities (with amendments and additions dated 15 July 2011)' approved by Decree No. 260 of the Government of the Kyrgyz Republic, dated 31 May 2001. A qualification exam (assessment) is compulsory for providers of private medical practices.

The Provisional Regulations on the Licencing of Private Healthcare Practice in the Kyrgyz Republic, approved by Order No. 377 of the Ministry of Health of the Kyrgyz Republic, dated 21 April 2017, set forth the licencing standards for the non-governmental health sector of the Kyrgyz Republic and a list of permitted types of healthcare activities in the private health sector for licencing (narcology and psychiatry are included in this list, whilst rehabilitation is not).

Postgraduate education programmes

KSMIRPD is a state higher educational institution that implements the system of continuous medical education for physicians, nurses and other professionals working within the healthcare system of the Kyrgyz Republic.

KSMIRPD offers programmes of postgraduate education through internship, clinical residency and postgraduate study for a wide range of medical specialties. These specialities include curricula for narcologists and psychiatrists amongst others. In KSMIRPD, postgraduate training is provided through one- and two-year internship programmes.

Clinical training is carried out primarily on the basis of the Republican Centre for Mental Health and the Republican Narcological Centre. KSMIRPD provides training for resident physicians, narcologists and psychiatrists via the Department of Neurology, Neurosurgery and Psychiatry, including on issues of rehabilitation in psychiatry and narcology. However, few hours are allocated to these topics.

All practicing physicians must pass a primary specialisation and systematic assessment every five years in their respective specialty.

In addition, within KSMIRPD, distance learning is provided on drug dependency and harm reduction for medical and non-medical professionals. This is available through financial support from international organisations (specifically through the website learn.aids.gov.kg and the website of KSMIRPD). However, whilst appropriate curricula and programmes have already been developed for psychiatrists and narcologists, for specialists with related profiles including psychologists, teachers and social workers, these types of programmes and manuals remain inadequate.

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RECOMMENDATIONS

Based on our needs assessment of the drug use and treatment services assessment in the Kyrgyz Republic, we put forth the following recommendations.

- **Promote evidence-based methods and approaches for rehabilitation through training for specialists and the exchange of experiences. This should include the development of a training system and comprehensive curriculum on rehabilitation for psychologists and social workers.**

'All of our doctors and nurses can complete a specialisation course every five years. At the end, they take examinations in a category. But, now, as far as I know, the issues related to the rehabilitation process in the curricula are presented poorly.'

'It would be great to also teach peer consultants, that is, a person who is the primary link. In many respects, the result of treatment will depend on them, whether the client goes further in treatment or not, including if they enter a medical institution or not.'

'I think it would be good to create a database of specialists who have already been trained in the rehabilitation process. These experts might not now be involved in this activity — they may be everywhere. It is desirable to create this database and use their potential for training new specialists.'

- **Hold a scientific and practical meeting of all specialists working in the sphere of addiction treatment, including the department at KSMIRPD and the Permanent Commission for developing training programmes in drug dependency treatment. This should include creating a working group for the development of curricula, and developing and updating of clinical protocols for the rehabilitation process.**

'We must revive, raise and restore from various pieces. We should bring together those who worked in this field into a working group. Those with experience and certificates could make valuable suggestions and begin to develop the concept of integrated rehabilitation approaches to treating people with drug dependencies.'

- **Update and improve the existing regulatory and legal framework. The existing normative acts 'Regulations on drug treatment centres' and 'Standards for the rehabilitation of patients with mental and behavioural disorders as a result of the use of opioids' need to be revised taking into account the reduction in the volume of services provided and the transition to an outpatient rehabilitation process at the Republican Narcological Centre.**

- **Introduce the concept of 'addiction consultant' or 'resident specialist on dependency' in the staffing list of the rehabilitation department, centre or process.**

'It seems to me that it is necessary to revise the staffing of the rehabilitation process and introduce such a concept as a 'dependency consultant.'

- **Increase financial support for rehabilitation services. This should include restoring the work of the rehabilitation centre or branch, at least at the level of Bishkek, possibly with the involvement of the Bishkek Municipal Administration.**

'Well, I think that detoxification should be free for people with a drug dependence. And, then, there should be a prolonged rehabilitation process for a person, too, preferably free of charge.'

'Unite efforts with the city to create a city rehabilitation centre. Thus, the city administration and the city health department could address some of the organisational issues.'

'I think we really need to develop a mechanism for payment and copayment for rehabilitation.'

'It is necessary to strengthen the work of rehabilitation centres in the civil society sector. We are doing our work very well here in the colonies. And when [a prisoner] is released they do not have much choice regarding where to go. And when they are released they do not stay there for long. So most likely there is not much support for them out there.'

- **Improve the mechanism of interaction between various structures and the subjects of the rehabilitation process (public and private treatment centres, services providing social, legal services, NGOs providing various services, local self-government bodies (akimiats), self-support groups such as AA and NA). This should include strengthening the interaction between the civil society sector and the penitentiary service with regard to the provision of rehabilitation services.**

'If we could somehow establish a communication process between physicians at narcological clinics and NGOs, there would be more opportunities, the coverage would be better and we would get a more realistic picture.'

'We need to revive the partnership we had before. We had established such a concept whereby a person who gets into our drug treatment programmes "Socium" and other institutions did not simply disappear from this circle.'

'It would be great if there was some mechanism to provide a place for NA and AA groups, and groups for relatives at the premises of the narcological clinics.'

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III_THE RUSSIAN FEDERATION

SUMMARY

In 2016, the total number of registered drug users in the Russian Federation stood at 495 982 individuals or 338.5 per 100 000 population.

Similar to previous years, most of the individuals registered in 2016 as having a drug dependence consisted of patients with opioid dependence (69.6%). The second largest group of patients included people with polydrug dependence and people who use other substances, representing 15.8% of all drug users, followed by patients with a cannabinoid dependence at 9.6%. The next group of patients consisted of those with a psychostimulant dependence (amphetamines, cocaine, etc.) amounting to 4.9% of all drug users.

In 2016, 262 924 drug users (or 179.4 per 100 000 population) injected drugs (that is, included PWID).

Specialists working in the area of drug treatment and rehabilitation state that 'salts', 'spices' and pharmacological and synthetic drugs have become increasingly widespread, whilst heroin, which used to be popular, is now used less and less. According to experts, such changes may require revisions to the approaches to treating drug dependent individuals in the Russian Federation.

In the Russian Federation, the **treatment of people with a drug** dependence is based on the Federal Clinical Guidelines developed by the Russian Society of Psychiatrists and approved by the Ministry of Health of the Russian Federation. In the Federal Clinical Guidelines, special emphasis is placed on the use of psychotropic drugs (initially, antipsychotic agents), which, in accordance with recent research and evidence-based medicine, appear ineffective and unsafe.

Drug treatment services may be provided only by healthcare institutions with the relevant licences and may be either state-run or private. To obtain a certificate as a psychiatrist-narcologist and to have the right to treat drug-dependent patients, a physician with the qualification of a primary care physician should receive residency training in this specialisation. No special training on the rehabilitation of drug dependent patients is necessary.

Medical rehabilitation is regulated by the 'Patient Management Guidelines. Rehabilitation of Patients with Drug Dependence' (2003), approved by Order of the Russian Ministry of Health.

The social rehabilitation of drug users is regulated by the National Standard 'Public Social Services. Rehabilitation Services for People with Drug, Psychotropic Substance and Alcohol Dependence. Key Types of Social Services' (2012). The main goal of rehabilitation is defined as the 'internal change of moral and spiritual values of the individual as well as mental habits, development and renewal of professional skills and the provision of employment opportunities (in particular, in specially organised settings).'

The activities of state-run rehabilitation centres are regulated by the above-mentioned regulations as well as internal orders and provisions. The activities of faith-based or private rehabilitation centres do not require certification.

As of 2016, state-run, private and faith-based organisations operated as rehabilitation centres in the Russian Federation. In addition, in different regions of the country, so-called 'motivational centres' — that is, private clinics offering the compulsory rehabilitation of drug-dependent individuals provided on an involuntary basis — also operated.

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The number of separate state-run rehabilitation centres in the Russian Federation stood at three, including two inpatient and one outpatient facilities. The number of beds in inpatient rehabilitation centres reached 195. The number of *rehabilitation centres (departments) in specialised drug (mental) treatment institutions* in the Russian Federation in 2016 reached 135, with the total number of beds totalling 3168. The number of inpatient medical rehabilitation units in such centres and departments stood at 70. In these institutions, 1466 psychologists, 575 specialists in social services and 846 social workers offer services. In outpatient rehabilitation facilities, the corresponding figures equalled 746, 367 and 427, respectively.

In 2016, outpatient rehabilitation programmes covered 89 297 patients with a drug dependence. In comparison, inpatient rehabilitation services were provided to 29 381 patients.

In state-run centres, treatment and rehabilitation services are provided free-of-charge and are covered by the Health Insurance Fund, provided that patients are officially registered with drug treatment facilities. If the patient prefers, treatment services may be provided anonymously albeit on a for-fee basis.

Between 2004 and 2009, the GLOBUS (Global Efforts against AIDS) project was implemented in the Russian Federation, which included harm reduction programmes for the most at-risk populations. In February 2011, Tatyana Golikova, the Russian Minister of Health and Social Development proclaimed that the Russian government does not believe in the effectiveness of harm reduction programmes and considers the implementation of OST dangerous. Currently, an official ban prevents the implementation of harm reduction and substitution maintenance therapy programmes in the Russian Federation.

Commercial rehabilitation centres function in all regions of the Russian Federation. However, no statistics exist on such centres. The price for such services varies from 30 000 Russian roubles (RUB) (€483) to RUB 60 000 (€875) per month. In some centres, the price may be considerably higher, reaching as high as €4200. Inpatient rehabilitation services in such centres may last from 45 days to 1.5 years.

In addition, the Russian Orthodox Church takes an active part in the provision of rehabilitation services. Roughly 80 rehabilitation centres function at Russian Orthodox Church facilities across the country.

In December 2012, the Church approved the concept of the rehabilitation of drug-dependent people in its declaration, ***'On the Participation of the Russian Orthodox Church in the Rehabilitation of Drug-Dependent Individuals'.*** This document describes key principles in the Church's view of rehabilitation and the peculiarities of organising the rehabilitation process. From the Church's standpoint, an indicator of successful rehabilitation apart from the sustained abstinence of a drug-dependent person is building motivation based on Christian values in the daily life of the individual.

In general, drug services including treatment and rehabilitation as well as information about such services are accessible. However, a number of problems persist, such as a lack of general standards and approaches to the activities of rehabilitation centres both state-run and private, no control over the quality of services, unequal access to services across regions and the use of approaches not based on prevailing evidence both in treatment and rehabilitation. Difficulties also exist in the delivery of relevant services to underage patients, disabled individuals and in families where both partners use drugs particularly if they have children. Barriers to seeking care in state-run clinics and rehabilitation centres include a lack of anonymity and the need to officially register as a drug user as well as the attitudes of personnel towards patients and the unsatisfactory conditions in such clinics. In private clinics, the high cost of services remains a barrier.

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It is very difficult to assess **the quality of services**. No unified approach exists to monitoring and evaluating Russian rehabilitation programmes.

Most state-run and private rehabilitation centres use a 12-step programme as well as a wide range of various psychotherapy methods including behavioural therapy, CBT, art therapy and hypnotherapy amongst others. Private and faith-based centres may be organised as TCs.

The main success criterion for any type of programme is sustained remission. In addition, other success criteria, for example, the per cent or number of patients completing inpatient treatment or rehabilitation courses, repeated hospitalisations and the level of client satisfaction may be used. Experts underline that we need to extend the list of programme success criteria adding indicators related to different spheres of life (e.g., health status, social bonds, employment, etc.) in line with international standards.

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CHARACTERISTICS OF THE DRUG USE SITUATION IN THE COUNTRY

A total of 292 407 drug-dependent people (311 785 in 2011), or 199.5 per 100 000 population (213.0 in 2015) registered via an outpatient drug treatment facility in 2016, a 6% decrease compared with 2015. In addition, another 203 575 people were diagnosed as misusing drugs (entailing harmful effects) in 2016, translating to a rate of 138.9 per 100 000 population (159.0 in 2015), a drop of 12.6% from 2015.

Overall, the number of registered drug users (including drug-dependent and drug misusing individuals) reached 495 982 in 2016, or 338.5 per 100 000 population, 9% lower than the 2015 indicator (371.9).

Similar to previous years, people affected by an opioid dependency (69.6%) accounted for the bulk of those registered as drug-dependent in 2016. A group of patients including those affected by polydrug misuse and those dependent on other drugs — 15.8% — followed, and those with a cannabinoid dependency — 9.6% — ranked third. Patients dependent upon psychostimulants (amphetamine, cocaine, etc.) occupied the fourth position, accounting for 4.9% of the total.

Between 2015 and 2016, indicators for the overall incidence of various forms of drug dependency revealed several trends. For example, the opioid dependency incidence shrank from 157.5 per 100 000 population to 138.9, a drop of 12%. Yet, the cannabinoid dependency incidence remained unchanged (at 19.3 per 100 000 population in 2015 compared with 19.2 per 100 000 population in 2016). An insignificant increase in the overall incidence was recorded amongst patients dependent upon other drugs and patients with a polydrug dependency — that is, an increase of 14.5% from 27.5 to 31.5 per 100 000 population — and amongst those dependent upon psychostimulants — that is, an increase of 13.7% from 8.6 to 9.8 per 100 000 population.

From the total number of PWUD, 262 924 people, or 179.4 per 100 000 population, injected drugs (i.e., PWID) in 2016. In 2015, PWID totalled 298 155, or 203.6 per 100 000 population). Registered incidence (appealability rate) dropped by 12% amongst this population.

PWID represent a group of the population at risk for HIV and other parenteral infections. Despite a continuing reduction in the rate of PWID seeking assistance from drug treatment facilities, the HIV incidence continues to increase amongst this key population. For example, whilst HIV incidence stood at 13.2% in 2009, the same figure climbed to 24.3% in 2016 amongst PWID.

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REGULATORY FRAMEWORK FOR THE TREATMENT AND REHABILITATION OF PEOPLE WHO USE DRUGS

In the Russian Federation, drug treatment is provided based on the Federal Clinical Guidelines developed by the Russian Society of Psychiatrists and approved by the Ministry of Health.

The treatment goal is for the patient to live free of drugs, a philosophy based on abstinence.

The therapeutic objectives consist of:

- suppressing morbid attraction syndrome and
- treating the somatic and neurological consequences of chronic intoxication from psychoactive substances (PAS).

Primarily, the therapeutic approach in the Russian Federation relies on integrated pharmaceutical and psychotherapeutic treatment. The Federal Clinical Guidelines specifically focus on the use of psychotropic drugs (initially, antipsychotic agents), which recent evidence-based medical research indicates are ineffective and unsafe.

To receive drug treatment assistance, a person needs to have an established substance abuse diagnosis. If a severe somatic or mental pathology is detected, the patient is urged to seek treatment from a somatic or mental health institution.

The duration of treatment is not regulated, and rehabilitation is provided on a voluntary basis lasting from 3 to 12 months.

All rehabilitation interventions fall within either medical (sociomedical) or social rehabilitation approaches.

Medical rehabilitation is regulated by the ***'Patient Management Guidelines. Rehabilitation of Patients with Drug Dependence'*** (2003), approved through an Order of the Russian Ministry of Health. This document defines the range of measures aimed at treating drug-dependent patients during rehabilitation. The objectives of medical rehabilitation are as follows:

- Providing a package of pharmacological, physiotherapeutic and other interventions aimed at suppressing the main symptom of the disease — that is, the morbid desire to use psychoactive substances.
- Removing asthenic (neurasthenic), affective, behavioural, mental and amnestic disorders caused by the use of psychoactive substances.
- Renewing communication skills.
- Training patients to acquire skills to cope with stressful situations and to say 'no' to drugs.
- Educating patients to develop the ability to detect an oncoming urge to use psychoactive substances and to manage relapses of disease.
- Training patients to analyse and assess self-destructive and constructive behaviours.
- Taking responsibility for one's behaviour and establishing a healthy lifestyle.
- Forming (or renewing) a systematic habit of work or study skills.
- Stabilising one's professional relationships and renewing positive social bonds.
- Neutralising one's drug-dependent subpersonality and its impact on one's personality as a whole, including recognition and development of constructive sides to one's personality.
- Forming and consolidating a normative value system and positive moral and ethical values.
- Forming a realistic life perspective.

- Employing psychotherapeutic interventions for the family members of patients aimed at expanding their knowledge concerning the sociomedical consequences of drug use, developing the skills necessary to provide psychological support to patients and manage their state to prevent relapses and overcome codependence.
- Providing sociomedical prevention of slips (using drugs once or twice during remission) and relapses.
- Establishing motivation to take part in rehabilitation programmes and the aspiration to live a life free of psychoactive substances.
- Forming purposeful activities and increasing normative levels of aspirations and social interests.
- Reestablishing emotional adequacy, the ability to differentiate between positive and negative emotions focusing on prioritising positive emotions when performing personal and social tasks.
- Improving the quality of life of patients with a drug dependence who would like to complete a rehabilitation programme and avoid relapses.

The **social rehabilitation** of drug users is regulated by the national standard ***'Public Social Services. Rehabilitation Services for People with Drug, Psychotropic Substance and Alcohol Dependence. Key Types of Social Services'*** (2012). The main goal of rehabilitation is defined as 'an internal change of moral and spiritual values of the individual as well as mental customs, the development and renewal of professional skills and the provision of employment opportunities (in particular, in specially organised settings)'.

'Rehabilitation consists of four components:

1. Revival, that is, renewing the universal spiritual and moral human values.
2. Work therapy in order to train and rebuild professional skills, thereby defining the social significance and relevance of the rehabilitant in society and one's responsibility to family members and relatives, renewing one's social and personal status and reintegration and resocialisation.
3. Social readaptation, the formation of compensatory social skills once a patient is free from psychoactive substance abuse, which led to the disruption of social bonds.
4. Creativity by way of establishing one's independence in making decisions and choosing the best result, and discovery of one's inner potential.'

The activities of state-run rehabilitation centres are regulated through the above-mentioned regulations as well as by internal orders and provisions. To deliver drug treatment services, private healthcare institutions must obtain the relevant licences. In other cases, if rehabilitation centres (private or religious) do not provide medical services, their activities do not require any certification.

In December 2012, the Russian Orthodox Church approved its concept of rehabilitation for drug-dependent people through the document ***'On the Participation of the Russian Orthodox Church in the Rehabilitation of Drug-Dependent Individuals.'*** This document describes the key principles of rehabilitation and the peculiarities of organising the rehabilitation process from the Church's point of view. Apart from its own original rehabilitation programmes, the Russian Orthodox Church allows for the use of methodologies taken from the experience of narcological services in the Russian Federation as well as methods developed in other countries provided that they are aligned with the Church's moral values, serving as a guarantee of human dignity and welfare.

The leading role in rehabilitation belongs to the Orthodox priest. The approach taken by the Church also seeks to engage the following specialists in the church-based rehabilitation: narcologists, medical professionals, psychologists and social workers. However, engaging with such professionals during the rehabilitation

process organised by the Orthodox community can only occur if they attend the Orthodox Church and strictly observe its rules or, as a minimum, share its Christian values.

From the Church's point of view, apart from the sustained remission of a drug-dependent person, a key indicator of successful rehabilitation lies in building motivation based on Christian values in the daily life of such a person.

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AVAILABLE TREATMENT FORMATS (STATE-RUN, FAITH-BASED, COMMERCIAL AND NON -GOVERNMENTAL

As of 2016, different organisational formats guided the operation of rehabilitation centres in the Russian Federation, consisting of state-run, private and faith-based facilities. Alongside these, in different regions of the country, so-called 'motivational centres' also offered services as private clinics for the compulsory rehabilitation of drug-dependent individuals on an involuntary basis.

Drug treatment services may only be provided by healthcare institutions with the necessary relevant licences whether state-run or private.

Currently, rehabilitation services are not regulated by national legislation.

The number of individual state-run rehabilitation centres in the Russian Federation stood at three, including two inpatient facilities and one outpatient facility. A total of 195 beds were available in inpatient rehabilitation centres. The number of rehabilitation centres (departments) in specialised drug (mental) treatment institutions in the Russian Federation in 2016 stood at 135. These consisted of 17 rehabilitation centres and 118 rehabilitation departments with a total of 3168 beds. The number of inpatient medical rehabilitation units in such centres and departments stood at 70. Within these institutions, a total of 1466 psychologists, 575 social service specialists and 846 social workers worked. The corresponding figures for outpatient rehabilitation staff stood at 746, 367 and 427, respectively.

In 2016, 89 297 drug-dependent patients enrolled in outpatient rehabilitation programmes (ORP) (compare with 91 700), amounting to 3.7% of the total number of patients seeking outpatient drug treatment services. Amongst patients with a PAS dependency enrolled in ORP, 48 898 individuals successfully completed outpatient rehabilitation, representing 55% of the total number of patients receiving outpatient rehabilitation services. Upon completing inpatient rehabilitation, 9 603 patients sought outpatient rehabilitation services. In total, 81.5% of patients who received inpatient rehabilitation services successfully completed their course of treatment (amongst 29 381 patients receiving such services).

The average duration of inpatient rehabilitation for patients successfully completing their treatment course stood at 42 days. Upon completion of inpatient rehabilitation, 14 949 patients were referred to outpatient rehabilitation services, representing 62.5% of those who successfully completed their inpatient rehabilitation course. However, we should note that 37.5% patients were not referred to outpatient rehabilitation programmes following inpatient rehabilitation treatment.

State-run rehabilitation centres are financed from the state budget, whereby treatment services are provided free-of-charge and covered by the health insurance fund provided patients officially register with drug treatment facilities. If a patient prefers, treatment services may be provided anonymously, but on a for-fee basis. Before beginning inpatient treatment, a patient must complete a minimum package of tests required for hospitalisation at a healthcare facility (consisting of, for instance, HIV, syphilis , hepatitis and X-ray).

For enrolment into a rehabilitation programme, the patient must be 'clean' for then days. That is, they must abstain from using any narcotic, although currently this rule is not always strictly observed.

'The only restriction, and even this one was recently subject to certain changes, is being clean for ten days (that is, not using any chemical substances). Due to the appearance of new types of drugs, we cannot be certain if a person used any substances during those ten days or not.'

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As a rule, only patients who received treatment (detox) services are enrolled in rehabilitation programmes. First, they are enrolled into a short-term rehabilitation programme (up to three months); then, if they wish, they are enrolled into a long-term programme (up to one year).

The number of rehabilitation centres run by the Russian Orthodox Church currently stands at about 80. The Russian Orthodox Church developed a concept for the rehabilitation of drug-dependent individuals and is currently implementing it. Such rehabilitation centres may receive financial support from the state. Yet, the methods used are not evidence-based and include only work therapy and engaging in church activities. Some centres offer consultations with psychologists.

Apart from the Russian Orthodox Church, rehabilitation services are also provided by churches from other Christian denominations as well as from Muslim-oriented rehabilitation centres.

'As for non-Orthodox centres, it depends, for example. Among Islamic centres, I think there are very few in the Russian Federation. If we talk about other denominations, such as Protestant, Baptist, Lutheran and so on, there are many of them. They work unofficially. They call themselves centres, but I think that among them there are not many real centres providing professional services encompassing at least social and work rehabilitation services.'

Private rehabilitation centres function across all regions of the Russian Federation. However, no statistics exist for such centres. We may assume at least 80 such centres operate, although in reality many more likely exist.

'Currently, there are an extremely large number of private rehabilitation clinics. It is difficult to count them. Detox centres, however, you can more or less estimate their number, because to provide private detox services it is necessary to obtain a licence from the Ministry of Health. Their number is known. But private rehab clinics – there is a huge number of them. Previously, when drug control was functioning, they counted about 70 rehabilitation and private clinics near Kazan, where drug-dependent patients were kept. And, this was only Kazan. To provide rehabilitation services, there is no need to obtain a licence.'

Such centres should have licences to provide health services and must comply with the requirements of the Federal Clinical Guidelines. Treatment and rehabilitation services are provided anonymously and on a commercial basis. If no detoxification services are offered by a centre, a standard requirement for clients before initiating rehabilitation is a certain period of sobriety (about five days).

Private rehabilitation clinics implement their activities on a for-fee basis. The price varies from RUB30 000 (€438) to RUB60 000 (€875) per month. In some centres, the price is much higher climbing to €4200 per month.

Inpatient rehabilitation courses of treatment may last from 45 days to 1.5 years.

Apart from rehabilitation centres, many so-called 'motivational centres' operate. Drug-dependent individuals are taken to such centres at the request of their family members without the patient's consent. No treatment in offered in such centres — only isolation and work therapy. Patients must pay to be enrolled in such programmes.

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THE MOST COMMON APPROACHES TO TREATMENT AND REHABILITATION

In practice, most state-run and private rehabilitation centres apply a 12-step programme as well as various psychotherapeutic methods such as CBT and art therapy amongst others. Some centres may use a 12-step model combined with some elements of psychotherapy depending on the needs of a patient, whilst others apply psychotherapeutic methods only.

'The activities of many rehabilitation centres are based on a 12-step programme, the so-called Minnesota model.'

'…it is a comprehensive model, including some elements of behavioural therapy, cognitive therapy, hypnotherapy and many other methods of psychotherapy.'

Private and faith-based centres, however, may be organised in the form of TCs.

'We use a method consistent with a therapeutic community. People come to such a community voluntarily with a specific goal: to become sober. They agree to a certain daily regimen. They make sure that this daily regimen is observed through their behaviour inside this community. As for all other people — trainers, volunteers and psychologists — they simply provide support both through individual counselling and in a general direction to, let's put it this way, keep people in this programme, so that they do not cross certain lines. They supervise the general course of the programme. To make sure treatment remains within the specific framework, to make sure it works. However, in general, they resolve many internal, discipline-related nuances if they occur on their own. There is a regimen — it is most important. This forms the basis for all other things. If any routine issues arise, they are resolved by the community.'

If a treatment follow-up programme exists, patients may receive support with social integration, improving their family relationships, developing the necessary social, household and professional skills they need as well as receive employment assistance. Of course, such comprehensive programmes are not always available; when they are available, they are not always in demand.

'As for social reintegration, it is ensured within the three-month treatment follow-up programme during which the patient reintegrates into society, into their family, and thinks about where they are going to work or already begin doing some odd jobs. We focus on this component of rehabilitation since simple therapy would not be effective without resocialisation.'

'We have some elements of social reintegration rather than a comprehensive programme. We start from the fact that they take care of themselves, since many of them are not even able to do that. Many people learn how to read there since many of them come and they cannot read; treatment ends with some work they are doing. In addition, we always have some volunteers coming. People come and bring their children, families, and they interact. We have a special playground there for children. Plus animals — they take care of animals. So, there are some elements of socialisation that we offer them. Although, of course, I cannot say that this is a comprehensive programme.'

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ACCESS TO TREATMENT AND REHABILITATION SERVICES

In general, drug services (treatment and rehabilitation) are accessible. Many rehabilitation centres are 'underloaded', although in some regions waiting lists are common. The number of occupied beds in rehabilitation departments for drug patients remains low compared to the number of occupied beds in treatment departments, perhaps illustrating either the lack of demand for such services or the need to implement outpatient rehabilitation programmes rather the inpatient models.

In the Russian Federation, state-run, private and faith-based rehabilitation centres operate. Treatment (detox) services are provided via both state-run and private rehabilitation centres. Experts highlight positive changes in the rehabilitation of drug-dependent individuals. First, these changes relate to the possibility of choosing a programme, the implementation of new approaches and programmes and to changes in attitudes towards drug use.

'In the last 10 to 15 years, [the situation] has changed drastically. Now, we have real rehabilitation. Whereas before we only used medications to treat drug addicts, now we have some rehabilitation interventions, maintenance therapy, psychological support and so on available. In our clinic, I can say that we also actively engage with the family members of our patients, an important contribution to their remission.Currently, more programmes are available. Now, we not only think about the stages of treatment, motivation and rehabilitation, but also consider the next stage of rehabilitation — that is, resocialisation…. At present, we can not only rehabilitate, but also provide employment opportunities'.

'Thank God, there are positive changes. Finally, many more people have begun to realise that it is not simple, that this problem is rather complicated. Now, much more accepting attitudes towards this category of patients exist; at last as a start drug-dependent users are perceived as sick people and not some bad guys. In those centres in which I worked, many staff members understand it very well. Maybe they continue implementing the same 12-step model, but they try to fill the content of the programme with a more or less liberal attitude and up-to-date information based on an evidence-based drug treatment approach. In particular, they do not demonstrate a strictly negative attitude towards harm reduction programmes, and the programme does not stipulate an absolute abstinence from drugs as a criterion of absolute recovery. Today, during individual consultations, they (young health workers) actively use modern approaches instead of the traditions of the national narcologists, which are so conservative.'

Simultaneously, however, a number of problems persist, such as a lack of general standards and approaches to the activities of both state-run and private rehabilitation centres. Furthermore, no control mechanisms exist to ensure the quality of services, to address issues such as unequal access to services in different regions or to address the use of approaches not based on evidence — both in treatment and rehabilitation. In addition, human rights violations and violence remain serious issues, particularly in so-called 'motivational centres.'

'The situation is not the same. Currently, drug treatment and rehabilitation services are provided in both state-run and private centres. Rehabilitation is also provided in faith-based rehabilitation centres so to speak under the aegis of religious confessions. There are no general standards in the delivery of rehabilitation and drug treatment services. The trends of a "cat's concert" or "everyone doing what they can" are strengthening.'

'There is no transparency, such that the situation in private rehabilitation centres, which provide rehabilitation services, is inhumane and sometimes even criminal in nature (as we know from the mass media and crime news).'

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'The standards include using psychotropic substances, in particular, neuroleptics and antipsychotics. This is the difference between Russian psychotherapy and post-Soviet psychotherapy or narcology compared to all other approaches. The list of drugs prescribed to drug-dependent patients includes a large number of antipsychotics, although such drugs are not included in WHO guidelines.'

Due to changes in the drug scene — in particular, the emergence and spread of 'designer drugs', pharmaceutical and synthetic drugs, and a reduction in the use of heroin which was previously widely used — experts talk about the need to revise approaches to drug treatment. That is, 'the drug treatment problem has become a mental health problem due to the appearance and use of new drugs.'

Recognising that, generally, information about treatment and rehabilitation services is accessible and a wide range of choices exist vis-à-vis rehabilitation centres, experts point out that a number of obstacles and barriers to accessing services remain. In state-run centres, the problems stem, first of all, from a lack of anonymity and the requirement of officially registering as a drug-dependent patient, possibly carrying negative consequences for the patient. These consequences may include prohibiting a patient from driving motor vehicles if remission is not sustained (according to an order from the Russian Ministry of Health) for at least three years and confirmed by a clinic certificate.

In addition, patients may be reluctant to seek help from state-run clinics due to the unsatisfactory conditions in such clinics as well as due to staff attitudes.

In private clinics, the high cost of services renders them inaccessible to most.

Furthermore, underage patients, disabled individuals and families where both partners use drugs especially if they have children also pose difficulties in the delivery of relevant services.

'We are not able to accept disabled individuals; our services are limited. We had such requests, but thus far we cannot, we do not have the ability to accept disabled patients. Entire families come, where both the husband and wife are drug- or alcohol-dependent, for example. We tried to work with such cases. But thus far it has not worked out very well because of certain difficulties. In addition, we have a limited number of beds, so there is no possibility to let them all stay here, particularly if they have children. We cannot work with underage patients. We have had such requests, but we cannot. We do not work with children and underage patients.'

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QUALITY OF SERVICES

Rehabilitation centre staff may include a variety of specialists including doctors, nurses, psychologists, medical psychologists, social workers and peer consultants from amongst former patients. Their qualification level stands as an important determinant of the quality of services.

Staff in state-run rehabilitation centres and the criteria for personnel selection are strictly regulated. In commercial and faith-based centres, the number and structure of staff vary depending on the needs and capabilities of the centre. Engaging the required specialists on a regular or a case-by-case basis continues as a standard practice.

To obtain a certificate as a psychiatrist-narcologist with the right to treat drug-dependent patients, a doctor qualified as a primary care physician (general practitioner according to Russian law) should receive residency or speciality training in this area. Such training is provided by relevant departments (psychiatry and narcology) in all medical universities across the country (consisting of more than 50 institutions). The training is delivered in accordance with the Federal State Educational Standard approved by the Russian Ministry of Health (2014) and stipulates a two-year residency training programme (1152 academic hours of study). After completing the residency training, the psychiatrist-narcologist must complete advanced training courses every five years. The Federal Educational Standard is mandatory in all Russian higher educational institutions, including both state-run and private institutions. During training, additional options include studying child psychiatry or forensic psychiatry. Furthermore, internships are mandatory. Such training may be provided both on a free (covered from the state budget) and for-fee basis.

Training in psychiatry-narcology is accessible and covers the requirements set by the state. However, educational standards in the treatment of drug-related disorders are based on outdated and unscientific concepts. Thus, in Russian narcology, the doctrine states that a 'morbid attraction' to drugs (and other PAS) is a psychopathological syndrome requiring therapy using antipsychotics (neuroleptics) — that is, substances typically used to treat schizophrenia. 'Harm reduction' approaches remain entirely ignored.

As such, training programmes should be revised, taking into account the results of evidence-based research. Special certified programmes for psychologists are necessary in order to develop the scientific basis of rehabilitation for drug-dependent patients. No special training in the rehabilitation of drug-dependent patients currently exists.

Within residency training programmes for psychiatrists-narcologists, one component dictates the study of rehabilitation technologies.

There are no specific requirements for the training and certification of social workers and counsellors who work in rehabilitation centres. Simultaneously, social workers and counsellors may gain work experience and training in such centres.

It is quite difficult to assess the quality of services available largely because monitoring and evaluation systems remain inappropriate. For all types of programmes implemented in the Russian Federation, a key treatment success criterion is a patient's sustained remission and complete abstinence.

Amongst state-run institutions, remission monitoring is mandatory. Treatment success is defined as a one- or two-year remission. This assessment is based on patient and patient relatives self-reporting.

'Remission is monitored through our social workers, and data are provided by outpatient clinics for those who receive further follow-up services, as well as through the Narcotics Anonymous and Alcoholics Anonymous communities.'

Furthermore, attempts are being made to monitor programme results achieved through private rehabilitation centres. But, in both private and faith-based centres, certain difficulties may be encountered when attempting to maintain regular communication with patients who received inpatient rehabilitation services or with their family members. This is particularly the case if no outpatient programme operates or if a patient does not agree to enrol in such an outpatient programme.

'In private facilities, we try to do it through calls and by supporting the patient when follow-up services are provided after a such patient is released from the rehabilitation centre. Their relatives come. There are support groups available.'

'Our church tries to elaborate upon some criteria, at least for ourselves, to understand how it all works. It is possible to keep in touch only with a person who wants to be kept in touch with, right? In most cases, those people get some help and go into remission. Or, vice versa, they have a relapse and then they come back. Sometimes, they come back for a second or third time. We keep in touch with them, because, above all, they are the ones who need it.'

Other more formal success criteria have been used, including, for example, the proportion or number of patients who completed inpatient treatment or rehabilitation courses and patients repeatedly hospitalised. Experts underscore that there is a need to extend the list of programme success criteria, adding indicators relating to different spheres of life such as the health status, social bonds and employment status amongst others in keeping with international standards. This would also extend to monitoring improvements 'in outpatient settings.'

In various types of rehabilitation centres, internal, 'programmatic' service quality criteria indicators may be applied. For instance, 'There are tools. Each professional has such criteria for their service delivery — the scope of completion of the rehabilitation programme, its quality, the lack of complaints from the side of patients and their family members.' For each patient, a medical record or medical history form is maintained, describing the treatment services provided, methods used and the patient's dynamics. However, this is not implemented in all private and faith-based centres.

Rehabilitation centres try to collect information on the client's satisfaction with the quality of services provided, both from such clients and based on indirect indicators.

'Once a year, we assess treatment success for patients who enrolled in our inpatient rehabilitation programmes. We find them in the community, or they come to us. There is a good tradition when patients come for anniversaries at the centre, where they share some words of appreciation. In addition, a feedback record book for patients of both post-rehabilitation and post-treatment programmes exists.'

'In my opinion, the primary indicator of success is the repeated visits to the facility in cases of relapse. If there is a relapse. And recommendations to one's acquaintances, friends and family members.'

'There is feedback available via the internet; this may also be viewed as an indicator.'

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Most experts voiced scepticism concerning the accuracy of data on client satisfaction based on client feedback or the possibility of collecting such information. Furthermore, not everyone viewed client satisfaction as an indicator of service quality.

'Some centres offer patients the opportunity to complete exit questionnaires: what you liked/did not like. Those forms are anonymous and, given this anonymity, it is difficult to check if a client completed it or if a nurse did simply to get positive feedback.'

'Of course, its primarily those clients who completed their rehabilitation courses and it worked out well for them who provide positive feedback.'

'Patients who are kept there are in most cases forced to stay there. So if you come to a patient in such centre and ask them, 'Would you like to continue your treatment?', of course, most will say, 'No.' It's clear that in such cases it makes no sense to speak about client satisfaction.'

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RECOMMENDATIONS

Russian experts suggested the following recommendations towards meeting the needs of drug users:

- **Implementation of standards vis-à-vis certification and licencing for rehabilitation centres under governmental control to ensure the quality of services. Standards should be based on evidence-based approaches.**

'If such a concept and standards are approved, and the implementation mechanism is approved — a clear mechanism, stipulating the level of service provision and the necessary staff to provide such services — and if service providers are licenced, then, I think, those services will be provided in a more civilised way.'

'Any centre, which would like to provide such services, or any commercial organisation or faith-based or community-based organisation that would like to do so, should get a licence. This would ensure that the level of its services would meet a set of requirements. There should be trained professionals staffing centres capable of providing such services. There should be social workers, specialists in social services, psychologists and maybe doctors. There should be licencing and control.'

'…apply a differentiated approach to treatment and the rehabilitation of patients. Such differentiation will be based, first, on the stage of dependence and on the substance the patient uses. Second, this differentiation should be based on the types of services provided, depending upon what result the patient would like to achieve. If a person is ready to reduce or decrease the risk of substance use, such a person should be included into programmes, so-called low-threshold programmes. There should be options for harm reduction, and rehabilitation aimed at complete abstinence and the 12-step model. And faith-based models should be available. If that is the choice of the patient, they may go there. But if the patient goes to a state-run institution, they should have some guarantees that it is not harmful, it is safe and there is respect for human dignity. Also, only evidence-based rehabilitation and treatment methods should be implemented.'

- **Effective rehabilitation should be offered as an alternative to imprisonment.**

'I support the approach of creating a system such that if there is a court judgment and the person is found sick, such a person should be forced by law to go through rehabilitation. Not go to jail, but go through rehabilitation as an alternative. Thus, there would be people there who really would work with them, help them and work with their substance abuse habits.'

- **Professional training, educational resources and reviews of evidence-based methods, as well as the organisation of scientific conferences, should be made available and organised.**

'A Russian-language website should be created for professionals providing drug treatment services, providing scientific information about the results from up-to-date studies based on evidence-based approaches.'

'…today probably the only thing I would like to have is training opportunities for specialists.'

'Additionally, training (support) may be offered. To train specialists, in particular, from civil society, non-governmental and faith-based organisations, specifically abroad.'

'I think that they (AFEW International) should provide as much information as possible to relevant specialists on which methods work and which do not work. Reviews of these methods should be continued.'

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17. Федеральный закон РФ «О внесении изменений в отдельные законодательные акты Российской Федерации и признании утратившими силу отдельных положений законодательных актов Российской Федерации по вопросам охраны здоровья граждан в Российской Федерации» от 25.11.2013 N 317-ФЗ

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SUMMARY

In 2015, 3591 persons were registered as patients with a drug dependence. In total, 699 942 people registered with mental and behavioural disorders caused by the use of psychoactive substances (PAS) within the Ukrainian healthcare system. The estimated number of people who inject drugs in Ukraine is 346 900 people (Alliance for Public Health, 2016). In addition, an estimated 21 700 underage drug users inject drugs, although the number of underage non-injecting drug users is unknown.

The drug scene may vary in different regions of the country. But, in general, acetylated opium, which was previously widespread, is now yielding its popularity to psychostimulants and pharmaceutical drugs. Designer drugs such as 'salts', 'mixes' and 'spices', which may be purchased through the internet and then be hidden at certain locations for pick up by the buyer, are becoming increasingly popular, particularly amongst young people.

Nationwide, the drug policy of Ukraine is defined by the ***'Strategy of the National Drug Policy for the period up to 2020'.*** The primary goal of the strategy is to define the priorities of the state policy, which is based on the need to transition from a punitive, repressive approach in drug policy to approaches based on treatment and prevention as the most effective models. Whilst the strategy is a rather progressive document in practice, no specific actions exist to ensure its comprehensive implementation at the national level.

Another problem with the national drug policy lies in the **restrictive legislation** for the possession of drugs for personal use. Ukrainian laws contain tables defining the amounts of narcotic substances, according to which the amount (volume) of substances seized may be classified as 'small', 'large' and 'especially large'. The extremely low threshold defining a 'small' amount of substances leads to disproportionately strict punishments for the majority of people who use or possess drugs for personal use.

The **provision of medical** care for patients with drug dependence is regulated by various normative guidelines and based on state-run drug treatment centres and mental health clinics. Detoxification and OST services can also be provided at private clinics which have the relevant licence. In addition, **rehabilitation services** may also be provided by private or commercial, civil society, charitable and faith-based organisations. A review of Ukrainian legislation shows that the existing regulatory framework does not create any legal barriers for the rehabilitation of people with a drug dependence; at the same time, there are no clearly defined mechanisms outlining the required permissions to open and maintain a rehabilitation centre (inpatient or outpatient) nor are there clear guidelines on the requirements for staff and the content of a rehabilitation programme. Furthermore, no mechanisms exist for assessing the quality of their work. Moreover, the mechanism of service delivery for people with experience with drug use but with no established diagnosis of 'drug dependence' is not defined, nor is the procedure or protocol for consultations, referral or support for underage people who use drugs.

Within the state system of medical care for people with a drug dependence, 33 drug treatment centres, 3 drug treatment hospitals, 40 drug treatment day care centres as well as over 500 substance abuse counselling offices operate across Ukraine. OST programmes offering buprenorphine and methadone (in tablets and liquid form) are implemented in 174 healthcare institutions in Ukraine. From amongst all these facilities, only two state-run medical centres provide comprehensive inpatient rehabilitation programmes.

Currently, no official statistics are available on the total number of non-governmental rehabilitation centres in Ukraine, although a quick overview of the available information shows that the number is quite large, exceeding 100. Amongst 93 assessed non-governmental centres, all offer inpatient services. Another 26 centres also provide outpatient services.

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The existing practice of work with people who use drugs includes various detoxification methods, substitution treatment, emergency care as well as social and psychological rehabilitation. The rehabilitation programmes used by centres vary greatly. In most cases, these are based on a 12-step approach. Apart from that, such centres use other approaches consisting of psychotherapy (individual and group therapy), gestalt therapy, family therapy, client-centred therapy, cognitive therapy, CBT, work therapy and art therapy amongst others. The choice of approaches and programmes depends on the experience and educational background of the specialists offering such therapy.

Treatment and rehabilitation services are generally accessible to people who use drugs; there is no deficit of information about such programmes. At the same time, a number of **problems** impact the delivery of high-quality assistance to drug-dependent people and result in **barriers to accessing** such assistance. These include the following:

- The programmes provided by state-run institutions are traditionally high-threshold. Despite the fact that many services are offered in different price-range categories, for many clients the need to pay for such services remains an issue.
- Specific services for minors and women who use drugs that would meet their needs remain lacking.
- Treatment and rehabilitation services are rarely available in prisons and typically irregularly provided by NGOs or faith-based organisations.
- There are also no guidelines on how the efficiency of treatment methods used should be assessed. There is no mechanism to ensure reliable control over service delivery, starting from diagnostics, registration for follow-up, service delivery and treatment success.
- Education on treatment and the rehabilitation of people with a drug dependence is available only for medical specialists (narcologists). No special training exists for social workers and psychologists, except for short courses and trainings.
- The absence of rehabilitation standards and protocols renders the quality control of services and evaluation of their effectiveness impossible.
- There is a need to develop missing and improve existing standards and guidelines. For instance, guidance or standards on the provision of services for people with psychostimulant dependence should be formulated.

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NATIONAL DRUG POLICY

At the legislative level, the national drug policy of Ukraine is defined by the ***'Strategy of the National Drug Policy for the Period Up to 2020'.***
. The primary goal of the strategy is to define the priorities of the state policy based on the need to transition from a punitive, repressive approach to drug policy to approaches based on treatment and prevention as the most effective models.

Those implementing the strategy consist of the Ministry of Social Policy, the Ministry of Health, the Ministry of Education and Science, the Ministry of Internal Affairs, the Security Service, the Ministry of Infrastructure of Ukraine, the Administration of the State Border Guard Service, the State Committee for Television and Radio Broadcasting, the Ministry of Finance, the Ministry of Youth and Sports, the Ministry of Justice of Ukraine, the State Service on Medicines, the State Service on Drugs Control and the State Fiscal Service of Ukraine.

Based on the principles of drug policy humanisation, the government defines its priorities as preventing drug dependence, overcoming stigma and treating and rehabilitating people with a drug dependence. The strategy stipulates the following activities:

- Revising the content of prevention activities to form protective social barriers and a readiness to confront the risks and ensure healthy lifestyles within society.
- Implementing prevention activities as a component of all types and forms of drug policy.
- Promoting healthy lifestyles in the general population, with a focus on children, schools and university students.
- Regular monitoring of the effectiveness of prevention activities.
- Cooperation between governmental authorities and civil society organisations with the mass media to raise public awareness and to present accurate, evidence-based information on the harms associated with using drugs, alcohol and tobacco.
- Reducing the level of stigma and discrimination towards people who use drugs, including people living with HIV, by raising the level of public awareness about such problems and establishing responsibility for the violation of the human rights of drug-dependent and HIV-positive people, particularly if such violations are based on discrimination directed at them.
- Creating an integral, accessible, effective, evidence-based and accountable system of treatment and rehabilitation based on genuine needs assessments.
- Implementing innovative methods of a coordinated biopsychosocial approach and pharmacological treatment based on interaction between healthcare institutions, social services, civil society and non-governmental organisations, including self-help groups and programmes.
- Ensuring the accessibility of all types of drug treatment services, the implementation of psychosocial and pharmacological programmes (including detoxification) in institutions of the penitentiary system, alongside support and supervision of this process amongst other steps.

It should be noted that the strategy does not contain any definition for the treatment or rehabilitation of or for resocialisation services for minors; furthermore, activities for women are not outlined, in particular, for mothers raising underage children with experience in the 'non-medical' use of drugs, but who are not officially registered as drug users or who do not have an established diagnosis of 'drug dependence'. At the same time, the importance of 'solving the problems' of pregnant women receives special attention.

That said, the document stipulates the formation of the conditions for the comprehensive, integrated use of all components of the healthcare system and their interaction aligned with evidence-based approaches,

opportunities. Emphasis is placed on ensuring that treatment and rehabilitation services for drug-dependent individuals adhere to international standards and guidelines. Furthermore, the strategy defines the need to launch and maintain a system to monitor the quality and effectiveness of such activities. Emphasis is placed on the importance of organising professional training programmes for specialists engaged in the prevention of drug use and drug treatment at higher educational institutions, although no options are offered to ensure the training of specialists on rehabilitation and resocialisation.

The strategy is implemented after annual approval of the relevant action plans and the allocation of funding from national and local budgets.

Parties involved in forming and implementing the drug policy in Ukraine

The Ukrainian law ***'On Drugs, Psychotropic Substances and Precursors'*** (1995) and the ***'Strategy of the National Drug Policy for the Period Up to 2020'*** together define the powers of the central executive authorities in the distribution of drugs, psychotropic substances, their analogues and precursors and combating their illicit trafficking.

The Ministry of Health of Ukraine is responsible for defining the national policy vis-à-vis drug distribution; takes part in developing national programmes and regulations related to the control of the distribution of drugs, psychotropic substances and their precursors; and is responsible for the provision of medical support, prevention and the rehabilitation of drug-dependent people.

The State Service of Ukraine on Medicines and Drugs Control is responsible for implementing the state policy in the distribution of drugs, psychotropic substances and their precursors and in combating their illicit trafficking; the licencing of economic activities related to the distribution of drugs, psychotropic substances and precursors; and implementing state regulation and control vis-à-vis the distribution of drugs, psychotropic substances and their precursors and combating illicit trafficking. The activities of this service are coordinated by the Cabinet of Ministers of Ukraine through the Minister of Health. Thus, the national drug control policy should be implemented through the Ministry of Health, which grants proper attention interventions aimed at the medical rehabilitation of drug-dependent people within a modern, balanced approach to the issue of drugs.

Until 2015, a State Service on Drugs Control (SSDC) existed in Ukraine. According to Order No. 647 of the Cabinet of Ministers of Ukraine, dated 12 August 2015, all functions of SSDC were taken over by the State Service of Ukraine on Medicines and Drugs Control. It is expected that the merger of the State Service on Medicines and the State Service on Drugs Control will significantly impact implementation of the drug policy in Ukraine. Uniting the functions of drug provision and control over the legal distribution of drugs and psychotropic substances into one department will contribute to satisfying the lawful needs of Ukrainian citizens in drug-containing medications, humanising drug policy in general and implementing approaches focused on medical and prevention activities.

The Ministry of Social Policy of Ukraine and the Ministry of Education of Ukraine are responsible for the organisational and logistical arrangements in the area of the prevention and rehabilitation of drug-dependent people and the prevention of substance use among children and young people.

The National Police of Ukraine assume responsibility for the implementation of the state policy in the area of combating the illicit trafficking of drugs, psychotropic substances, their precursors and psychoactive substances. In addition, police implement activities aimed at the prevention of crimes as well as activities aimed at the social adaptation of people released from places of confinement.

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The laws of Ukraine contain tables defining the amounts of narcotic substances according to which the amounts (volumes) seized may be classified as 'small', 'large' and 'especially large'. The severity of the punishment is defined by the amount (volume) of the substance seized. One of the key problems in the national drug policy is the extremely low threshold for 'small' amounts of substances, which leads to disproportionately strict punishments for the majority of people who use or possess drugs for personal use.

According to experts, whilst in theory Ukrainian law outlines a progressive drugs strategy, in practice no specific actions to ensure its comprehensive implementation exist. In particular, the following reflect Ukrainian drugs policy:

'Our state and our authorities, for instance, the Ministry of Health, they are not so eager to work in this area and develop some national support programmes. So, currently, it is all based on public enthusiasm. Fortunately, so far some assistance comes from foundations, charities and so on.'

'A priori a state-run policy may not exist (e.g., training programmes in the rehabilitation of drug-dependent people) because the state has not worked towards the rehabilitation of drug addicts. Yes, they can act as intermediaries, they can organise something. But, for whom? They do not have any institutions called rehabilitation centres, they do not work in this area. Why would they? They prefer to stay on the sidelines. It is clear that they should do it, but they do not think it is necessary. Because there are no state facilities there, no state specialists.'

'There should be one national protocol developed to be followed by all such rehabilitation centres. Consequently, when there is control and there are rules, which are the same for all, to be developed and launched at the legislative level, then we will have some order and control.'

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CHARACTERISTICS OF THE DRUG USE SITUATION IN THE COUNTRY

As of 1 January 2016, 699 942 people with mental and behavioural disorders caused by the use of psychoactive substances (PAS) were registered within the Ukrainian healthcare system. In 2015, 113 609 patients registered for further follow-up with such diagnoses, amongst whom were 32 587 people with established diagnoses of PAS dependence. In total, 28 921 (88.8%) patients with chronic alcohol abuse syndrome and alcohol-induced psychotic disorders and 3 591 (11.0%) patients with a drug dependence were registered.

According to the Public Health Centre of the Ministry of Health, as of 1 July 2017, a total of 306 295 people living with HIV were registered in Ukraine, including 97 584 AIDS cases and 43 206 cases of AIDS-associated deaths. In 2016, a total 17 066 people were newly diagnosed as HIV-positive, amongst whom 10 506 transmitted HIV through same-sex and heterosexual contact (61.6% as opposed to 59.3% in 2015 and 56.7% in 2014) and 3728 through injecting drug use (21.8% compared with 21.7% in 2015 and 24.23% in 2014).

An estimated 346 900 PWID live in Ukraine (Alliance for Public Health, 2016). A biobehavioural survey among PWID found that 80% of PWUD are men. The largest age group consists of drug users over 25 years of age (89.5%, with an average age of 34 years). Most PWUD have completed their secondary education, almost one in four is legally married and another 35% are unmarried but have regular sexual partners. In total, 71% of PWID hold down regular or odd jobs.

Most PWID initiated using substances through non-injecting drug use (66%). Most tried drugs for the first time at a young age when they were under 19 years old. At first use, 73% had experience with non-injecting drug use whilst 59% injected.

The most popular drug amongst Ukrainian respondents remains an opium extract or 'shirka'. Amongst stimulants, respondents most often named a methamphetamine solution or 'vint' as their drug of choice. As for the drugs used only via non-injecting administration, the most popular drug was marijuana (cannabis) reported by 27% of respondents, whilst 4% of respondents only used an amphetamine via non-injecting routes, 1% reported using tramadol and 2% reported other pharmaceutical drugs.

As for the frequency of drug use, PWID on average reported injecting drugs once in the 24 hours preceding the interview, about 5 times during the most recent week and about 20 times during the most recent month. Using information updated from 2015 amongst underage drug users, the total number of adolescents in risk groups, an estimated 129 000 youth aged 10 to 19 years (inclusive) use drugs in Ukraine. Amongst these, 21 700 reported injecting drug use (17 500 boys and 4200 girls). The number of non-injecting drug users remains unknown. However, considering the tendency towards wider spread non-injecting drug use amongst young people, we may assume that this number is much higher.

Since 1995, Ukraine has taken part in the project 'ESPAD: The European School Survey Project on Alcohol and Other Drugs'. According to ESPAD survey results, 11.3% students aged 15 to 17 years had used any illicit substance (15.4% boys and 7.9% girls). In addition, 10.6% of respondents had tried marijuana or hashish at least once during their lives (14.5% boys and 7% girls).

Specialists involved in treating and rehabilitating drug-dependent people reported recent considerable changes taking place in Ukraine's drug scene. These changes relate to the spread of different types of drugs, the appearance of new PASes, their means of production and administration and to their accessibility and consequences on people's health. The situation may vary in different regions of the country; but, in general, acetylated opium, which has been widespread, is now being replaced by psychostimulants and

pharmaceutical drugs. Designer drugs ('salts', 'mixes' and 'spices'), which may be purchased through the internet and then hidden at certain locations for pick up by the buyer, are becoming increasingly popular, particularly amongst young people.

'If I take our experience over the last 25 years, I would say that the situation has drastically changed. First, the substances that people use are changing, the production methods are changing as well as the ways of administering such substances. Moreover, the population of drug users is also changing. In the beginning, let's say in the early 1990s, drug users primarily used poppy straw extract, that is, home-made opium. Now, there are plenty of things, and they are all sold in pharmacies. Apart from that, there are so-called quasi-legal drugs. These include salts, mixes and spices. These are the things which recently became quite widespread.'

'Today, in every second apartment building in Kyiv, there are telephone numbers written with offers of 'salts', 'spices' and other designer drugs. Really, our patients confirm that if you make a call or even go online without calling — you can do it all through the internet, ordering whatever you want, and it does not matter how old you are, if you are 12 or 13 — they will leave a drug stash for you. You transfer money, they tell you where the stash is, the time and the place the drugs will be there, and you go there and pick it up.'

New types of drugs, which vary in terms of content and how they are produced, have a much more destructive effect on users' mental and physical health and lead to disabilities in a short period of time.

'in the last five years, the positions of opiates have weakened immensely. Psychostimulants are now dominating. These are very complicated, very problematic substances. If we take amphetamine, this is a drug our doctors have known for decades. But, as a rule, this substance was brought from abroad. Today, a large portion of the substance is produced in our country. From what I understand, if some ingredient is missing, they try to replace it with something else, and as a result we get a totally new substance. So, it is a big question if it is still amphetamine. Two years ago, we faced a challenge which was totally new for us — we had many cases of psychosis after using an amphetamine. Before, we did not have such a problem. Either the format for drug use or the drug itself, its formula — something has changed. Now, we have cases of psychosis, which develop not through long-term use, not as a part of withdrawal, but just after three Fridays, three parties — and an ambulance team brings the adolescent to us.'

'As strange as it may sound, ten years ago psychoactive substances were much cleaner and of much better quality. So, yes, the person, of course, became dependent and destroyed their health. It was all there, but the consequences were much less than now. Because there are so-called "pharmaceutical drugs." You know, like codeine, like tramadol. This "crocodile", this "godishka" [one-year drug] — almost all drugs are like this now. In fact, after a year of use, people are developing irreversible side effects. Their jaws are decaying, their vision is lost, they are destroying themselves. Just a year or two, and there are irreversible processes, people become almost disabled. And there is another important thing: they have such a strong effect on the mental state of people that, when they come to us, we are not able to help them because we are not a mental health clinic. So, they come to us after using these drugs for a year, and they have such severe mental health disorders that it falls instead within the sphere of psychiatry. Often, they reach a point of no return.'

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REGULATORY FRAMEWORK FOR THE TREATMENT AND REHABILITATION OF PEOPLE WHO USE DRUGS

In this section, we outline the various strategy documents guiding policy and activities aimed at treating and rehabilitating Ukrainian people who use drugs.

1. ***Order No. N735-r of the Cabinet of Ministers of Ukraine, dated 28 August 2013, Kyiv, 'On Approval of the Strategy of the National Drug Policy for the Period up to 2020'*** **(http://zakon2.rada.gov.ua/laws/show/735-2013-p).**

This strategy defines the essence and the current trends related to the national drug policy based on an integrated and balanced approach to reducing the supply of drugs illegally distributed, whilst also reducing demand and combating drug dependency as a dangerous social phenomenon. The human being, their life and health, honour and dignity and integrity and safety are recognised as the highest social value. The strategic direction chosen by the state seeks to shift from a punitive, repressive approach to approaches based on treatment and prevention.

Furthermore, this strategy defines the direction of state policy in the area of drugs and describes the approaches and principles to be observed when establishing and revising the regulatory framework within the context of drug control and the provision of support to people who use drugs. To do so, the strategy states that treating and rehabilitating people with a drug dependence require new approaches, such as the comprehensive, integrated use of all components of the healthcare system and their interaction aligned with evidence-based approaches, ensuring access to medical services, whilst expanding treatment and introducing alternative punishment opportunities.

The Ministry of Health of Ukraine coordinates the development of the annual ***Action Plan for the Strategy Implementation***, approved by the Cabinet of Ministers of Ukraine. Responsibility for implementing the plan falls on the ministries specified within the strategy, alongside other central executive authorities and regional and Kyiv city administrations. The above-mentioned bodies submit information on implementing the plan to the Ministry of Health, which aggregates all information and submits it to the Cabinet of Ministers of Ukraine. All expenses associated with implementing the action plan fall under the national and local budgets allocated for the relevant year as well as covered from other sources not prohibited by law.

2. Resolution No. 932 of the Cabinet of Ministers of Ukraine, 'On approval of the procedure to prepare regional development strategies and action plans on the implementation of such strategies as well as monitoring and evaluation of the effectiveness of such regional strategies and action plans', dated 11 November 2015 **(http://zakon3.rada.gov.ua/laws/show/932-2015-%D0%BF).**

This procedure defines the mechanisms for preparing and implementing regional development strategies and action plans, including their implementation, the monitoring and evaluation of their effectiveness and regulation of the development and implementation of regional strategies and action plans for such strategies in terms of drug policy.

3. ***Resolution No. 1393-p of the Cabinet of Ministers of Ukraine, 'On the approval of the action plan to implement the National Human Rights Strategy for the period up to 2020', dated 23 November 2015*** **(http://zakon2.rada.gov.ua/laws/show/1393-2015-p).**

This action plan contains provisions for the development and approval of standards for the delivery of medical and social rehabilitation and psychosocial adaptation services for underage patients, patients with drug dependence and patients with experience in psychoactive substance use. It also outlines guidelines on the

creation of a governmental social contract system to order such services based on international best practices.

4. *Law of Ukraine No. 60/95-VR, 'On narcotic drugs, psychotropic substances and precursors'*, dated 15 *February 1995* (http://zakon2.rada.gov.ua/laws/show/60/95-вр).

Until 2013, legislative documents regulated the delivery of treatment and rehabilitation services to people with a drug dependence (that is, with an official diagnosis) as individuals suffering from mental health disorders characterised by a mental and (or) physical dependence on narcotic drugs or psychotropic substances. This characterisation was based on the results from a medical examination carried out in accordance with the ***Law of Ukraine No. 62/95-VR, 'On narcotic drugs, psychotropic substances and precursors', dated 15 February 1995***. In that document, no distinction is made between people who use drugs depending on the type of substance used or the experience of drug use. If a person is addicted to narcotic drugs or psychotropic substances but does not have an established diagnosis of 'drug dependence' (article 12 of the law, based on the conclusion of a medical consultative board), such a patient is not viewed as ill and, correspondingly, does not require treatment or rehabilitation. Furthermore, the category of people who use narcotic drugs but do not misuse them does not define their status nor the mechanism of service delivery to such people, including rehabilitation services.

5. Law of Ukraine No. 62/95-VR, 'On measures to counter the illicit trafficking of drugs, psychotropic substances and precursors and their abuse', dated 15 February 1995 (http://zakon3.rada.gov.ua/laws/show/62/95-вр).

6. Guidelines to perform Article 12 and the procedure to perform Article 13 of the Law of Ukraine 'On measures to counter the illicit trafficking of drugs, psychotropic substances and precursors and their abuse.'

7. Guidelines 'On the procedure for the identification and registration of people who use illicit narcotic drugs or psychoactive substances', by Order No. 306/680/21/66/5 of the Ministry of Internal Affairs of Ukraine, the Prosecutor General's Office of Ukraine and the Ministry of Justice of Ukraine, dated 10 October 1997 (http://zakon3.rada.gov.ua/laws/show/z0534-97).

The document regulates procedures related to interaction amongst law enforcement agencies, corrective labour institutions and healthcare facilities to ensure the registration of drug users and their treatment history.

As such, law enforcement agencies refer people who use illicit drugs or psychotropic substances for medical examinations to healthcare institutions providing drug treatment. For this purpose, the referral of people dependent on such substances for medical examination may be based on information received from enterprises, organisations, facilities, mass media or other individuals stating that such people use illicit narcotic drugs or psychotropic substances or that they a drug intoxicated. According to experts, this provision on identifying people who use illicit drugs or psychotropic substances is outdated and may be interpreted as a compulsory measure towards medical check-ups.

The grounds for registering such people for further follow-up may be established through the diagnosis of 'drug dependence', 'substance abuse' or a state of drug intoxication. People who avoid voluntary medical examinations or check-ups are brought to a drug treatment institution by law enforcement officers on a compulsory basis.

Furthermore, law enforcement agencies keep track of all individuals found to use illicit drugs or psychotropic substances, except individuals who sought medical attention willingly and who follow a doctor's recommendations.

More specifically, paragraph 8 of the procedure states that if following a medical examination a diagnosis of 'drug dependence' or 'substance abuse' is established, the medical consultative board of the drug treatment facility must offer that individual a course of voluntary treatment as well as social and medical rehabilitation.

8. Joint order of the Ministry of Health and the Ministry of Internal Affairs No 158/417, 'On the approval of the procedure for medical examination and medical check-up of people who abuse narcotic drugs or psychotropic substances', dated 16 June 1998 (http://zakon5.rada.gov.ua/laws/show/z0482-98).

This document approved the procedure for the medical examination and medical check-up of people who abuse illicit drugs or psychotropic substances. The procedure defines the conditions of such examinations and check-ups.

9. Law of Ukraine No. 966-IV, 'On social services', dated 19 June 2003.

This law regulates the primary principles for receiving social services, in particular, amongst people with an established diagnosis ('drug dependence'), and includes a list of services and general standards for their delivery.

10. Law of Ukraine No. 2460, 'On the associations of citizens', dated 16 June 1992 (http://zakon3.rada.gov.ua/laws/show/2460-12).

This law describes the mechanism for the creation and rights of civil society organisations, including the associations of citizens organised to satisfy and protect their lawful social, economic, creative, age-related, national, cultural, sports-related or other joint interests. Civil society organisations have a right to register legal entities and carry out economic activities required to perform their statutory goals. In particular, the law regulates the activities of civil society organisations providing rehabilitation services.

11. Regulation of the Cabinet of Ministers of Ukraine No. 979, 'On the approval of the standard provisions on resocialisation centres for drug-dependent youth', dated 16 September 2009 (http://zakon3.rada.gov.ua/laws/show/979-2009-n).

This document outlines the standard provisions describing the general standards of creating resocialisation centres for drug-dependent young people and contains recommendations for regional administrations to create such centres in Ukraine.

12. Ministry of Health Order No. 200, 'On the approval of the procedure to provide substitution maintenance therapy to patients with an opioid dependence', dated 5 June 2012 (http://zakon3.rada.gov.ua/laws/show/z0889-12).

This document outlines the procedure to provide substitution maintenance therapy to patients with an opioid dependence, and includes a description of the criteria and procedure to enrol patients into an opioid substitution treatment (OST) programme, including the rights and obligations of the healthcare institution, health workers and patients and key types of documentation amongst other procedures. We must note that the current version of the law stipulates that the only eligibility criterion for enrolment in an OST programme is an established diagnosis of opioid dependence. Patients under 18 years of age with such a diagnosis may also be enrolled in an OST programme with written permission from their parents or other legal guardians, particularly if they have comorbidities or diagnoses such as HIV, hepatitis B or C, TB, pregnancy, symptoms of sepsis or cancer.

13. Joint order of the Ministry of Health, the Ministry of Internal Affairs, the Ministry of Justice and the State Service of Ukraine on Drugs Control No. 1868/22180, 'Procedure for the cooperation of healthcare institutions, law enforcement bodies, pretrial detention centres and correctional facilities to ensure uninterrupted opioid substitution treatment', dated 7 November 2012 (http://www.moz.gov.ua/ua/portal/dn_20121122_821.html).

This order regulates the procedure for cooperation amongst key governmental bodies engaged in the provision of uninterrupted treatment using substitution therapy for patients with an opioid dependence.

14. Order No. 681, 'On the approval of the clinical guidelines to provide medical aid in the area of "narcology"', dated 21 September 2009 (http://www.moz.gov.ua/ua/portal/dn_20090921_681.html), with specific reference to the section on 'narcology' (http://medstandart.net/byspec/49).

This order contains a list of clinical guidelines on the provision of support to people in various clinical conditions, including addiction syndrome and withdrawal amongst others. All of the guidelines related to the use of drugs describe the provision of support to people who use opioids, whilst no separate clinical guidelines are included in the order on the provision of support to people who use or misuse psychostimulants.

Amongst other things, this order approves the procedure for conducting medical check-ups and for the completion of medical examination protocol to identify substance abuse and intoxication. An integrated approach is used depending on the symptoms and severity of the condition.

In addition, the drug treatment standards approved through this order from the Ministry of Health of Ukraine are formally mandatory. In fact, however, they are formulated in such a way that they allow for the use of various drugs and medical interventions, ranging from substitution therapy to massage and acupuncture.

Furthermore, an assessment of the consistency between national documents on the treatment of opioid dependence and international standards implemented in 2015 by the Ukrainian office of UNODC demonstrated that current clinical guidelines on drug treatment in many cases fall short from established international standards. In addition, certain contradictions exist across some national standards, such as the standard for treating HIV-positive people who inject drugs. First, such contradictions relate to the management of comorbidities, providing integrated support and the resources available. Current clinical guidelines remain quite general and difficult to use as working algorithms. Additional documents describing the standards to provide support to HIV-positive PWID and OST are insufficient to fill existing gaps in service needs. A number of basic international principles, such as 'Community engagement in treatment', 'Policy development' and 'Treatment of drug dependence as an alternative to criminal sanctions', are not reflected in current regulations.

15. Ministry of Health Order No. 268, 'On organising activities to monitor the alcohol and drug situation in Ukraine', dated 11 May 2006.

16. Request of the Cabinet of Ministers of Ukraine No. 14297/1/1-05, in response to a letter from the UNDP Office on the project, 'National observatory of control over alcohol and drugs', dated 29 March 2005.

17. Ministry of Health Order N 260-o, 'On the reorganisation of the state institution "Ukrainian medical and monitoring centre on alcohol and drugs of the Ministry of Health of Ukraine" to the state institution "Ukrainian medical and monitoring centre on alcohol and drugs of the Ministry of Health of Ukraine', dated 17 December 2013.

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18. Ministry of Health Order No. 12-o, 'On voiding order No 260-o of the Ministry of Health, dated 17 December 2013', dated 18 February 2015, terminating the procedure of reorganisation (restoring the status) of the state institution, 'Ukrainian medical and monitoring centre on alcohol and drugs of the Ministry of Health of Ukraine' (http://www.ummcda.org.ua).

The above-mentioned legal acts regulate the creation and functioning of the state institution Ukrainian Medical and Monitoring Centre on Alcohol and Drugs of the Ministry of Health of Ukraine. The key functions of the centre consist of monitoring the drugs and alcohol situation in Ukraine, coordinating activities and organising cooperation amongst central executive bodies, healthcare institutions and NGOs concerning prevention, diagnostics and treatment activities related to drugs and alcohol and meeting the needs of the population through qualified and accessible drug services.

According to Ukrainian regulations, only specialised licenced healthcare institutions may provide services to patients with a drug dependence. As a rule, state-run drug treatment centres and mental health clinics provide support for acute disorders induced by the use of drugs and provide OST services. Rehabilitation services may also be provided by commercial, civil society, charitable and faith-based organisations. Meanwhile, no clearly defined mechanisms exist establishing how to receive the required permissions for the above-mentioned organisations to open and maintain a rehabilitation centre (inpatient or outpatient), whilst no clear guidelines exist establishing the requirements to staff and offer a rehabilitation programme or to assess the quality of their work.

All medical, psychological and social rehabilitation programmes for drug treatment are included in the 1998 interim standards on the diagnosis and treatment process for inpatient care in Ukraine and the 2002 standards on the provision of medical assistance to adults in ambulatory-outpatient institutions in Ukraine. The above-mentioned standards cover different detoxification methods, substitution treatment, emergency care and psychological rehabilitation programmes (including the 12-step model and others). However, these standards do not define the key principles of drug services delivery and — more importantly — do not establish the goals of treatment.

A person with an established diagnosis of 'drug dependence' may receive state-funded treatment on a voluntary basis. If they avoid such treatment or exhibits unsafe behaviour, they may be subject to compulsory treatment based on a relevant court decision. Patients 16 years or older are referred to specialised treatment and education facilities for up to a one-year term. All other patients are referred to treatment facilities within the healthcare system.

Part 4 of article 309 of the Criminal Code of Ukraine outlines the possibility of relief from criminal responsibility for the actions stated in part 1 of article 309 of the Criminal Code of Ukraine, that is, the illegal production, manufacturing, purchase, possession, transportation or delivery of narcotic drugs, psychotropic substances or their analogues with no intent to sell. The grounds for such relief from criminal responsibility for such a person consist of voluntarily seeking help in a healthcare institution and initiating drug treatment.

In cases receiving relief from punishment with a probation period in accordance with the Criminal Code, article 76, part 2, paragraph 5 states that the court may impose an additional obligation to complete a course of treatment for mental and behavioural disorders resulting from the use of psychoactive substances.

Results from a review of Ukrainian legislation show that the existing regulatory framework does not create barriers to rehabilitation for people with a drug dependence. Yet, there are no clear mechanisms to regulate rehabilitation centre activities, most of which base their work on internal regulations.

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The state regulates the mechanism of voluntary treatment for people who use narcotic drugs or psychotropic substances. A mechanism is also used in certain conditions providing for the compulsory treatment of patients with a drug dependence or substance abuse diagnosis.

No clear guidelines or programmes exist on the standards for rehabilitation programmes (inpatient or outpatient). Consequently, no mechanism exists to assess the quality of services and the efficiency of interventions.

The mechanism of service delivery, specifically with regard to social services for people with experience of drug use but with no established diagnosis of 'drug dependence', is not defined as well as the procedure or protocols for consultations, referral or support for underage patients with such experience. A regulation is in place on opening and maintaining resocialisation centres for drug-dependent young people, which provides social rehabilitation services to people under 35 years of age with no children and only with an established diagnosis of 'drug dependence'.

Finally, no guidelines provide a description of counselling for drug-dependent persons with history of drug use provided by specialists in social protection and education. Similarly, no mechanism has been established to monitor and evaluate the services provided.

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AVAILABLE TREATMENT FORMATS (STATE-RUN, FAITH-BASED, COMMERCIAL AND NON -GOVERNMENTAL

In accordance with data from the Ukrainian Medical and Monitoring Centre on Alcohol and Drugs of the Ministry of Health of Ukraine, as of 1 January 2016, the Ukrainian drug service recognised the following units providing medical services, specifically related to treatment and the rehabilitation of people who use drugs:

- 33 drug treatment centres, including 23 with an inpatient department with a total of 2457 beds.
- 3 drug treatment hospitals with 378 beds.
- 40 drug treatment day care centres with 1404 beds.
- 508 offices of substance abuse counsellors.
- 162 for-fee or private offices of substance abuse counsellors.
- 19 drug treatment departments in mental health hospitals with 753 beds.
- 274 beds for drug-dependent patients in central district and city hospitals.
- 27 offices offering anonymous services to people with a drug dependence.
- 15 offices of substance abuse counsellors for adolescents.

Altogether, the Ukrainian drug treatment service has 807 facilities offering treatment or rehabilitation services for people who use drugs with a total of beds 5266 available within inpatient departments. A total of 1147 drug treatment doctors (or narcologists) work in Ukraine.

In accordance with the existing standards, a comprehensive approach guides the provision of diagnostics, treatment and rehabilitation services. During the initial stage of treatment, medical and biological methods are used, followed by psychosocial interventions aimed at bringing patients back to full-fledged social activities (rehabilitation). However, whilst the standards of service provision stipulate the medical and social rehabilitation of patients with a drug dependence apart from detoxification, in practice patients do not always have access to such services.

'If we take state-run drug treatment in our country, it actually stipulates detoxification services, terminating drug-using marathons, taking people with an opioid dependence out of a state of withdrawal.'

OST programmes are implemented in 174 healthcare institutions in Ukraine. According to data from the Alliance for Public Health, in 2016 OST services were delivered to 9214 individuals, consisting of 967 who received buprenorphine, 260 who received liquid methadone and 7987 who received methadone tablets.

The cost of detoxification services vary greatly depending on the region, type of healthcare facility as well as the type of drugs for which an individual is seeking treatment. For instance, a three- to ten-day detoxification course in a private clinic may cost 6000 to 7000 Ukrainian Hryvnia (UAH) (€190–220; http://clinic.org.ua/tsenyi/tsenyi; http://addiction.com.ua/price-list).

Methadone substitution treatment is provided free-of-charge to patients registered with drug treatment institutions and primarily financed by a GFATM grant. In 2016, 106 individuals received OST covered from local budgets.

In addition, patients may receive buprenorphine-based OST, with the cost of such a programme depending upon the individual dosage. On average, costs may total UAH2000 to 3000 (€63–95) per month.
Detoxification and OST services can be also provided at private clinics that have the relevant licence.

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Rehabilitation (non-medication) programmes for drug-dependent individuals in Ukraine are implemented by the state (in drug treatment centres, day care departments, central district hospitals and city hospitals as well as in mental health clinics), by civil society or charitable organisations, faith-based communities and organisations and private or commercial centres.

In total, across Ukraine two state-run medical centres operate within the structure of the Ministry of Health offering comprehensive inpatient rehabilitation programmes in drug treatment institutions — in Kyiv (sociotherapy) and in Dnipro. In addition, four state-run rehabilitation centres for the resocialisation of drug-dependent young people (19–35 years old) function under the Ministry of Social Policy — in the Kyiv, Zhytomyr, Mykolaiv and Khmelnytskyi regions with a total of 85 to 90 beds available. According to the Ukrainian Medical and Monitoring Centre on Alcohol and Drugs of the Ministry of Health of Ukraine, 349 people with drug dependence and 210 family members sought assistance from such centres in 2015. Amongst these, 180 persons enrolled in resocialisation programmes, whereby 95 completed the full course of treatment offered by such programmes.

Currently, no official statistics are available on the total number of non-governmental rehabilitation centres in Ukraine. In addition, no aggregated information exists on the number of centres based on the type of ownership or the format of rehabilitation service delivery. The systematic collection and aggregation of such data fall under the responsibility of the Ukrainian Medical and Monitoring Centre on Alcohol and Drugs of the Ministry of Health of Ukraine.

The available formats for the delivery of **rehabilitation services** to people with a drug dependence consist of the following:

- professional medical advice (outpatient and inpatient);
- rehabilitation programmes;
- therapeutic communities (inpatient); and
- spiritual psychotherapy and faith-based rehabilitation programmes.

According to the Law of Ukraine No. 987-XII, **'On religious freedom and faith-based organisations', dated 23 April 1991,** faith-based organisations may open charitable facilities (i.e., shelters, orphanages, hospitals and rehabilitation centres), which have the rights of legal entities to fulfil their statutory goals. Thus, NGOs, charitable foundations and faith-based organisations may treat patients if they obtain licences for the provision of medical services according to the procedures set forth in existing laws whilst medical services are regulated by other legislative acts. As for the delivery of rehabilitation services, the content of such programmes (including the time schedule, accounting and reporting documents, conditions for staff members and patients, the quality criteria and criteria to assess performance and service delivery) is formed and defined by the statutory goals of such organisations, their resources, the preferences of their owners as well as the administrative and professional personnel. That is, there is no clear mechanism defined by specific regulations related to the work, guidelines and standards.

We should note that neither faith-based organisations nor charitable foundations have a right to receive payment for their services — they may only receive donations. Free rehabilitation is generally based on the mechanism of self-support through work done by patients, such as developing work skills and the self-discipline of drug-dependent people. Such facilities are not covered by the law 'On social services'. Their activities are regulated instead by internal regulations, which may stipulate the provision of social services amongst other things.

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Based on the results of a mapping exercise prepared from analysing data from 93 centres, the cost of participating in inpatient rehabilitation programmes varies from UAH4000 (€127) to UAH27 000 (€854) per month. On average, the recommended duration of such programmes is six months (but should be at least one month). In total, eight centres present themselves as Christian, Orthodox or faith-based, whilst others identify as community-based or private facilities. Based on descriptions and the prices of centres, it remains quite difficult to clearly differentiate civil society, private and commercial rehabilitation centres.

All 93 centres offer inpatient rehabilitation services. In addition, 26 centres also provide outpatient services. Most of these centres are located in the larger cities of Ukraine, including Kyiv, Kharkiv, Dnipro, Odessa and Lviv or situated not far from such cities. Almost all centres are co-ed — for both men and women. After further clarification (by phone), some centres indicated that they may accept underage patients at the request of their parents. A total of 36 centres offer services for the family members of drug-dependent patients. All centres present their rehabilitation programmes as voluntary for patients, although some have information on their websites on the use of 'compulsory motivation' (that is, compulsory treatment).

Apart from compulsory treatment, other violations of patients' rights including physical violence, exploitation, and violations of human dignity amongst others occur.

'There are some centres to which people are taken against their own will, and are forced to be there. They do not have any freedom; there are guards who watch them. If they try to escape, they are caught and punished.'

'People were brought there because no one would ever agree to be a slave at their own will. Some were brought in car trunks; some in handcuffs. They came there and some of them had no idea what was waiting for them. And then it all started. I mean, the territory is closed, smoking is prohibited. If you smoke, you have to dig a hole — two metres deep — to bury the butt, if they catch you. You work, you pray, and God forbid you complain. Then you get physically abused, they humiliate you, can chain you to a tree or make you stay under the hot sun. Well, all kinds of things. We do not talk about it, but I actually think that it is criminal behaviour towards those sick people and violently using them for one's own interests.'

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THE MOST COMMON APPROACHES TO TREATMENT AND REHABILITATION

Ukrainian healthcare institutions primarily apply the following models to treat opioid dependence:

- Inpatient detoxification using clonidine and nonspecific substances (intravenous infusions with glucose, hemodez or polyglucin solutions; tranquilizers, neuroleptics, sleeping medicines, vitamins and general tonics) for 10 to 14 days with further discharge of patients and recommendations to abstain from drugs.
- Detoxification using buprenorphine injections with tranquilizers and sleeping medicines in inpatient departments with a further rehabilitation course in non-governmental rehabilitation centres.
- Drug treatment with tranquilizers, thymoleptics and antidepressants in inpatient facilities for 14 to 21 days with the recommendation to attend rehabilitation programmes or meetings of Narcotics Anonymous following discharge from the facility.
- Substitution maintenance treatment with methadone or buprenorphine.

A mapping exercise of rehabilitation centres across the country indicated that the following approaches are used:

- 65 centres rely on a combined approach whereby several methods are employed simultaneously, most often detoxification plus therapeutic community and a 12-step model.
- 45 centres rely on a 12-step model.
- 25 centres rely on a therapeutic community.
- 22 centres rely on detoxification.

The rehabilitation programmes used by centres vary greatly. In most cases, these programmes are based on the 12-step approach, specifically, the 'Minnesota model', which is widespread. Apart from that, such centres use other approaches including psychotherapy (individual and group therapy), gestalt therapy, family therapy, client-centred therapy, cognitive therapy, CBT, work therapy, art therapy and training to build one's social skills. The choice of approaches and programmes depends on the experience and educational background of the specialists who offer such therapy.

'There is no single package of rehabilitation services. Primarily, the 12-step programme is used.'

'Today, if we look at the percentage distribution, the Minnesota model is the most widespread. Yes, it is true. But, our people, I mean our psychologists, they use everything. These include behavioural approaches, all the methods and approaches which work in their opinion. I have no right to criticise their schemes, upon which this department works, since they proved effective all those years. All of the approaches used in the behavioural psychotherapy model.'

'Transactional analysis, existential and psychoanalysis — absolutely all approaches of therapy, psychotherapy and psychology are used — they are applied when working with dependencies. Group and individual work — those are just small areas. Sometimes there are therapeutic groups, depending on how you understand it. They may be called review of the day, reflections, emotion group — there are different names, but it may have a therapeutic effect on the recovery process. Awareness-raising classes or interventions or intervention-motivational groups — well, yes, they can be applied. Interviews? — Well, yes, it is an option. Additionally, there may be counselling sessions with a psychologist if they specialise in a certain area. Nobody is regulating it — it is up to you.'

A range of non-standard methods are offered by centres. These include sports therapy, spiritual therapy, relaxation techniques, procedural psychology, psychodrama, energy psychotherapy, 'Deep PEAT', 'DP- 4',

'Working on Inner Selves', Tapas Acupressure Technique (TAT), Emotional Freedom Technique (EFT), 'Equilibrium', 'Rendezvous of the Past', 'Quantum Shift', 'Holotropic Breathwork', 'Laughter Therapy' and other methods.

Some centres also offer services such as massage, sauna, gym, hiking and swimming.

Upon completion of a programme, many centres provide further social and psychological support.

NA groups actively function throughout Ukraine. Such groups may operate at all types of rehabilitation centres, at civil society organisations or as separate self-help or initiative groups.

'In almost all cities, villages and any populated area, there are what we call self-help groups such as "Narcotics Anonymous." That's a real 12-step model.'

'Generally speaking, the 12-step model is what Alcoholics Anonymous and Narcotics Anonymous do. This is a wonderful community, and in Kyiv there are many groups operating.'

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ACCESS TO TREATMENT AND REHABILITATION SERVICES

Access to OST programmes varies greatly in different regions of Ukraine and is generally inadequate. In particular, a mere 21.5% of people with a drug dependence are covered by OST services in comparison to the recommended rate of 35% of all registered individuals as drug-dependent. The proportions vary depending on the region from 44.1% coverage in the Vinnytsia region to 6.8% in the Odesa region.

Nonetheless, we can note some positive trends. For instance, in 2016, one in five patients began receiving OST for several days via unsupervised administration using alternative models (through prescriptions from healthcare institutions via 'home care'). The percentage of people who received OST via unsupervised administration in 2016 across 18 regions increased from 6% to 23.3%. Furthermore, in 2016 the number of patients who paid for OST increased nearly fourfold compared with 2015.

National legislation allows for the provision of substitution treatment services in places of confinement, that is, in accordance with the interdepartmental order No. 821/937/1549/5/156, dated 22 October 2012, ***'On the approval of the procedure for cooperation between healthcare institutions, law enforcement bodies, pretrial detention centres and correctional facilities to ensure uninterrupted opioid substitution treatment',*** OST patients are guaranteed uninterrupted treatment when held in pretrial detention centres as well as in places of confinement such as correctional facilities when serving their sentences.

To ensure OST programme implementation in places of confinement with restrictions on patient freedom, a joint order was drafted for approval by the Ministry of Health, the Ministry of Internal Affairs and the Ministry of Justice of Ukraine, ***'On the approval of the procedure for interaction amongst healthcare institutions, bodies and departments of the national police, pretrial detention centres and penitentiary institutions to provide medical help to detained, incarcerated and convicted persons with tuberculosis and the provision of treatment services'.*** However, this order was never approved.

Currently, OST programmes are not implemented in places of confinement despite a general favourable legislative environment. Thus, uninterrupted treatment is not available to OST patients in prisons.
Furthermore, in places of confinement, no access to rehabilitation services exists.

'Currently, rehabilitation programmes are not available. It is working only in one of our colonies. We implemented such activities there, within one of our projects as well. The project was about HIV, but we tried to use the opportunities and the resources that we had, we entered colonies and initially tried to organise groups of Narcotics Anonymous and Alcoholics Anonymous there. They worked for a while, and then this work stopped. Because it was all based on enthusiasm. It is very hard to get in there as you can imagine. There are a lot of efforts needed. Now, from what I know, the only people who can get inside prisons, colonies or camps are representatives of various religious denominations. So, in fact, no rehabilitation services are implemented there.'

According to experts, treatment and rehabilitation services are generally accessible to people who use drugs. Detoxification services may be received via both state-run and private clinics. Currently, better access to substitution maintenance therapy is available. Rehabilitation services offered extend much further than the existing demand. A map of rehabilitation centres in Ukraine shows that no deficit of information about such programmes exists. The number of such centres across Ukraine exceeds 100 (93 centres were analysed), many of which have more than one branch in Ukraine's larger cities.

Access to rehabilitation programmes depends first on the cost of such programmes. Thus, faith-based rehabilitation programmes remain the most accessible.

Outpatient support programmes, in particular, those that follow the Narcotics Anonymous model of self-help groups, are popular and accessible.

'There are no barriers, trust me; the opposite is true. There is a great surplus of services. Greatest. Not deficit, but surplus. Offers exceed by several times the demand.'

'If one has internet access, it's more than enough (that is, advertising). You will be overloaded with all of the offers. But in your local drug treatment centre they can inform your parents, for example. In particular, our drug treatment centre shares information about our rehabilitation centre, about other options available, such as faith-based rehabilitation programmes and so on. They give our phone number and then people call us, saying that they've been given our number in the drug treatment facility.'

At the same time, experts claim that a number of problems impede the delivery of high-quality assistance to drug-dependent individuals and barriers limit access to such assistance.

Staff attitudes continue to affect the number of people seeking help from state-run institutions. Moreover, the programmes provided by state-run institutions traditionally adopt high-threshold approaches.

'Certainly, discrimination exists, which is quite widespread. It may come from doctors, from whomever. For example, what sense does it make to treat them, if they are a drug addict? If they kick the bucket, it is even better; there will be fewer addicts.'

'In Kyiv as well as in all other regions, clinics and hospitals have never been low-threshold structures. Of course, there are certain eligibility criteria as well as patient capacity.'

Whilst there is a rather wide range of services delivered, questions remain regarding their integrity and quality. No approved or recommended standards on the delivery of rehabilitation services have been set. Thus, no comprehensive approach to state funding for rehabilitation and the associated services, the protection of human rights or for the external quality monitoring from the side of governmental agencies and local authorities have been established.

Let's take as an example a biopsychosocial model to take a person and plan a rehabilitation programme for them for a year. They receive inpatient treatment once or twice for a year and then receives further follow-up from their local psychiatrist or narcologist. Then they spend four months in some rehabilitation centre, today they receive money depending on the number of beds taken, if we are talking about state-run facilities. And, for example, they have to complete retraining… if they are not able to do their usual work because of their health status, they need to be trained in a new profession. This is what our charities or employment offices do. However, those things are not carried out within our rehabilitation programme. In some places, money is allocated to cover different components, but it is not linked to one person, not linked to the programme. Thus, there is no proper rehabilitation.'

Despite the many services being offered along a range of prices, amongst many clients, the need to pay for services remains an issue. Here, it is important to note that OST programmes are financed by GFATM or by the state budget, and thus free to patients (although fee-based programmes also exist). However, OST programmes on their own cannot cover the range of people's needs in drug treatment.

'Well, let's say that emergency care is provided to all people, including drug users. But, for treatment, again, a drug user can get some intensive care and then they are told that they must pay money to get further assistance to feel more or less fine.'

'So the person has no money, nothing. Where will they go? They have UAH1000 to UAH2000, they call a rehabilitation centre and they tell them how much they must pay. Where will they go? They will get some alcohol with this thousand UAH, will get drunk and forget about it.'

Experts also point out that problems persist in ensuring minors can access services that meet their age-specific needs. The only state-run rehabilitation centre featuring a department that works with minors operates in Dnipro in the regional drug treatment centre. Many community-based and private centres do not work with clients under 18 years of age or offer only a limited range of services to them (e.g., only individual counselling sessions). Even in cases where a rehabilitation centre agrees to work with underage patients, they are often treated in the same way as adult patients not taking into account their age-specific needs and life experiences. According to specialists, this may carry negative consequences. A unique example of a specialised outpatient rehabilitation centre for underage patients who use PASes is the Dialogue Centre run by the New Family NGO in Chernivtsi. The programme offered by this centre was developed specifically for adolescents aged 14 to 18 years old lasting from three to nine months.

'Really, only in Dnipro in the state-run drug treatment centre is there such a facility. In Ukraine, it is a huge problem — substance abuse among children and adolescents. Because psychiatry and narcology are different areas of specialisation, there are children's psychiatrists, but there are no children's narcologists. From the legal point of view, a specialist trained to work with adults cannot provide services to children.'

'There is no access for children under 18 years of age. Maybe it is just my point of view, but if I am only 18 and if I am working through my childhood traumas, childhood fears and problems, if I am just learning to live in the world of grown-ups, it is not right for me to sit at one table with people who are 28 or 30 years of age, whose experience is twice that of mine. It also violates the security of our adolescents — they attend centres and they learn about some types of drugs and ways of administering them in those centres, not because someone is telling them this information secretly, but because they hear it at the general therapy group, when other participants share their experience — they hear it.'

'It's clear that we do not admit minors, right, I mean children. However, there are people who call us with such problems. They call all the time. Yes, they have children 14 to 15 years old.'

'I want to say that it is a totally different area of work, line of expenditures, etc. It should be clear that the organisation has to have such resources. If hypothetically there was an organisation that could finance it, we would surely be able to cope with this work. For this purpose, there should be a separate building, where such adolescents could come, where the activities for them would be organised. Not to mix them with 50-year-old drug users. Because that will only make their dependence worse. There should be specialists working with their family members, offering so-called family group therapy. It is very important for all, but for adolescents it is of paramount importance. If we take our organisation, I can say that we have enough competencies and professional knowledge. But it also entails huge expenses.'

Additionally, issues surround the provision of services for women.

'In most cases, they are co-ed: men and women stay in one centre. There are very few centres specifically for women. At least, we were looking for women's rehabilitation centres to refer a girl for rehab, and for three years we have not seen any such centre opening.'

'In general, there are very few centres providing such services to women and mothers; I am not even talking about underage girls.'

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QUALITY OF SERVICES

Medical services in the country are licenced and should comply with the requirements of the regulations issued by the Ministry of Health of Ukraine.

'In general, if there is a need to obtain a licence for medical services, such licences are issued by the Ministry of Health, and such centres must comply with all of the regulations of the Ministry of Health. The Ministry of Health can control the activities of such centres. They need to go through accreditation, and if there are some complaints, there may be special inspection commissions created. A department exists which assesses treatment quality. There is also a licencing department. It must evaluate compliance with the licencing requirements.'

Quality control for all types of medical services is performed in accordance with the procedure approved by Order No. 752 of the Ministry of Health of Ukraine, dated 28 September 2012. In Ukraine, the following orders from the Ministry of Health also standardise healthcare services related to ICD-10 codes F10 to F19:

- ***Order No. 476, 'On the approval of the Standard of treatment for HIV-positive people who inject drugs', dated 19 August 2008.***
- ***Order No. 645, 'On the approval of the guidelines "Substitution maintenance therapy in the treatment of opioid dependence syndrome"', dated 10 November 2008.***
- ***Ministry of Health Order No. 681, 'On the approval of the clinical guidelines to provide medical aid in the area of "narcology"', dated 21 September 2009.***

In the report provided by the Ukrainian Medical and Monitoring Centre on Alcohol and Drugs of the Ministry of Health of Ukraine in 2016, it stated that the Ministry of Health Order No. 681, 'On the approval of the clinical guidelines to provide medical aid in the area of "narcology"', dated 21 September 2009, does not comply with modern requirements related to the delivery of healthcare services. In the same report, the monitoring of the quality of services provided to people with a drug dependence found that most healthcare guidelines failed to comply with evidence-based medicine.

As a rule, treatment monitoring is conducted only within the healthcare facility and depends on the resources available within the facility and on the professionalism of the chief physician and other relevant specialists. Furthermore, no guidelines exist on assessing the efficiency of the treatment methods used. No mechanism is in place to ensure the reliable control over service delivery, from diagnostics, to registration for follow-up, for service delivery or for treatment success. This certainly impacts access to quality services and their effectiveness.

Monitoring and evaluation of the effectiveness of rehabilitation programmes depends on the characteristics and possibilities of each individual organisation and programme. These characteristics include the form of ownership and source of funding, staff availability and regulatory requirements to their activities and the approaches used amongst others. No single algorithm or programme, no standards of rehabilitation programmes (inpatient or outpatient) and no defined mechanism to assess the quality and efficiency of work are in place. Thus, experts worry about a lack of comprehensive approaches related to the observance of human rights in rehabilitation centres.

'We have absolutely no guidelines to ensure the quality of rehabilitation services. There should be some state commission for drug treatment issues which could go and inspect centres.'

'About two week ago, the prosecutor general's office closed four rehabilitation centres: three in the Kyiv region and one in Kyiv. There were similar cases in Lviv and Mykolaiv. Now, law enforcement officers are working a bit in this direction. But, again, they close one centre, and another opens. Or they close some facility, and then a month later the same people appear elsewhere. Here, the state should adopt a comprehensive approach to this issue.'

As mapping the centres providing rehabilitation services showed, the key criterion of efficiency used for the internal evaluation of such programmes is the short-term remission of the clients of such centres, which is monitored when keeping in contact with clients after completion of inpatient rehabilitation programmes. Some centres state their 'success rate' on their websites, which is not explained and varies from between 30% and 80%. However, using only this criterion based on remission (either short- or long-term) is insufficient to access the success of programmes since it does not take into account the chronic and recurrent nature of the disease.

'If there are sober people, if it helped at least someone, then it makes sense to talk about a certain effectiveness. But, again, the price one has to pay to become sober is also a huge issue.'

'The main factor used to measure if a programme works or not is if the person uses drugs or not. However, even this, in my opinion, isn't the most important factor. We need to remember that drug dependence is a recurrent chronic disease. Thus, the disease will always remain with the person in some suppressed form and, if it becomes acute, it may lead to a relapse.'

Another indicator used to demonstrate programme efficiency is the percentage of people completing the programme.

'Retention in the programme, because three months is in fact a lengthy term. We lose about 20% of our patients. These are people who fail to stay in the program for 90 days.'

'So, it is one of the criteria, if I enter a six- or nine-month programme and stay there for six to nine months – it means that the programme is in fact very good and one can work with it. But then no one monitors if the person has any slips or not. I mean, there is no system that could accurately assess the efficiency of rehabilitation programmes.'

However, experts note that it is not correct to assess the effectiveness of rehabilitation efforts only based on people's behaviour in artificially created conditions. Good practice relies on monitoring the state of the client at least for one year after they complete the inpatient stage of rehabilitation. Typically, after completing an in- or outpatient rehabilitation treatment course, clients are encouraged to attend NA meetings, self-help groups, religious services and 'home-based groups' (in faith-based centres). If such groups function at a rehabilitation centre or in a partner organisation, the centre may monitor the duration of remission, and observe any relapses and the general dynamics. To receive feedback (and to attract new clients), such centres may also organise conferences, open house days, celebrations dedicated to the anniversaries of such centres, 'open' groups and groups for family members amongst other events.

'The main question is not even the quality of interventions implemented over a month or two, but what the person will take home after leaving the centre. What support will they have, what will they do?'

'First, their remission. Because we aim for absolute abstinence. But, of course, when a person quits psychoactive substances, this is often only the beginning of their problems. So then, if they are just released from the rehabilitation centre, as it often happens, when people shake their hand and say thank you, then 99% of them will relapse.

So, in fact, the main effectiveness criterion, if we want to speak about some result, is remission for at least one to three years. *This is a specific indicator.'*

'For us to understand that we provide quality services, we want to see our former patients attending Narcotics Anonymous meetings.'

'There is a feedback mechanism; there are family days; there are celebrations of rehabilitation anniversaries, all of which are attended by our former patients.'

'Of course, at first we support and supervise them. Well, by supervising I mean checking how they are doing, correcting something. But anyway, you know, this is a closed community, so information spreads anyway. There is a sponsor, there are groups, and we try to keep track of what is going on. So we monitor them for up to a year. I mean, for a year we check on them and then it depends. Depends on them. If they show some initiative and get involved, then, of course, we continue working with them. Otherwise, we keep track for up to a year.'

However, centres do not always have sufficient resources to provide long-term support to the participants of their rehabilitation programmes. During the process of rehabilitation, the staff members of such centres track the dynamics of their clients via internal monitoring systems. But, it is very difficult to access the efficiency of such programmes beyond the inpatient context.

'Whilst they are in the programme, whilst they are in rehabilitation, it may be evaluated. Depending on how they get involved, how they work, what comments or feedback they give. Here it is possible to measure it. But as soon as they leave the centre, they enter an environment we are not familiar with. Because they may be from a different city or from a different social group, for example. They enter an environment where we are not able to control them.'

'They call us a lot. We also call some of them. We cannot keep in touch with everyone since we do not have sufficient human or financial resources for it. The only thing we can do — we always bring them to Narcotics Anonymous groups. NA groups work in almost every town and we have a list of their focal points and phone numbers. Some of them follow our advice and really attend those groups. Some do not. It depends on them.'

When creating a monitoring and evaluation system in the area of rehabilitation, experts recommend implementing modern comprehensive approaches to the assessment of rehabilitation effectiveness aligned with international best practices.

'NIDA — the National Institute on Drug Abuse — they have a document called "The effectiveness of rehabilitation for people with a drug dependence". For example, paragraph 1 of this document stipulates a reduction in criminal behaviour. So if a person used to commit offences three times a year, and now they commit one offence because they no longer use drugs, it gives us grounds to discuss the specific effectiveness of the rehabilitation process they are going through. This document contains 13 provisions on how to assess the effectiveness of rehabilitation.'

'We need to have a look at the patient's physical health, their emotions, their intellectual abilities and their spiritual life. And then at the entire system of their relationships, how they rebuild relationships with the world around them. First of all, of course, it's about their family, job, hobbies, friends and so on. When we see some improvements here, then we can say that there is some effectiveness of the rehabilitation programme. The fact is that health is not only a physiological concept; it is also a social factor.'

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Staff qualification and training

The staffing structure of rehabilitation centres and specialised healthcare institutions varies, and depends on the form of ownership, the resources available and the ideology of such facilities. In state-run institutions, substance abuse and mental health specialists, psychologists, social workers and other specialists work with patients. The staff of community-based and faith-based rehabilitation centres typically consist of psychologists, social workers and peer consultants. In addition, physicians from specialities in other areas, mid-level health professionals or physical training experts amongst others may provide services. In Ukraine, a number of centres exist where most staff members represent peer consultants and other workers with no educational background in medicine or psychology.

In Ukraine, narcologists may provide medical services to patients with a drug dependence. The profession of narcology requires a complete higher education (specialist's or Master's degree) in the area of 'medicine', with a qualification in 'general medicine' with an internship in the area of 'psychiatry' and a further qualification in 'narcology', as well as a relevant doctor's certificate. Narcologists must complete advanced training courses (at least once between attestation cycles). In addition, they have regular attestations to receive or confirm their qualification.

The quality of services provided by relevant specialists in the area of treatment and rehabilitation is ensured by attestations and advanced training courses, regulated by the following training programmes and regulatory documents:

- Online advanced training course ***'Opioid dependence therapy'*** for health professionals by the Ministry of Health (https://courses.prometheus.org.ua/courses/course-v1:MOZ+TOD101+2017_T2/about).
- Order No. 650 of the Ministry of Health of Ukraine, '***On revision of the regulation on the procedure of doctors' attestation'*** (http://zakon3.rada.gov.ua/laws/show/z0176-16), dated 2 October 2015.
- Ministry of Health Order No. 359, ***'Regulation on the procedure of doctors' attestation',*** dated 19 December 1997 (http://zakon2.rada.gov.ua/laws/show/z0014-98).
- Ministry of Health Order No. 359, ***'On further improvement of doctors' attestation',*** dated 19 December 1997 (http://zakon2.rada.gov.ua/laws/show/z0014-98).
- Law of Ukraine No. 5067-VI, '***On professional staff development***', dated 5 July 2012 (http://zakon2.rada.gov.ua/laws/show/4312-17).
- Ministry of Health Order No. 48, ***'On the procedure of onsite training for doctors who worked in their area of specialisation for less than three years and their further permit to provide medical services',*** dated 17 March 1993 (http://zakon2.rada.gov.ua/laws/show/z0019-93).
- Ministry of Health Order No. 73, ***'On approval of the regulation on organising examinations during pre-attestation cycles',*** dated 18 May 1994 (http://zakon2.rada.gov.ua/laws/show/z0146-94).

Attestation for medical psychologists is organised in the same way as for doctors in accordance with the orders of the Ministry of Health (see above). As for the practicing psychologists, their activities fall within the attestation and regulations of the Ministry of Education and Science of Ukraine, provided that they work in educational institutions of any ownership format or in centres of practical psychology and social work. Thus, the attestation of practical psychologists is carried out in accordance with the standard provision on the attestation of education workers in Ukraine (Order No. 310 of the Ministry of Education and Science of Ukraine, dated 20 August 1993, registered by the Ministry of Justice of Ukraine on 2 December 1993, by Order No. 176), which was subsequently revised and amended (Order No. 419 of the Ministry of Education and Science, dated 1 December 1998, registered by the Ministry of Justice of Ukraine on 15 December 1998, No. 792/3232).

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Attestation of social workers is conducted in accordance with the ***'Attestation procedure for social workers and other specialists providing social and rehabilitation services',*** approved by Order No. 612 of the Ministry of Social Policy of Ukraine, dated 1 October 2012.

In Ukraine, no special provisions or training programmes exist for social workers and psychologists who work in rehabilitation centres. A number of higher education institutions offer short-term courses in addictology, which, however, remain inadequate to ensure the full-fledged education of specialists in this area. Such specialists gain specific knowledge and experience directly through their workplace.

The majority of rehabilitation centres state that their staff members include substance abuse specialists or 'peer' consultants (typically, the former clients of such centres). But, such professions are not included in the occupational classification of Ukraine, and educational institutions in the country do not offer training in this area. Thus, no training programmes nor standards to define the quality of their work are in place.

The employer may ensure control over the education and advanced training of staff members by engaging external experts to provide such training and by developing relevant internal procedures. The staff members of such centres may from time to time receive some training (usually short-term courses or workshops) and complete internships to develop their professional skills. But, there are no general approaches to such training nor universal requirements related to the knowledge and skills of specialists in the area of drug user rehabilitation.

'As for the courses, there are no special training courses. Some training may be organised by people who have implemented certain models of rehabilitation for quite a long time, at their own risk. To earn some money, they organise some short-term versions of what I call training at their premises, gathering consultants from similar rehabilitation centres. It's usually two or three days, maybe a week. These consultants or their managers pay some money for each of them to participate, and that's how it is all done. The trainers present the approaches which they themselves implement. They present their rehabilitation programmes, that's how this training is organised. Then, they issue some kind of certificates or some diplomas or documents. But, again, all those things are amateur. There are no centralised opportunities for people to earn a state certificate in this area.'

'The organisation is called the Christian University of Humanities. The Christian community gives them money and they offer such training; they have been offering it for several years already. They issue some kind of diplomas where they write that the person received a qualification in addiction psychology. So, the specialisation is really addictive behaviour, addictions. But, again, it will not be a state diploma.'

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RECOMMENDATIONS

Based on our needs assessment, we can make the following recommendations towards drug use policies in Ukraine.

- **Develop a comprehensive national policy on the treatment and rehabilitation of drug-dependent people and mechanisms for its practical implementation.**

'This is what must change — the attitude of the government towards the rehabilitation policy. Yes, it (rehabilitation policy) should certainly be developed.'

'What is needed here is to establish orders, issued by the Ministry of Health, saying that, for example, each regional narcology department should organise a rehabilitation centre, which would function based on standard guidelines. Such standard guidelines should define all aspects, including the staffing structure of such a centre, staff qualifications and so on.'

'It is very important for each region to have a certain number of rehabilitation centres, depending on the population size and the level of drug dependence in the population, with such a centre receiving support from the state budget.'

'It is not mandatory for them (rehabilitation centres) to be state-run. But, the state should control compliance with a set of conditions and standards for treatment services.'

'All of the resources could be stipulated — these should be included in the standard, in the national strategy: the unified base, the monitoring system, the staff qualifications and inspections. If it was all done and regulated by procedures, who is responsible for what — it would solve many existing problems.'

'The one-stop shop model, when the person could come to one place and get all of the information and help there, not to have a situation when they come to this place and are told to go somewhere else, because they also have some other problem. There is a need for comprehensive services. This is how, for example, I see it. There is a phone call, a person says they have a drug problem. They are invited for a consultation. There should be state-run programmes, not private ones, where they will be told to pay this or that sum of money. They receive a consultation. The next stage — they are referred for detoxification. In the next stage — rehabilitation and then resocialisation. There may also be a legal support component, depending on their problems, which they acquired due to their [drug] dependence.'

- **Create an advisory council to develop and implement treatment and rehabilitation standards.**

'There should be a roundtable discussion, involving relevant specialists, who know the topic, people who actually work in this area. Moreover, maybe it would be worthwhile to invite a person who knows the approaches implemented in America or the European Union.'

'There should be some unified guidelines developed; to prepare such guidelines, the relevant specialists who work in this area should be involved. These should include law enforcement officers, health professionals, psychologists, supervisory bodies. This should help to develop a quality product, which would include all of the legal, medical and psychological aspects.'

- **Develop the missing components and improve existing standards and guidelines to reflect the needs of all groups, including women, minors and inmates who use drugs. This should include translating and adapting the relevant international documents.**

'The first step should include developing standards and clinical guidelines. Civil society organisations could draft these documents. They could organise translation and editing and then we, as experts, could give our comments.'

'With regards to the clinical guidelines, they are available only for opioid dependence. If we talk about other problems with other PASes, there are no guidelines on how to manage such patients. I mean people who have, first of all, psychostimulant dependence.'

'In general, those guidelines should describe comorbidities. Up to 70% of cases are comorbidities, including addiction and post-traumatic stress disorder, autism or schizophrenia. The existing guidelines should be updated with algorithms on how to manage patients with comorbidities.'

- **Improve the quality of services by developing a set of criteria on the effectiveness, creating adequate systems for the licencing of rehabilitation services and for the monitoring of service quality.**
'There should be mandatory accreditation of activities for all such facilities. There should be a specific instrument.'

'The state should control compliance with the set conditions and standards for treatment services.'

'The second step is, of course, revision of all rehabilitation centres to ensure their standardisation with further licencing of the services provided.'

'I think that we will have standardisation anyway, and, if it is implemented, I guess that its threshold should be lower, as low as possible, at least at the first stage, for about five to seven years. Not to cut off those organisations that really can do it, but due to some reasons, they do not have money to build certain systems. Otherwise only big commercial institutions will be able to enter this market, who will manage the market. So here there should be a flexible approach to the standardisation of services.'

- **Train specialists in the rehabilitation of people with dependencies, develop training programmes and organise onsite training.**

'Training should be organised for doctors, nurses, counsellors and psychologists. They need to be trained in the rehabilitation of people with dependencies. They need to have some onsite training.'

'There is no institution, which would train personnel (for the area of rehabilitation).'

'It is first of all about education. Training programmes. Not only for doctors. The main focus should be on psychologists and social workers.'

- **Engage local authorities and community members in the supervision of compliance with a set requirements and standards of rehabilitation services provision, the monitoring of human rights observance and so on.**

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'A working group should be created, which would include experts and local community representatives who check how safe such centres are.'

- **Systematic work should be undertaken on issues of substance misuse in schools, including the training of psychologists, the development of guidelines, working with parents and working with children.**

'In addition, I think that we do not have good linkage between psychologists in schools and psychologists in healthcare institutions, because problems start in schools, substance abuse issues as well. We have 25 000 psychologists subordinate to the Ministry of Education, but the psychologists who work in schools need to see cases, which fall within the competence of medical psychologists, and maybe recommend psychologists in healthcare institutions for such adolescents. There is no linkage between school psychologists and medical psychologists. People think that a psychologist should know everything. But school psychologists do not receive special training in medical psychology. We do not have any guidelines on "when" and "how" a school psychologist should cooperate with a psychologist in a healthcare institution. There is no contact point. If you (AFEW International) work with adolescents, maybe a focus could be made on finding such points of interaction.'

'Why do we not introduce courses for family members in schools, which would be mandatory? Maybe even without children? And then with children, of course? For family members it could be an awareness-raising course on how to recognise the signs of drug dependence, what dependence is, why people develop it and how parents should behave.'

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ANNEXES

Overview of most popular approaches to rehabilitation and treatment worldwide

- The Minnesota Model of Addiction Treatment (the 12-step programme or the abstinence model)
- Harm Reduction Psychotherapy
- Cognitive Behavioural Therapy (CBT)
- Community Reinforcement Approach (CRA)
- Community Reinforcement and Family Training (CRAFT), an extension of the Community Reinforcement Approach
- The Matrix Model
- Therapeutic Communities (TCs)

ANNEXES

THE MINNESOTA MODEL OF ADDICTION TREATMENT (THE 12-STEP PROGRAMME OR THE ABSTINENCE MODEL)

When it appeared and who developed it

Based on the first-person account of Daniel Anderson (Anderson, McGovern & DuPont, 1999), the Minnesota model was developed in a state mental hospital in the US by Drs. Nelson Bradley and Daniel Anderson in the 1950s. At the time, neither man had any previous experience working with addicts. The motivation behind the creation of the Minnesota model was to aid alcoholics in a more 'helpful and humane' manner (p. 112). Through a review of the literature, psychological examinations, interviews with alcoholics and interviews with recovering Alcoholics Anonymous (AA) members, the Minnesota model was developed. The model was first applied at an organisation known as the Hazelden Foundation, which was one of two facilities working directly with alcoholics via AA, or a 12-step programme at the time. From there, it spread across the country and eventually worldwide.

Goals and objectives

To obtain sobriety and remain sober from all addictive drugs.

Brief content (components)

The Minnesota model combines trained non-professional staff (sober drug addicts) with professionally trained staff, and together they apply the theory and the 12-steps of AA (Anderson, McGovern & DuPont, 1999).

The primary elements of the Minnesota model are:

1) 'Integration of professional staff with trained recovering alcoholics'.
2) 'Focusing on the disease concept and our link to the 12-step fellowship'.
3) 'Dedication to family involvement'.
4) 'An insistence on abstinence from the use of all addictive drugs'.
5) 'An emphasis on patient and family education'.
6) 'An individualised treatment plan'.
7) 'A continuum of care integrating sustained aftercare into all treatment plans' (Anderson, McGovern & DuPont, 1999, p.112).

Anderson notes, however, that the two most important elements of the Minnesota model are a respect for each individual client and their family, meaning that each individual should be provided with an individualised treatment plan. In addition, the Minnesota model is dedicated to the idea that, through the help of a 'Higher Power' (p. 112) and the AA model, recovery (i.e., sobriety) is obtainable (Anderson, McGovern & Du Pont, 1999).

The primary component of the Minnesota model is to follow the 12-steps. Muck et al. (2001), who focused on the 12-step method as treatment for adolescents with substance use disorders (SUDs), have broken down the 12-steps as follows:

'The first three steps help the adolescent to be more honest, decide to stop using drugs and alcohol and choose a new lifestyle. Steps four through nine, the action steps, help adolescents continue to be honest, develop and implement an action plan for a changed lifestyle and correct past wrongs where possible. Steps 10 through 12 are the growth steps, which encourage adolescents to continue to work a recovery programme throughout their lives. Typically, the first five steps are covered in the treatment programme, whereas steps 6 through 12 are addressed in aftercare and through ongoing involvement in community self-help groups' (p. 147).

Whilst this quote refers to 'adolescents' when describing the 12-steps, these 12-steps apply to adults following this method as well.

Additionally, Muck et al. (2001) explain that treatment will most likely include group therapy, individual therapy, family counselling, lectures and psychoeducation, leisure activities, writing projects and attendance at AA or NA meetings after leaving an inpatient facility, if that was included in the original treatment plan.

What philosophy or psychological approaches form the basis of the approach

The Minnesota model is based upon the philosophy of AA, also known as the 12-step programme. The Minnesota model views SUD as a disease, and thus claims to provide recovery from SUD, rather than a cure. AA was developed in 1935 by a New York stockbroker named Bill W. and a surgeon from Ohio named Dr. Bob S., both of whom were self-proclaimed alcoholics. Bill W. wrote the AA textbook in 1939, which outlined the 12-steps of recovery they believed effective in aiding others with an alcohol dependency. The 12-step method is followed through peer-lead self-help groups, meaning that no trained professional is present during these meetings ('Historical Data: The Birth of A.A. and Its Growth in the U.S./Canada', 2017). An emphasis is placed on a 'Higher Power', necessary to successfully achieve sobriety, as can be seen in the 12-steps themselves. AA currently has over 2 million members worldwide (Glaser, 2015).

Clients' criteria to enter (age, type of drugs, previous experience in treatment and rehabilitation, health issues, etc.)

The criteria for admission into a programme that follows the Minnesota model will largely depend on the criteria of the facility itself (i.e., all male facility, all female facility, facility that treats adolescents, etc.). However, the Minnesota model itself does not appear to have any criteria. Whilst AA focuses specifically on those who are addicted to alcohol, other versions of AA have since been developed, such as Narcotics Anonymous (NA), which focuses more broadly on all drugs rather than just alcohol. NA, however, still follows the same 12-step programme as AA. The AA philosophy itself has no criteria, although public support groups following the 12-step programme may create their own specifications of who can join (i.e., all male, all female).

Duration

The original Minnesota model prescribed a 28-day inpatient treatment programme individualised for every client. After the 28-day inpatient programme, the client is expected to continue attending AA meetings. However, since then, the model has developed to include outpatient options and more leniency regarding the duration of stay in facilities following this model (Anderson, McGovern & DuPont, 1999). Again, each facility will most likely dictate the appropriate duration of an inpatient stay. On its own, AA consists of peer-lead support groups which do not involve professionally trained individuals. Individuals can choose to attend AA or NA meetings for as long as they want.

Effectiveness (criteria of effectiveness, system of monitoring and evaluation, etc.)

The concept of a 'successful treatment outcome' for the Minnesota model rests upon the client being able to remain sober. Studies which concentrate on the effectiveness of 12-step programmes tend to focus on comparing individuals who have or have not completed the programme, rather than comparing the 12-step programme to other treatment options (Muck et al., 2001). Research into 12-step treatment has shown the following:

1) Inpatients with alcohol use disorders who attended AA meetings on a weekly basis were found to have a higher number of abstinent days and a reduction in alcohol consumption than those who attended AA meetings less frequently or not at all (Gossop et al., 2003).

2) Individuals who participated in AA, NA or both had abstinence rates of a year, a rate higher than individuals who did not participate in either group (Crape et al., 2002).

3) Individuals who continue to attend AA meetings over long periods of time, such as four to eight years, were more likely to remain abstinent for a 16-year period (Moos & Moos, 2006).

Moos and Timko (2008) note that although there is a lack of empirical evidence into the effectiveness of NA self-help groups, the fact that AA and NA follow the same 12-steps, have similar meeting styles and similar literature implies that outcomes from studies on AA will be similar to those for NA.

Unfortunately, due to the anonymous nature of the AA system, it has been challenging for researchers to successfully research the effectiveness and success rates of the 12-step programme when not combined with in- or outpatient treatment. However, Dodes (2014) attempted to research retention rates for AA, in addition to investigating the sobriety of AA members. The results of this research places AA's success rate between 5% and 10%. Furthermore, he suggested that solely relying on 12-step programmes as a treatment method often leads to relapse.

Approval or recommendations for the approach or method from national or international bodies

Approximately 60% of public drug treatment programmes in the US rely on a 12-step model as their leading method of treatment, and 80% of drug treatment programmes reported using the 12-step method 'at least sometimes' (Substance Abuse and Mental Health Administration, 2011). Arguably, this makes it one of the most widely used and popular treatment methods in the US.

However, abstinence-based treatment methods have, in recent years, received wide criticism from researchers who focus on understanding effective treatment methods for people who use drugs. One of the main arguments is that relapse amongst those who undergo treatment through abstinence-based programmes is common, and that relapse is considered a failure on the part of the individual not able to remain sober. The labelling of relapse as a failure may lead to feelings of shame or guilt (Mancini, Linhorst, Borderick & Bayliff, 2008). Furthermore, research has shown that clients of abstinence-based treatment programmes may lie or hide their drug use from healthcare providers, primarily to avoid feelings of shame and guilt, which in turn may 'reinforce a sense of worthlessness already existing in clients' (Mancini et al., 2008, p. 398).

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ANNEXES

HARM REDUCTION PSYCHOTHERAPY

When it appeared and who developed it

According to more recent literature surrounding harm reduction psychotherapy, it appears that several researchers were at the forefront of developing this therapy, most notably Edith Springer, Andrew Tatarsky , Jeannie Little and Dr. Patt Denning, currently the executive director and director of clinical services and training, respectively, at the Centre for Harm Reduction Therapy in California. In Little's (2006) research paper on harm reduction therapy groups, she indicates that the earliest piece of literature introducing the idea of harm reduction psychotherapy was Springer's research on the effective of AIDS prevention amongst active drug users (Springer, 1991). This research was followed by Tatarsky's research into harm reduction psychotherapy, with a focus on 'problem drinking' (Tatarsky, 1998) and Denning's research into harm reduction as a therapeutic approach for people living with HIV, personality disorders and substance abuse backgrounds (Denning, 1998).

Goals and objectives

One of the fundamental goals of harm reduction — and, therefore, harm reduction therapy — is to reduce the harms associated with drug use. However, harm reduction therapy places an emphasis on the fact that the client should, in collaboration with a trained professional, be the one who sets their own specific goals. Every client should be seen as an individual and will, therefore, have different expectations of where they wish to be in terms of their drug use. For some, this might involve abstinence, whilst for others it may simply equate with moderation and reducing any harms they experience due to their drug use (Tatarsky, 2003).

Brief content (components)

Harm reduction psychotherapy is the incorporation of 'public health principles and interventions, motivational interviewing and psychiatric treatment with psychodynamic psychotherapy to create an integrated model of treating individuals with substance abuse and psychiatric or emotional problems' (Little, 2006, p. 69).

Clients of harm reduction psychotherapy work on improving their drug-related as well as social, emotional and psychiatric issues (Little, 2006).

The Harm Reduction Therapy Centre (HRTC), based in California (US), is a prime example of how harm reduction therapy is implemented. Their programme includes the following:

- The comprehensive assessment of substance use, emotional or psychiatric, social and vocational issues.
- Brief educational groups to orient new clients to the harm reduction model.
- Individual therapy centred on collaboratively developed goals.
- Trauma-specific treatment.
- Group therapy (optional).
- Medication-assisted treatment using psychiatric and addiction medicine, including opioid substitution therapy (HRTC - The Centre for Harm Reduction Therapy and Dr. Patt Denning, n.d.).

What philosophy or psychological approaches form the basis of this approach

The philosophical basis of this approach is the concept of harm reduction. Harm reduction was first created in an attempt to reduce the rate at which people who inject drugs transmitted HIV. Since then, the harm reduction philosophy has expanded into what is not simply seen as a public health approach, but which at its core aims to reduce the harms associated with psychoactive drug use and to reduce other risk behaviours associated with psychoactive drug use (Lee, Engstrom & Petersen, 2011).

In combination with the harm reduction philosophy, cognitive behavioural research focusing on the facilitation of motivating a change in addictive behaviour and the transtheoretical model of change are used (Little, 2006).

The Transtheoretical Model of Change (TTM) was developed in the late 1970s when researchers determined that, through the study of smokers, people will quit smoking when they are ready to quit. Thus, TTM focuses on the decision-making of individuals and acknowledges that change in behaviour occurs continuously in a cyclical system. In TTM, there are six stages of change, and in order to move from stage to stage, the application of affective, cognitive and evaluative processes is needed (LaMorte, 2016).

Clients' criteria to enter (age, type of drugs, previous experience in treatment and rehabilitation, health issues, etc.)

There are no client criteria for harm reduction therapy. On their website, HRTC notes that their centre often works with people who have not yet made the decision to change their substance use, and that through this therapy the promotion of healthy changes and choices can begin (HRTC, The Centre for Harm Reduction Therapy, n.d.).

'We welcome people who are still using, who don't know whether they want to change, or how, and who are looking for a thoughtful alternative to "quit now and forever" treatment programmes. A person's goals can range from complete abstinence to controlled or safer use. We move as quickly or slowly as the client can, and we recognise that the final outcome of treatment is not always certain at the beginning and that successes can be both small and large' (HRTC - The Centre for Harm Reduction Therapy, n.d.).

Duration

There is no set duration, since the goals are created on an individual basis by the client and the therapist together. Harm reduction therapy acknowledges that every person is different and, therefore, the duration of treatment will vary from person to person.

Effectiveness (criteria effectiveness, system of monitoring and evaluation, etc.)

Due to the fact that harm reduction therapy emphasises the need for each client to create their own goals in terms of what they wish to achieve during their time in treatment, it is difficult to successfully measure the effectiveness of this therapy. Furthermore, there is no criteria for effectiveness, since each individual's criteria is set personally and, therefore, will vary.

However, the effectiveness of harm reduction strategies has been confirmed by a vast amount of research over the past decade. Multiple international organisations support these practices.

Approval or recommendations for the approach or method from national or international bodies

Because harm reduction therapy is a relatively new approach to SUD treatment, there is not much information available on the national or international support of this method. However, organisations like WHO, UNODC and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have all recommended that harm reduction strategies be implemented internationally in order to respond to and prevent the spread of HIV, and to reduce other harms associated with drug use. These organisations have used harm reduction practices as the basis of their comprehensive package of interventions for reducing the spread of HIV and for the reduction of drug use–related harms (UNAIDS, 2016).

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COGNITIVE BEHAVIOURAL THERAPY (CBT)

When it appeared and who developed it

Dr. Aaron Beck developed CBT whilst practicing as a psychiatrist at the University of Pennsylvania in the 1960s. By carrying out several experiments on depression, he found that individuals suffering from depression would experience negative thoughts spontaneously, thoughts he labelled 'automatic thoughts'. Beck found that when he aided patients in recognising and assessing these automatic thoughts, the patients were able to think more clearly and were able to function and feel better. Beck named this process 'cognitive therapy'; it is now more widely referred to as 'cognitive behavioural therapy' ('History of Cognitive Behaviour Therapy', 2016).

Goals and objectives

The goals of CBT when focusing on substance abuse involve the therapist and client working together in order to identify:

- harmful behavioural patterns or thoughts,
- patterns of self-destructive behaviour and
- situations or states of mind in which drug use may be more likely.

Once these patterns and behaviours have been identified, the therapist and client's goal will be to promote alternate patterns of thought, regulating emotions which may lead to drug use and regulating harmful behaviours. Another goal is to develop coping strategies which may help the client to handle situations or states of mind potentially leading to drug use (Carroll & Onken, 2005; 'Cognitive Behavioural Therapy for Addiction', 2017).

Brief content (components)

Waldron and Kaminer (2004) explain that CBT should not be considered as a 'single unitary approach' (p. 94). This is because a number of treatment approaches can be labelled as cognitive behavioural treatment, but will differ in terms of the emphasis on specific issues and the components included as a part of the treatment.

However, researchers have indicated that CBT when focusing on substance abuse will most likely include the following components: 'self-monitoring, avoidance of stimulus cues, altering reinforcement contingencies and coping skills training to manage and resist urges to use. In addition, other skills-focused interventions (e.g., drug and alcohol refusal skills, communication, problem-solving, assertiveness), mood regulation (e.g., relaxation training, anger management, modifying cognitive distortions) and relapse prevention are often incorporated to promote sobriety' (as cited in Waldron & Kaminer, 2004, p. 94).

Magill and Ray (2009) identified the following strategies as being fundamental to any form of CBT for substance abuse treatment:

- recognising inter- and intrapersonal triggers that may lead to relapse,
- coping skills training,
- drug-refusal skills training,
- functional analysis of substance use and
- increasing non-drug using activities.

Waldron and Kaminer (2004) further note that the typical components of CBT for substance abuse will include homework assignments, behavioural rehearsal, modelling and feedback.

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Examples of CBT approaches include:

- motivational interventions,
- contingency management and
- relapse prevention (McHugh, Hearson & Otto, 2015).

CBT can be run either in a group or an individual setting (McHugh, Hearson & Otto, 2015).

What philosophy or psychological approaches form the basis of the approach

CBT is based upon social learning theories and operant conditioning (Carroll & Onken, 2005).

Carroll and Onken (2005) explain that the essential characteristics of these theories, in the context of substance abuse treatment, include building an understanding of the antecedents and consequences of drug use, being able to recognise states of mind or situations in which one is especially vulnerable to drug use, learning how to avoid those states or situations and, finally, learning cognitive and behavioural skills in order to cope with those situations and states if they cannot be avoided.

Clients' criteria to enter (age, type of drugs, previous experience in treatment and rehabilitation, health issues, etc.)

There do not appear to be any set criteria for who can benefit from CBT. However, Waldron and Kaminer (2004) note that CBT for adolescents with substance abuse issues will be different than CBT for adults in some ways. They explain that 'as youths move through adolescence, cognitive skills, emotional maturity and social functioning are changing, autonomy increases and parent–adolescent communication moves toward symmetry. Thus, behavioural targets of change (e.g., how privileges are negotiated, identification of contingencies) will vary widely depending on the age and developmental level of the adolescent' (p. 95).

Bentler (1992) suggested that substance abuse during one's adolescent years may lead to a disruption in the development of a variety of skills (i.e., interpersonal and educational skills acquisition, prosocial identity formation, coping skills, etc.). Therefore, CBT would need to be expanded upon to focus on skills that adolescents may not have been able to develop naturally.

Duration

As mentioned by Waldon and Kaminer (2004), CBT should not be considered a single approach, since multiple interventions fall under the broader scope of CBT. Therefore, it is not possible to accurately assess the duration of CBT (McHugh, Hearson & Otto, 2010). Furthermore, CBT is typically incorporated into a treatment centre's programme, and, therefore, the duration of CBT will most likely depend on the length of stay allowed at each individual facility.

McHugh, Hearson and Otto (2015), by reviewing studies on the duration and effectiveness of CBT for substance abuse, noted that research remains inconclusive regarding the most effective duration. They note that whilst some studies found a positive correlation between longer durations of CBT and positive outcomes for clients, other studies found no difference between varied durations of treatment.

Effectiveness (criteria effectiveness, system of monitoring and evaluation, etc.)

Dutra et al. (2008) found through a meta-analysis of 34 studies focused on CBT for SUD that the strongest effect occurred when treating problems related to cannabis use, followed by cocaine and opioids. The smallest effect was found when trying to treat an individual who had a substance abuse problem with more than one drug. Effectiveness was measured in terms of how many days an individual abstained from using the

drug for which they were seeking treatment.

Magill and Ray (2009) assessed 53 controlled trials of CBT, which focused on adults who had been formally diagnosed with either illicit substance or alcohol use disorders. Their results indicated that CBT does indeed have a significant treatment effect, albeit a small one. They noted that at 6-month and 12-month follow-up periods, the effect of CBT was lower than it was directly following treatment. Based on their results, they suggested that CBT is most effective with marijuana use disorders when combined with other psychosocial treatment, and amongst women and when delivered in a briefer format. It is important to note that this meta-analysis considered the effectiveness of CBT as how many days individuals remained abstinent after CBT.

Based on the meta-analyses mentioned above, we can assume that CBT considers abstinence a suitable outcome, and, therefore, CBT is considered successful if the individual remains abstinent. However, unless individuals are required to return to a treatment facility for follow-up examinations, it is difficult to assess whether they have remained abstinent.

Alternative

An alternative version of CBT is known as computer-based training for cognitive behavioural therapy (CBT4CBT). This is a web-based programme that teaches people with SUDs skills to manage or reduce their substance use. The programme uses practice exercises, examples, videos and interactive graphics to:

- understand substance use,
- change substance use,
- cope with cravings,
- be able to say 'no' to substances,
- learn problem-solving skills,
- recognise and change thoughts about substances,
- improve decision-making skills and
- reduce the risk of contracting HIV or hepatitis.

The client completes modules, each of which takes between 45 minutes to 1 hour. Individuals are generally required to complete one module per week. It is important to note that CBT4CBT is intended for use when combined with a standard form of an outpatient substance abuse treatment programme ('CBT4CBT (Computer-Based Training for Cognitive–Behavioural Therapy)', 2017).

Approval or recommendations for the approach or method from national or international bodies

NIDA lists CBT as one of the evidence-based treatment behavioural therapies that can be used to treat substance abuse disorders, referred to on their website as 'drug addiction' ('Cognitive-Behavioural Therapy (Alcohol, Marijuana, Cocaine, Methamphetamine, Nicotine)', 2017).

The Substance Abuse and Mental Health Services Administration (SAMHSA) includes CBT4CBT in its National Registry of Evidence-based Programmes and Practices (NREPP) ('CBT4CBT (Computer-Based Training for Cognitive–Behavioural Therapy)', 2017).

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COMMUNITY REINFORCEMENT APPROACH (CRA)

When it appeared and who developed it

Originally known as 'community reinforcement,' the community reinforcement approach (CRA) was developed by Hunt and Azrin in 1973, a version focused on the treatment of alcoholics. In 1976, Azrin improved upon this method, which was then further developed by Sisson and Azrin (1986). This latest version (Sisson & Azrin, 1986) focuses primarily on working with the family members of an individual with an alcohol use problem, forming the basis of the community reinforcement and family training (CRAFT) method (discussed below). Miller and Meyers (1999) note that community reinforcement is now usually referred to as CRA.

Goals and objectives

Miller and Meyers (1999) assert that the central goal of CRA is to 'rearrange a person's life so that abstinence is more rewarding than drinking' (Miller & Meyers, 1999, p. 116). Here, 'drinking' is used because the original purpose of CRA was to focus on those with an alcohol misuse problem.

Miller and Meyers (1999) also explain that in order to achieve this central goal, two steps are necessary, namely: enhancement of positive reinforcements for abstinence and elimination of positive reinforcements for alcohol consumption. Again, whilst this description solely discusses alcohol, the fundamental idea of positive reinforcement enhancement and elimination can be applied to any substance.

Roozen et al. (2004) explain that one of the fundamental goals of CRA is to change the environmental circumstances in the individual's life. This may occur through changes in recreation, labour and family involvement in order to build a healthier lifestyle viewed as more optimal than a life involving substance misuse.

Brief content (components)

A combination of various types of treatment are implemented. These may include the following:

- Building motivation by helping the client realise the negative consequences of current behaviours and the advantages of changing their behaviours involving substance use or misuse.
- Initiating sobriety by setting goals with the therapist to achieve abstinence.
- Analysing drinking patterns by identifying when substance consumption (in this example, alcohol) is most likely to occur.
- Increasing positive reinforcement to help engage the client into the community and to make substance-free life more rewarding than a life using substances.
- Behaviour rehearsal by practicing coping skills, such as interpersonal communication.
- Involving significant others by learning skills in order to improve positive reinforcements and communication between the client and family members (Miller & Meyers, 1999).

Roozen et al. (2004) also note that 'voucher-based incentive programmes' are also widely used in combination with CRA, and can be used as a means to promote abstinence. Vouchers for services or retail items are typically provided to someone in a CRA programme once they have submitted a substance-free urine sample.
homework assignments, behavioural rehearsal, modelling and feedback.

What philosophy or psychological approaches form the basis of the approach

The original version of this method, community reinforcement, is based on the social learning theory model (Azrin, 1976).

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Meyers and Smith (1995) argue that CRA recognises the importance of environmental influences on substance dependence. Therefore, CRA includes methods that focus on shifting these environmental influences rendering them more positive rather than ones that lead to continued substance use.

Shottenfeld et al. (2000) explain that CRA is based on the theoretical assumption that substance dependence continues due to a combination of a lack of positive reinforcements unrelated to substances and the presence of substance-related reinforcements.

Roozen et al. (2004) describe CRA as a 'biopsychosocial multifaceted approach' (Roozen et al. 2004, p. 1), which aligns with previous explanations of CRA. The biopsychosocial model, developed by Engel (1977), suggests that substance abuse disorders should be looked at by combining the biological, cognitive, psychological and sociocultural perspectives (Donovan & Marlatt, 2013).

Clients' criteria to enter (age, type of drugs, previous experience in treatment and rehabilitation, health issues, etc.)

Whilst the original form of CRA was geared towards working with those with alcohol consumption problems, research has shown that CRA has also been effective when working with people with other substance issues, such as heroin and cocaine (Miller & Meyers, 1999).

Duration

Miller and Meyers (1999) noted that in previous research focusing on alcohol-dependent clients individuals received an average of five to eight CRA sessions, producing positive treatment outcomes.
NIDA describes CRA as an 'intensive 24-week outpatient therapy' programme ('Community Reinforcement Approach Plus Vouchers (Alcohol, Cocaine, Opioids)', 2012).
There appear to be no other indications regarding a set time frame for this type of programme, since different researchers will provide varying suggestions regarding the best time frame.

Effectiveness (criteria effectiveness, system of monitoring and evaluation, etc.)

CRA is viewed as 'successful' or 'effective' if the individual achieves and maintains abstinence. Whether this includes abstinence solely from the 'problem substance' or all psychoactive substances remains unclear.

Roozen et al. (2004) conducted a systematic literature review of research focused on the use of CRA for those with a substance use disorder, specifically alcohol, cocaine and opiates. They reviewed the effectiveness of '(1) CRA compared to usual care and (2) CRA versus CRA plus contingency management' (Roozen et al., 2004, p. 1). Unfortunately, they provided no clear definition regarding 'usual care'.

Their results indicated that when compared to 'usual care,' however, CRA was more effective in reducing the number of days alcohol was consumed. Yet, they found conflicting results as to how effective it was in leading to continuous abstinence from alcohol. They also found that the combination of CRA and 'incentives' (i.e., vouchers) was more effective in promoting abstinence amongst individuals seeking abstinence from cocaine compared to those seeking abstinence from alcohol or opiates. CRA with 'incentives' also appeared more effective than CRA on its own when focusing on individuals with a cocaine use problem. Almost no evidence existed suggesting that CRA was more effective than methadone programmes for people with opioid use problems.

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Approval or recommendations for the approach or method from national or international bodies

NIDA (2012) lists CRA as one of the evidence-based treatment behavioural therapies that can be used to treat substance abuse disorders, referred to on their website as 'drug addiction' ('Community Reinforcement Approach Plus Vouchers (Alcohol, Cocaine, Opioids)', 2012).

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ANNEXES

COMMUNITY REINFORCEMENT AND FAMILY TRAINING (CRAFT): AN EXTENSION OF CRA

When it appeared and who developed it

The original version of CRAFT, known as community reinforcement, was developed by Hunt and Azrin (1973). Several years later, Azrin (1976) improved upon this method, which was then extended by Sisson and Azrin (1986). This latest version (Sisson & Azrin, 1986) focuses primarily on working with the family members of those with an alcohol use problem, forming the basis of the CRAFT method. The CRAFT method is referred to in some research as the community reinforcement training (CRT) programme, whilst the programme labelled community reinforcement by Hunt and Azrin (1973) is now generally referred to as CRA (Miller & Meyers, 1999).

Goals and objectives

The goal of CRAFT is to 'increase family compliance with an intervention for persons with substance abuse in order to increase the rate of engagement of those addicted individuals in treatment' ('Community Reinforcement and Family Training (CRAFT)', 2017, p. 1)

Brief content (components)

CRAFT is conducted in an outpatient setting. The components of CRAFT typically include the following:

- building motivation,
- functional analysis,
- contingency management,
- communication skills training,
- treatment entry training,
- immediate treatment entry,
- life enrichment and
- safety training ('Community Reinforcement and Family Training (CRAFT)', 2017).

What philosophy or psychological approaches form the basis of the approach

CRAFT is based upon CRA. CRA focuses on achieving abstinence from alcohol use through a process of increasing the positive reinforcement of sobriety and decreasing the positive reinforcement for drinking alcohol (Miller & Meyers, 1999). For a more detailed explanation of CRA, view the previous section of this report.

CRA was originally created with a focus on alcohol, whilst studies have shown that CRA is also effective when focusing on other drugs such as heroin and cocaine (Miller & Meyers, 1999).
The original version of this method, community reinforcement, is based on the social learning theory model (Azrin, 1976).

Clients' criteria to enter (age, type of drugs, previous experience in treatment and rehabilitation, health issues, etc.)

This programme is predominantly focused on the family members or significant other of clients rather than the clients themselves. Therefore, the criterion for this method is that an individual is a family member or the significant other of an individual with SUD. Furthermore, this programme would be used in combination with an evidence-based treatment programme for the individual with SUD.

Duration

Kirby et al. (1999) conducted a study on CRT, essentially the CRAFT method. They required participants to attend a total of 14 hours of treatment, spread out over 10 weeks, in order to be considered as having

completed the programme. However, this criterion was set by the researchers of that study, and, therefore should not be seen as the 'official' duration of CRAFT.

Miller and Meyers (1999) argued that based on studies conducted on the CRAFT method, an average of five sessions with a concerned family member were needed for the individual to seek treatment.
SAMHSA states that CRAFT consists of 12 to 14 1-hour sessions given twice weekly for 4 weeks, and once weekly for another 6 weeks. However, they note that this may vary depending on the family member or significant other ('Intervention Summary – Community Reinforcement and Family Training (CRAFT)', 2017).

Effectiveness (criteria effectiveness, system of monitoring and evaluation, etc.)
Kirby et al. (1999) conducted a study on the effectiveness of CRT (or CRAFT) in relation to the more standard 12-step self-help group. In total, 32 family members of individuals who use drugs participated in this study. The results showed that family members involved with the CRAFT method were more likely to stay in the programme longer and were more likely to complete the programme.

For the purposes of this study, the impact that SUD had on the family member was measured using the Family Impact Survey, which focuses on the following areas: financial, lifestyle, physical abuse, involvement with legal and other governmental agencies, health, relationship and emotional problems. Mood, family functioning, social functioning and self-esteem were also measured using other scales. A significant reduction in financial- and health-related issues were reported after tens weeks of either programme. Reductions in physical abuse, relationship and social-emotional issues were close to being significant. Additionally, the overall mood of the family members had increased significantly at the ten-week follow-up interview. This indicates that the CRT method may be effective in improving the overall quality of life of the family members of someone with SUD.

In addition, results showed that those working with the CRT method were more likely to have a family member with SUD enter treatment when compared to 12-step group members. This indicates that the CRAFT method may be an effective way to not only improve the quality of life of the family members of people with SUDs, but also increase the chance of that individual seeking treatment if they have not done so already.

A similar study was conducted by Meyers and Wolfe (2004) which showed very similar results to that of Kirby et al. (1999).

These studies used psychological assessment measures in order to accurately assess the effectiveness of the CRT programme. It is unlikely that this would be done without psychological research. Yet, there does not appear to be a set system to evaluate the effectiveness of the CRT method. Thus, future research should focus on whether the quality of life of the family member(s) involved had improved or not, which could be done through a discussion with the professional implementing CRT.

Approval or recommendations forthe approach or method from national or international bodies
SAMHSA includes the CRAFT method in its NREPP ('Intervention Summary – Community Reinforcement and Family Training (CRAFT)', 2017).

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ANNEXES

THE MATRIX MODEL

When it appeared and who developed it

The Matrix model was developed by Rawson, Obert, McCann and Mann at the Matrix Centre in Southern California in the mid-1980s (Rawson, Obert, McCann & Mann, 1985). This model was developed in response to 'the first wave of cocaine abusers' (Rawson et al., 1995, p. 118) who began seeking treatment. Whilst originally named the 'neurobehavioral model,' it was renamed to match the organisation at which this model was developed (Rawson et al., 1995).

Goals and objectives

The original goals of the Matrix model were outlined by Rawson et al. (1995), and explained as able to provide a structure via which cocaine users and abusers could achieve the following:

- remain abstinent from all drugs,
- complete the 12-month treatment process,
- learn about drug 'addiction' and relapse,
- receive support from a trained therapist,
- receive education for the client's family members,
- be introduced to self-help programmes and
- be held accountable through urine tests.

Brief content (components)

The Matrix model is described as an intensive outpatient treatment programme (Rawson et al., 1995; 'About Matrix Institute on Addictions', 2017).

The original Matrix model procedure contained multiple components. These included the following:

1) *Individual sessions* consisting of 20 individual sessions provided with a trained therapist in the first six months of treatment.
2) *Educational groups* provided during the first 16 weeks of treatment for clients and their family members. The primary aims consisted of educating clients on subjects including the biology of 'addiction', the medicinal effects stimulants have on the body and the impact use has on family members amongst other issues.
3) *Stabilisation groups* provided during the first two weeks of treatment aiming to help clients remain sober over the upcoming weekend.
4) *Relapse prevention groups* on skills to recognise when relapse may be imminent and how to prevent relapse.
5) *Conjoint sessions* including the client as well as their significant other with the aim of strengthening communication between the two parties. A minimum of seven conjoint sessions must be scheduled within the first six months of treatment.
6) *Urine tests* collected randomly on a weekly basis to test for any drugs in the client's system.
7) *AA meetings* provided onsite once a week which clients are encouraged to attend.
8) *Relapse analysis* if a relapse occurs, whereby the therapist sets guidelines on how to work with a client on understanding why the relapse occurred and how this information can be used to avoid a relapse in future.
9) *Social support groups* aim to help establish new friendships and take part in non-drug related activities together (Rawson et al., 1995).

Obert et al. (2000) note that due to economic constraints the programme was modified to include more group sessions, fewer individual sessions and no family groups.

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The current website of the Matrix Institute does not provide a detailed explanation of the procedure. Thus, it is difficult to determine whether this same structure is currently followed. They do provide the following information regarding what the Matrix model programme includes:

- early recovery groups,
- relapse prevention groups,
- family education groups,
- individual sessions,
- social support groups and
- 12-step meetings ('About Matrix Institute on Addictions', 2017).

What philosophy or psychological approaches form the basis of the approach

Unfortunately, the original developers of the Matrix model are not entirely clear regarding the philosophical or psychological approaches applied to develop it. Rawson et al. (1995) simply explain that:

'the sequenced treatment materials have evolved from applying concepts described in theoretical and applied research to the needs of cocaine abusers attempting to stop cocaine use. Treatment materials drew heavily upon published literature pertaining to the areas of relapse prevention, family and group therapies, drug education, and drug abuse monitoring' (Rawson et al., 1995, p. 119).

Clients' criteria to enter (age, type of drugs, previous experience in treatment and rehabilitation, health issues, etc.)

This model was originally designed to aid those with a cocaine use or misuse problem. However, the official Matrix Institute website now describes the programme as appropriate for SUDs involving any illicit or prescription drug, as well as alcohol ('About Matrix Institute on Addictions', 2017).

Duration

The duration of the original Matrix model programme is explicitly described as lasting 12 months (Rawson et al., 1995). Later reviews of the Matrix model noted that economic pressures resulted in a revised programme lasting only 16 weeks (i.e., four months) (Obert et al., 2000).

The Matrix Institute website explains that, based on research into the effectiveness of the Matrix model, a four-month programme is recommended for all clients. However, because treatment programmes are individualised, this time frame may vary ('Intensive Outpatient', 2017). An example of a treatment schedule can be found at https://www.matrixinstitute.org/treatments/outpatient/.

SAMHSA also describes the Matrix Model as a 16-week programme ('Matrix Model', 2017).

Effectiveness (criteria effectiveness, system of monitoring and evaluation, etc.)

The Matrix model programme is considered effective if the client remains abstinent, since that is one of the primary goals of this model. Based on the description of the programme provided by Rawson et al. (1995), this criterion is monitored through weekly urine tests. However, this only applies when the client is taking part in the Matrix model programme.

Approval or recommendations for the approach or method from national or international bodies

NIDA lists the Matrix model as an evidence-based treatment option for those with SUDs involving stimulants ('The Matrix Model (Stimulants)', 2012).
SAMHSA includes the Matrix model in its NREPP ('About Matrix Institute on Addictions', 2017).

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THERAPEUTIC COMMUNITIES (TCS)

When it appeared and who developed it

Therapeutic communities (TCs) first appeared as a result of the increase in residential treatment for SUDs, an outcome of the self-help recovery movement (i.e., Alcoholics Anonymous) in the 1950s (NIDA, 2015). Sacks and Sacks (2010) found that groups within residential treatment progressed into democratically run, self-supporting residencies that helped with the recovery of SUDs and helped to encourage abstinence. This was the beginning of TCs.

Goals and objectives

TCs have a '*recovery orientation*' (NIDA, 2015, p. 2), meaning that there is a focus on the individual as a whole and on what lifestyle changes can be made, rather than focusing only on achieving drug use abstinence.

Multiple studies indicated that TCs push individuals to look at their own behaviours, encouraging them to engage in living better lives. These better lives are based on a willingness to learn, working hard, accepting responsibility for one's own actions and being honest (as cited in NIDA, 2015).

Vanderplasschen et al. (2013) also noted that the TC method understands that SUDs often entail relapses, and these relapses should be used as a chance to learn.

NIDA (2015) explains that TCs view recovery from SUDs as 'a gradual, ongoing process of cognitive change through clinical interventions, and it is expected that it will take time for programme participants to advance through the stages of treatment, setting personal objectives along the way'. Furthermore, 'the goal is for a TC participant to leave the programme not only drug-free, but also employed or in school or training. It is not uncommon for programme participants to progress in their recovery to take on leadership and staff roles within the TC' (NIDA, 2015, p. 2).

Brief content (components)

TCs are considered a form of long-term residential treatment for SUDs. Vanderplasschen et al. (2013) describe TCs as being 'drug-free environments in which people with addictive problems live together in an organised and structured way to promote change toward recovery and reinsertion into society' (Vanderplasschen et al., 2013, p. 1).

Clear expectations outline how individuals should behave whilst involved in a TC, and behavioural as well as psychological rewards are given to those who follow what is expected of them. Examples of rewards include praise or increasing one's status within the group (NIDA, 2015).

Bunt, Muehlbach and Moed (2008) explain that the TC procedure is divided into three stages. NIDA (2015) described these three stages in the following ways:

- Stage one consists of requiring the individual to participate in all activities, since this will help introduce them to the TC environment and begin to develop positive attitudes, behaviours and responsibilities.
- Stage two entails introducing the incorporation of SUD treatment methods, such as CBT.
- Stage three involves preparing the individual to leave the TC and become a part of the outside community.

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The daily routine in a TC generally includes the following:

- morning and evening house meetings,
- the assignment of jobs to be completed,
- group sessions,
- seminars,
- personal time,
- recreational time and
- individual counselling (NIDA, 2015).

Assigned jobs are an important part of TCs, since they teach individuals respect, responsibility, the importance of work and so on. Another important aspect of TCs lies in the concept of 'mutual help,' which essentially means that positive social exchanges, bonding and establishing social relationships amongst those living together in a TC can in turn support individuals throughout the treatment process (NIDA, 2015).

NIDA (2015) explains that:

'TC participants are encouraged to be accountable for their behaviours and to set goals for their own personal well-being, positive participation in the broader community and life after leaving treatment. An important therapeutic goal is to help people identify, express and manage their feelings in appropriate and positive ways' (NIDA, 2015, p. 5).

What philosophy or psychological approaches form the basis of the approach

TCs view the concept of 'addiction' or SUDs from the biopsychosocial perspective. The biopsychosocial perspective explains 'addiction' as a combination of biological, psychological and social factors (Perfas & Spross, 2007).

Clients' criteria to enter (age, type of drugs, previous experience in treatment and rehabilitation, health issues, etc.)

There is no indication that any criteria exist for clients who wish to follow the TC method. Client criteria will most likely depend on the facility of which that TC is a part.

Duration

According to the Centre for Substance Abuse Treatment (1999), the duration of treatment averages about one year, but may extend to up to 18 months depending on how an individual progresses in the programme.

De Leon (2012) indicated that the longer the duration of treatment, the more positive the outcomes.

Approval or recommendations for the approach or method from national or international bodies

NIDA as well as the Centre for Substance Abuse Treatments both classify TCs as viable options for the treatment of SUDs.

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TEMPLATES OF ASSESSMENT INSTRUMENTS

DESK RESEARCH TEMPLATE

Objective 1. to analyze international experience in the area of treatment and rehabilitation for PWUD

Please provide information on the evidence based approaches and methods used in treatment and rehabilitation of drug users worldwide. Please try to answer the following questions while describing each approach and method:

- Title of the approach or method
- When appeared and who developed
- Goals and objectives
- Brief content (components)
- What philosophy or psychological approaches make the basis of the approach
- Clients' criteria to enter (age, type of drugs, previous experience in treatment and rehabilitation, health issues etc.)
- Duration
- Effectiveness (criteria effectiveness, system of monitoring and evaluation etc.)
- Approval or recommendations of the approach or method by national or international bodies.
- etc.

Please also add any recommendations or policies regulating treatment and rehabilitation on the international level (WHO, UNODC, Council of Europe, Pompidou Group etc.), description of different forms (ownership, regiments etc).

Title of the document/resource used	*Brief description*	*Link*
1. 2. ….		

Objective 2. to identify and document all the available forms of treatment and rehabilitation for PWUD in selected countries of EECA region

By "forms" we understand ownership of the centers, services or clinics (state, commercial, faith-based and non-governmental), regiments (outpatient, inpatient/residential), finance support (state or local budgets, international donors, private donations, medical insurance etc.).

Please make review of available forms of treatment and rehabilitation in your country. Add any relevant details.

Title of the document/resource used	*Brief description*	*Link*
1. 2. …		

TEMPLATES OF ASSESSMENT INSTRUMENTS

Objective 3. to collect data on the approaches and methods applied in treatment and rehabilitation

Please provide information on the evidence based approaches and methods used in treatment and rehabilitation of drug users in your country. Please try to answer the following questions while describing each approach and method:

- Title of the approach or method
- When appeared and who developed
- Goals and objectives
- Brief content (components)
- What philosophy or psychological approaches make the basis of the approach
- Clients' criteria to enter (age, type of drugs, previous experience in treatment and rehabilitation, health issues etc.)
- Duration
- Effectiveness (criteria effectiveness, system of monitoring and evaluation etc.)
- Approval or recommendations of the approach or method by national or international bodies.
- etc.

Please also add any recommendations or policies regulating treatment and rehabilitation on the international level (WHO, UNODC, Council of Europe, Pompidou Group etc.)

Title of the document/resource used	*Brief description*	*Link*
1. 2. …		

Objective 4. to evaluate the access to treatment and rehabilitation services for PWUD in the region

Most of the information will be gained during the expert interviews however some information can be also received from additional sources such as: various researches or overviews, websites of rehabilitation centers or clinics and other publications.

Title of the document/resource used	*Brief description*	*Link*
1. 2. …		

Objective 5. to assess the quality of provided services

Analysis of services' quality may cover the following aspects:

- existing standards and protocols of services;
- educational curriculum for professionals;
- certification of programs and professionals;
- monitoring and evaluation system;
- approved package of documentation;
- etc.

TEMPLATES OF ASSESSMENT INSTRUMENTS

Objective 6. to analyze existing normative guidance and specify gaps in legislation, protocols, standards, educational programmes for specialists

Please try to list all the documents that link to treatment and rehabilitation in your country.

Title of the document/resource used	*Brief description*	*Link*
1. 2. 3…		

Objective 7. to provide recommendations on building capacity of local key actors and the AFEW Network basing on the evidence based international practices

Using information above please provide recommendation and conclusions that can be used for building capacity of local key actors and the *AFEW Network*

Title of the document/resource used	*Brief description*	*Link*
1. 2. …		

TEMPLATES OF ASSESSMENT INSTRUMENTS

MAPPING TEMPLATE

Mapping is generally defined as methodology used to link community resources with an agreed upon vision, organizational goals, strategies, or expected outcomes. Mapping focuses on what communities have to offer by identifying assets and resources that can be used for building a system.

There are several principles that are unique to mapping efforts. First, mapping strategies focus on what is already present in the community. The idea is to build on the strengths within a community. Second, mapping is relationship-driven. Key to mapping efforts is the development of partnerships–a group of equals with a common interest working together over a sustained period of time to accomplish common goals. Third, mapping embraces the notion that to realize vision and meet goals, a community may have to work across programmatic and geographic boundaries. These principles provide the foundation for the mapping process.

In our country mappings we will focus on the first and second principles. The third principle of mapping will be addressed as a result of the whole assessment

Information received during the mapping will contribute to reach next objectives:

Objective 2. to identify and document all the available forms of treatment and rehabilitation for drug users in selected countries of EECA region
Objective 3. to collect data on the approaches and methods applied in treatment and rehabilitation
Objective 4. to evaluate the access to treatment and rehabilitation services for drug users in the region

I. Present resources and facilities

1.1. Governmental treatment and rehabilitation facilities

Please list available rehabilitation centers, programs using the following scheme where applicable:

- title
- inpatient/outpatient
- source of financial support
- cost
- approach(es) used
- duration
- location
- target group (age, gender, type of drugs)
- criteria to enter
- effectiveness data
- comments

General conclusions

Please make general conclusions on the facilities available in your country and its total number, approaches used and accessibility.

1.2. Non-governmental and faith-based treatment and rehabilitation facilities

Please list available rehabilitation centers, programs using the following scheme where applicable:

- title
- inpatient/outpatient
- source of financial support
- cost
- approach(es) used
- duration
- location
- target group (age, gender, type of drugs)
- criteria to enter
- effectiveness data
- comments)

General conclusions

Please make general conclusions on the facilities available in your country and its total number, approaches used and accessibility.

1.3. Private (commercial) treatment and rehabilitation facilities

Please list available rehabilitation centers, programs using the following scheme where applicable:

- title
- inpatient/outpatient
- source of financial support
- cost
- approach(es) used
- duration
- location
- target group (age, gender, type of drugs)
- criteria to enter
- effectiveness data
- comments

General conclusions

Please make general conclusions on the facilities available in your country and its total number, approaches used and accessibility.

1.4. Educational institutions

Please describe any educational programs and institutions that provide training for professional in the country. Please add details whether its approved on the national level or just local initiative, compulsory or optional; what kind of professionals are trained; criteria of entering; payment conditions etc.

General conclusions

Please make general conclusions on the availability, accessibility of specialized education as well as gaps in the system. Please provide any recommendations or suggestions based on the received information.

II. KEY ACTORS AND PARTNERSHIP

Please make a list and briefly describe all key actors in the sphere of treatment and rehabilitation for drug users. Please add information about their role/responsibilities, attitudes and influence on the availability and accessibility of services in the country.

General conclusions

Please make general conclusions on the availability, accessibility of specialized education as well as gaps in the system. Please provide any recommendations or suggestions based on the received information.

TEMPLATES OF ASSESSMENT INSTRUMENTS

GUIDE FOR THE EXPERT SEMI-STRUCTURED INTERVIEW

A semi-structured interview is a qualitative method of inquiry that combines a pre-determined set of open questions (questions that prompt discussion) with the opportunity for the interviewer to explore particular themes or responses further. A semi-structured interview does not limit respondents to a set of pre-determined answers (unlike a structured questionnaire) and are used to understand how interventions work and how they could be improved. This also allows respondents to discuss and raise issues that may not have been considered by the researcher, but might be important for the study.

This method will help to collect the following information:

1. to assess the quality of provided services;
2. to analyze existing normative guidance and specify gaps in legislation, protocols, standards, educational programmes for specialists;
3. to provide recommendations on building capacity of local key actors and the *AFEW Network* basing on the evidence based international practices.

I. INTRODUCTION

1. Introduce yourself, organization and project you present
2. Briefly describe goals and objectives of the assessment as well as expected duration of the interview
3. Ask respondent to sign informed consent
4. Check if the person has any questions about assessment or procedure
5. Ask respondent about his/her experience, current job title and other information and fill in the following table:

Name of the respondent:	
Organization:	
Job title:	
Responsibilities:	
Experience related to treatment and rehabilitation of drug users	

II. GENERAL SITUATION IN THE SPHERE OF TREATMENT AND REHABILITATION OF DRUG USERS

1. How would you describe situation with treatment and rehabilitation of drug users in the country?
2. Has something changed recently in this sphere?
3. Can you describe drug scene in the country? What types of drug are more popular?
4. Do you think there are any cultural context that influences treatment and rehabilitation in your country (values, traditions, religious)?

III. TREATMENT AND REHABILITATION FACILITIES IN YOUR COUNTRY

1. Are there any governmental treatment and rehabilitation clinics/centers in the country (including detox, OST, rehabilitation center, NA, self-help groups etc.)? If yes please add details:

– How many?
– Location of facilities?

– Inpatient/outpatient regiments?
– What is the duration of the program(s)?
– How many patients can receive services in one center/clinic at one time?
– What is the average admission fee or is it free of charge? If it is free of charge who covers expenses (insurance, local or state budget etc.)
– What are the criteria to enter the programme(s)?
– What kind of professionals and what are their competencies (psychologists, social workers, health care professionals, peers, certified or not etc.)
– Are there any specific normative guidance that regulates work of centers and clinics?
– Are there any reporting documentation used in the centers and clinics?
– What approaches and methods are used in governmental treatment and rehabilitation centers and clinics? Does it include the component of social reintegration?
– How would you evaluate access to services in governmental institutions? Are there any barriers (cost, locations, complex of services, legal, attitudes etc.)? Is information about facilities available through advertising, referral system?
– How would you evaluate effectiveness of governmental services? Is there any information about its effectiveness?
– How would you evaluate quality of services and attitude of professionals? What instruments and procedure are used to evaluate the quality of services?
– Is there monitoring of treatment success? If yes, what are the treatment success indicators?
– Is there any clients' satisfaction indicators? How the clients' satisfaction being monitored?

2. Are there any private (commenrcial) treatment and rehabilitation clinics/centers in the country (including detox, OST, rehabilitation center, NA, self-help groups etc.)?? If yes please add details:

– How many?
– Location of facilities?
– Inpatient/outpatient regiments?
– What is the duration of the program(s)?
– How many patients can receive services in one center/clinic at one time?
– What is the average admission fee or is it free of charge? If it is free of charge who covers expenses (insurance, local or state budget etc.)
– What are the criteria to enter the programme(s)?
– What kind of professionals and what are their competencies (psychologists, social workers, health care professionals, peers, certified or not etc.)
– Are there any specific normative guidance that regulates work of centers and clinics?
– Are there any reporting documentation used in the centers and clinics?
– What approaches and methods are used in governmental treatment and rehabilitation centers and clinics? Does it include the component of social reintegration?
– How would you evaluate access to services in governmental institutions? Are there any barriers (cost, locations, complex of services, legal, attitudes etc.)? Is information about facilities available through advertising, referral system?
– How would you evaluate effectiveness of governmental services? Is there any information about its effectiveness?

– How would you evaluate quality of services and attitude of professionals? What instruments and procedure are used to evaluate the quality of services?
– Is there monitoring of treatment success? If yes, what are the treatment success indicators?
– Is there any clients' satisfaction indicators? How the clients' satisfaction being monitored?

3. Are there any non-governmental and faith-based treatment and rehabilitation clinics/centers in the country (including detox, OST, rehabilitation center, NA, self-help groups etc.)?? If yes please add details:

– How many?
– Location of facilities?
– Inpatient/outpatient regiments?
– What is the duration of the program(s)?
– How many patients can receive services in one center/clinic at one time?
– What is the average admission fee or is it free of charge? If it is free of charge who covers expenses (insurance, local or state budget etc.)
– What are the criteria to enter the programme(s)?
– What kind of professionals and what are their competencies (psychologists, social workers, health care professionals, peers, certified or not etc.)
– Are there any specific normative guidance that regulates work of centers and clinics?
– Are there any reporting documentation used in the centers and clinics?
– What approaches and methods are used in governmental treatment and rehabilitation centers and clinics? Does it include the component of social reintegration?
– How would you evaluate access to services in governmental institutions? Are there any barriers (cost, locations, complex of services, legal, attitudes etc.)? Is information about facilities available through advertising, referral system?
– How would you evaluate effectiveness of governmental services? Is there any information about its effectiveness?
– How would you evaluate quality of services and attitude of professionals? What instruments and procedure are used to evaluate the quality of services?
– Is there monitoring of treatment success? If yes, what are the treatment success indicators?
– Is there any clients' satisfaction indicators? How the clients' satisfaction being monitored?

- **Do you know what kind of mentioned above facilities patients prefer in the country and why?**
- **Do any kind of facilities should get license in order to provide services for drug users? How is it regulated?**
- **Any other comments?**

IV. NORMATIVE GUIDANCE

1. Please name all normative guidance that regulates the sphere of treatment and rehabilitation of drug users in the country? Are there any standards, protocols, laws, programs or other papers?
2. What do you think should be improved in normative guidance? What additional documents development or review of existing ones needed?

TEMPLATES OF ASSESSMENT INSTRUMENTS

V. EDUCATION AND CERTIFICATION OF PROFESSIONALS

1. Are there any educational curriculums for specialists working in this sphere? If yes, please specify what kinds, what professionals can be trained, quality of education and other relevant information.
2. Are there any requirements for the professionals working in the sphere (obligatory certification or post-graduate studies, supervision

VI. CONCLUSIONS AND RECOMMENDATIONS

1. Are there any suggestions of improving the system of treatment and rehabilitation of drug users? How can quality of services be improved? What other approaches or forms should be introduced in the country?
2. Do you have any suggestions for *AFEW* how we can contribute improvements?

TEMPLATES OF ASSESSMENT INSTRUMENTS

INFORMED CONSENT FOR EXPERT INTERVIEWS (IN THE RUSSIAN LANGUAGE)

Информированное согласие об участии в исследовании
"ПОТРЕБНОСТИ И БАРЬЕРЫ В ЛЕЧЕНИИ И РЕАБИЛИТАЦИИ ПОТРЕБИТЕЛЕЙ НАРКОТИКОВ В СТРАНАХ РЕГИОНА ВЕЦА"

AFEW Интернешнл приглашает вас принять участие в исследовании, направленном на изучение ситуации с доступом к реабилитации и лечению потребителей наркотиков. Перед тем, как принять решение о принятии участия в исследовании, пожалуйста, внимательно прочитайте информацию о целях и условиях исследования.

AFEW Интернешнл — международная сеть неправительственных организаций, целью которой является улучшение здоровья уязвимых групп населения. Нашей целью является содействие укреплению здоровья уязвимых групп и расширению доступа к услугам общественного здравоохранения в области профилактики, лечения и ухода при ВИЧ, туберкулезе, гепатите С, а также обеспечению сексуального и репродуктивного здоровья.

Данное исследование проводится в рамках проекта «Восполняя пробелы: права и здоровье уязвимых групп населения» и направлено на достижение следующих целей:

1. Изучение потребностей по улучшению качества существующих программ реабилитации или внедрению новых услуг, направленных на лечение и реабилитацию потребителей наркотиков.
2. Определение приоритетных направлений инвестирования ресурсов сети *AFEW* в сфере запуска или поддержки программ лечения и реабилитации потребителей наркотиков в регионе ВЕЦА.
3. Развитие потенциала партнеров в Украине, Грузии, Кыргызстане, Таджикистане, Казахстане и России в сфере реабилитации и европейских подходов к реабилитации.

Для достижения указанных целей планируется проведение кабинетного исследования, картирования услуг и интервью с экспертами.

Интервью с вами будет касаться вашей оценки текущей ситуации в сфере оказания услуг по лечению и реабилитации для потребителей наркотиков, существующей нормативной и методологической базы, потребностей и барьеров в получении услуг. Участие в исследовании является добровольным, конфиденциальным и, по желанию, анонимным. Ваша личная информация не будет нигде опубликована, на основании предоставленной профессиональной информации будут сделаны обобщающие вывода и рекомендации. Вы можете задавать вопросы или остановить интервью в любой момент. Предполагаемая длительность интервью около 1,5 часов. С целью обработки данных интервью будет записываться.

Для того, чтобы принять участие в исследование, поставьте вашу подпись для подтверждения того, что:

- Ваше решение является добровольным;
- Вы понимаете цели и характер исследования;
- Вы понимаете, что интервью будет записываться для обработки данных, записи интервью публиковаться не будут, отдельные цитаты (без указания личной информации) и обобщенная информация будет использоваться для написания отчета;
- Вы можете задавать любые вопросы, которые вас интересуют о данном исследовании;
- Вы можете отказаться принимать участие в исследовании в любой момент, не объясняя своего решения или не отвечать на отдельные вопросы;
- Вы понимаете, что вам гарантируется конфиденциальность и, при необходимости, анонимность при анализе полученной информации и публикации отчета исследования;
- Вы понимаете, что у вас есть доступ к результатам исследования, которые по вашему требованию вам должны предоставить организаторы исследования.

Для корректного анализа данных, пожалуйста, укажите следующую информацию, поставьте подпись и дату (указывая информацию, вы тем самым даете согласие на ее использование):

ФИО (или только имя)_____
Должность_____
Место работы (по согласию)_____
Возраст_____
Пол (обведите) М Ж

Подпись:_____ Дата:_____

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