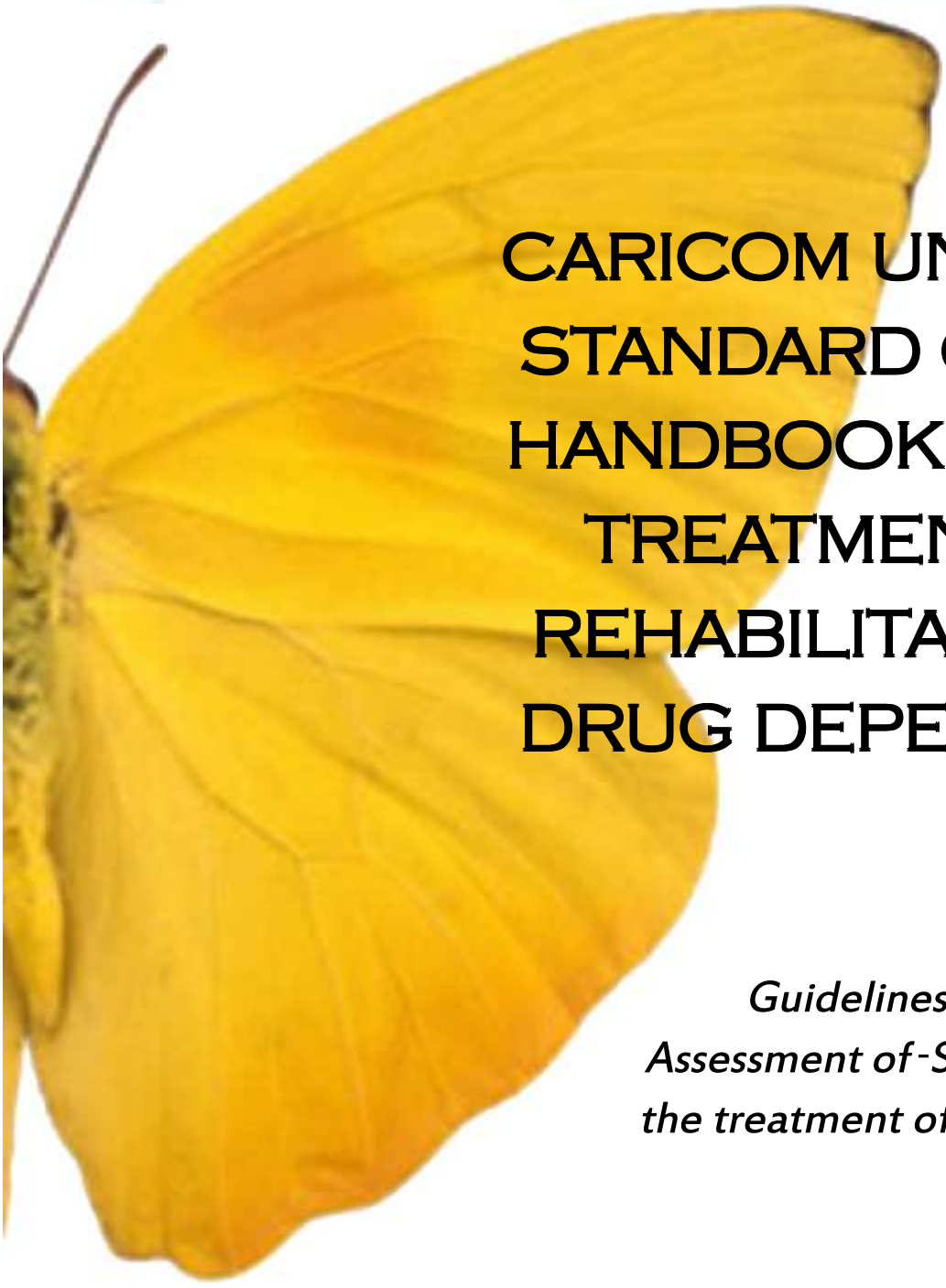

CARICOM UNIVERSAL STANDARD OF CARE HANDBOOK FOR THE TREATMENT AND REHABILITATION OF DRUG DEPENDANCE

Guidelines and criteria for the Assessment of -Standards of Care in the treatment of Drug Dependance

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Preface

In the Caribbean Community, care, treatment and rehabilitation of persons addicted to drugs are administered through public, private and Non Governmental organizations. In recent times and in response to unmet needs, a number of treatment facilities have been established. Many of these facilities are not guided by standards related to facilities, services and personnel. Additionally, the administration of these services is very often challenged by inadequate human resources, insufficiently trained personnel and lack of funds to establish and maintain structures and programmes.

It was against this background, that the CARICOM Secretariat, in collaboration with the Inter- American Drug Abuse Control Commission (CICAD) and with funding from the European Union (9th EDF) embarked on an exercise, involving service providers, policy-makers and clients, to develop a Handbook for Member States to guide, the fledgling but diverse treatment and rehabilitation sector in the region.

The CARICOM Universal Standard of Care Handbook for the Treatment and Rehabilitation of Drug Dependence, outlines, in the main, a minimum set of standards which are relevant and implementable for CARICOM countries, while at the same time complying with international standards for safety and efficacy. The Handbook draws on seminal publications in the area of assessing standards of care, input and recommendations from providers of treatment and care for substance dependence/addiction in CARICOM Member States and from the CARICOM Technical Advisory Body (TAB) for the Regional Drug Demand Reduction Strategy. The 'Standards of Care of the Treatment of Drug Dependence-Experience in the Americas' (2000) compiled under the auspices of the Organization of American States/Inter – American Drug Abuse Control Commission (OAS/CICAD) and the Pan American Health Organization (PAHO), and the publication 'Assessing the Standards of Care in Substance Abuse Treatment' (WHO,1994), form the basis for the major assessment section of the Handbook.

I trust that service providers from the public and private sectors, non government organizations, students undertaking drug addiction studies and other agencies engaged in the provision of services and programmes for persons with drug dependency, will find this document a useful guide and source of information.

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Scope of the Document

The purpose of this Manual is to provide basic guidelines and criteria for the development of a minimum set of standards for the care and treatment of drug dependence in the CARICOM region.

The Handbook is adapted from the *Standards of Care of the Treatment of Drug Dependence* prepared in 2000 by the Organization of American Status/Inter-American Drug Abuse Control Commission (OAS/CICAD) and the Pan American Health Organization (PAHO). The reference document, '*Assessing the Standards of Care in Substance Abuse Treatment*' (WHO, 1994), is an equally important point of departure.

The recommendations of CARICOM demand reduction experts are also captured in this publication through the instrumentality of the CARICOM Secretariat.

Glossary of Terms

ABUSE
"Pattern of psychoactive substance use that is harmful to health." The harm may be physical (as in the case of hepatitis resulting from the administration of injectable psychoactive substances) or mental (for example, episodes of depression disorders associated with massive indigestion of alcohol).

ACUTE INTOXICATION
"Condition subsequent to the administration of a psychotropic substance that gives rise to disturbances in the level of awareness, cognition, perception, affect, or behavior, or in other psycho physiological functions and responses."

The disturbances are directly related to the acute pharmacological effects of the substance and resolved with time, with complete restitution except in the event of complications that prevent restitution (trauma-related tissue damage, aspiration of vomit, deliria, coma, convulsions, and other medical complications).

CIRCUMSTANTIAL USE
"Form of use characterized by the search for a desirable expected effect in order to contend with a specific personal or professional situation or condition; it entails risk to the user and community, particularly if it develops into intense use."

CURE
"Condition in which the individual, upon completion of the therapeutic process, has achieved total and permanent abstinence from substance use, abandoned the behavior associated with such use, and attained a satisfactory level of a social/family functioning, all for a period of at least two years."

DELIRIUM TREMENS
"Extreme form of alcohol withdrawal syndrome, with psychotic manifestations severely detrimental to the general condition of the patient."

DEPENDENCE
"Set of behavioral, cognitive, and physiological phenomena that occur in connection with repeated use of the substance in question, which characteristically include the following: a powerful desire to use the drug, a deterioration in capacity for self-control in its use, persistence in such use despite harmful consequences, the assignment of higher priority to use of the drug than to other activities and obligations, increased tolerance for the drug, and at times withdrawal syndrome resulting from physical dependence."

Dependence syndromes may exist for a specific psychoactive substance (tobacco, alcohol, or diazepam), a class of substance (e.g. opiates), or a broader variety of pharmacologically different psychotropic substances.

EXPERIMENTAL USE
"Non-pathological form of use motivated by curiosity, generally with friends. It involves a short-term test of one or more substances with a maximum frequency of 10 times."

HALFWAY HOUSE
"Therapeutic alternative that consists of offering an interim space between the external social environment and the therapeutic community, either upon admission, during the induction and withdrawal management phase, or following discharge, during the process of social reintegration and follow-up."

INDUCTION
"Phase of therapeutic intervention in which persons seeking treatment are admitted, and efforts are made to promote motivation for change, awareness of the illness, and a participatory attitude toward the recovery process."

ORIENTATION GROUPS
"Therapeutic activity which consists of providing persons affected by psychotropic substance use, their families, and other interested persons in the community with basic guidance on the health problems associated with the use of these substances, treatment modalities, and means to prevent or minimize the resulting harm. Such groups may operate within a specific treatment program for substance use problems or form part of comprehensive community prevention strategies."

PSYCHOACTIVE SUBSTANCE OR DRUG
"Any pharmacological substance active on the central nervous system, which, when introduced in a live organism, is capable of producing behavioral alterations."

RECREATIONAL USE
"Voluntary act of substance use that does not tend to escalate in frequency or intensity."

RELAPSE
"Return to pathological substance use, or related behavior, by an individual undergoing some stage of a therapeutic process."

SELF-HELP GROUPS
"Community organizations made up of individuals affected by substance use, their families, and relatives, as well as religious, cultural, or social groups, that do not depend on government agencies, and whose mission is to support prevention, treatment, and rehabilitation efforts."

SYMPTOMATIC GROUPS

"Therapeutic intervention modality for pathological use of psychotropic substances by patients with associated diagnoses, such as organic or functional psychosis, mild or moderate mental retardation, or organic cerebral damage; substance use represents one more symptom of such a disorder."

THERAPEUTIC COMMUNITY

"Treatment modalities in which all of the institution's resources are channeled toward restoration of the patient's health, by creating an alternative microsocial setting with highly structured relationships between its members, promoting the active participation of subjects in treatment for the purpose of individual and collective change."

TOLERANCE

"Need to use the substance in greater quantities or with greater frequency in order to experience effects obtained earlier with smaller doses." This involves a mechanism of neuro-adaptation to the substance.

WITHDRAWAL

"Group of symptoms, varying in degree of severity and degree of integration, that appear during absolute or relative abstinence from the use of a psychotropic substance following a phase in which the substance was used continuously."

Acronyms

(AA)	Alcoholics Anonymous
(ANS)	Autonomic Nervous System
(CARDIN)	Caribbean Drug Information Network
(CARICOM)	Caribbean Community and Common Market
(CICAD)	Inter-American Drug Abuse Control Commission of the Organization of American States
(CNS)	Central Nervous System
(DTs)	Delirium Tremens
(EU-LAC)	European, Latin American and Caribbean city
(GDP)	Gross Domestic Product
(GI)	Gastro Intestinal
(HIV)	Human Immunodeficiency Virus
(IV)	Intravenous Fluids
(LSD)	Lysergic Acid Diethylamide
(OAS)	Orgzation of Ameriana State
(OBS)	Obvious Organic Brain Syndrome
(PAHO)	Pan American Health Organization
(PCP)	Phencyclidine
(SCBIP)	Street/Community Based Intervention Programmes
(T&R)	Treatment and Rehabilitation
(UN)	United Nations
(UNODC)	The United Nations Office For Drugs and Crime
(USA)	United States of America
(WHO)	World Health Org

Chapter 1

THE TREATMENT OF PROBLEMS RELATED TO DRUG DEPENDENCE

1.1 Drug use and dependence as a public health and socio-economic problem

The illicit drug trade in the Caribbean region generates an estimated US$3.3 billion representing 3.1% of the Gross Domestic Product (GDP) of the Caribbean. This trade represents an average of 20%-65% of some economies of Caribbean states. The per capita income of the illegal drug trade in the Bahamas was US$1000 compared to Jamaica, Belize and Puerto Rico that ranged between US$160-US$200. It is estimated that the average Caribbean citizen spent US$11.00 per year on illegal drugs when compared to an American citizen at US$300 and a British citizen at US$200. (Platzer, Mirella and Nestares, 2004).

The illegal drug market has driven corruption in the Caribbean. In the year 2000, illegal drugs generated an income of US$ 320 million for public sector employees in the Caribbean public sector. Customs, justice and security systems have been compromised. The cause of gang violence is often related to fights over drug turf and reprisal killings. On the other hand, drug dealers attract loyalty and prestige because they provide employment and social assistance that governments cannot provide. According to Griffith (2004), Caribbean leaders, recognizing the capacity of drug dons to control and incite sections of the population, corrupt systems and compromise the power of constituted authorities, have stated that the illegal drug trade threatens the peace and security of the region. Griffith (2004) concluded that the circumstances related to drug related violence severely undermine the rule of law and essential framework for the flourishing of civil society.

> ***"Caribbean leaders, recognizing the capacity of drug dons to control and incite sections of the population, corrupt systems and compromise the power of constituted authorities, have stated that the illegal drug trade threatens the peace and security of the region"***

1.2 Historical trends in drug use and trafficking in the region

Over the last 20 years, there was a tendency to focus resources on security and trafficking perspectives related to illegal drug use. The destination countries of the north provided the external stimulus and funding for drug interdiction and eradication which influenced activities undertaken by Caribbean governments. Caribbean states were characterized as "transit countries" with little attention or funding attached to dependence and addiction. However, the geographical location of the region in relation to major markets of

the United States of America (USA) and Europe makes it an attractive transit zone for other drugs such as heroin and cocaine from South America. The United Nations Office For Drugs and Crime (UNODC) report (2001) estimated that 60% of these drugs land in the region en route to the markets of the USA and Europe. Yet, experts estimate the residual impact on regional demand at 3.7% of the Caribbean adult population which "is slightly lower than the global average of 4.2%" Marijuana is the illicit drug of choice in the Caribbean, dwarfed in prevalence by the legal substances, alcohol and tobacco.

Since the early 1990's, there has been dawning recognition of the need for the provision of treatment services for substance abusers. The early small band of treatment providers consisted mainly of faith based or non-governmental organizations. By 2002, CARICOM countries signaled a shift in regional drug policy indicating that the problem of drug abuse should be considered a public health problem.

The histories of legal and illegal drugs in the Caribbean vary. Cannabis sativa (marijuana, herb, kali, kaya) is the only natural illegal drug grown in the Caribbean. There is debate about the introduction of Ganja to Jamaica, whether East Indian or African Origins. However, by early 20th Century, the substance was being used by working class Jamaicans. By the 1950's, it was strongly associated with the rituals of the Rastafarian movement. The substance entered the rest of the Caribbean later in the 1970's.

Cocaine, crack cocaine, heroin and ecstasy entered the region during the 1970's. As early as 1973, the Bahamas was reporting an increase in drug offences. By 1983, the Bahamas was caught up in a freebase (crack) epidemic. According to Archer (2003), the Bahamas was the first to report this phenomenon outside of the producer nation, Columbia in South America. Regional supplies are derived from the illegal trans-shipment trade that pays henchmen with drugs, guns or money for services rendered. In the case of drugs, these are sold on the local market for profit. Despite, over 30 years of trans-shipment activity in the Caribbean, the abuse of cocaine, crack cocaine, heroin and more recently, ecstasy, consumption patterns have remained remarkably low (less than 0.1%). Injection drug use, often associated with the abuse of cocaine and heroin, are hardly reported.

School surveys conducted through the Caribbean Drug Information Network (CARDIN) with the support of OAS/CICAD provide useful information about patterns of use among adolescents. Lifetime prevalence for alcohol and tobacco exceed 60% and 20% respectively. Marijuana use among the cohort of secondary school adolescents exceeds 10%. The comparative school survey shows inhalant use exceeding 15% in several states. There is evidence of incipient tranquilizer and stimulant use. Other studies suggest that the gap between male and female drug consumption is narrowing. There is concern about the age of first use which ranges between 11-12 years old.

At the current time, there are more users of alcohol and tobacco than all other psychoactive substances. There is a wide gap between treatment needs and available services.

1.3 Models for the treatment of drug dependence.

The variation in socio-demographic characteristics and in the drug use patterns of the population using drug dependence treatment programs, and the need to obtain satisfactory responses in terms of rehabilitation, call for diversity in the delivery of services. The call by the CARICOM heads of Government to treat

substance abuse as a public health issue has sparked greater efforts to encourage substance abusers to seek treatment. The introduction of drug courts provides a route through which non-violent drug offenders may access treatment and rehabilitation.

Standards of Care in the Treatment of Drug Dependence (Excerpted) OAS/CICAD.

In most countries, the development and implementation of treatment options for drug dependence has resulted mainly from the initiatives of private or non-governmental organizations, such as foundations, religious groups or community organizations. In very few cases were such treatment programs promoted by government agencies. The proliferation and consolidation of these services in the absence of official health policies and plans prevented government health agencies from playing any practical regulatory role in the design, application, or evaluation of treatment programs, which nonetheless relied on public sector contributions, in the form of grants, subsidies, or tax exemptions, in order to operate.

In the less advanced countries, the development of treatment for drug dependence has been shaped by imported and replicated therapeutic practices being introduced in the developed countries. These intervention models were applied without sufficient prior evaluation as to their real utility in different socio-cultural contexts and for substances different from those used in the countries where these treatment programs were developed.

The most widely used and promoted treatment models were developed mainly during the 1960s and 1970s, and, in view of the rapid and intense social transformations that have been exerting pressure on the treatment system, have been widely called into question. The ensuing crises indicate a clear need to adapt these models to the health-care reforms being developed in most countries.

The characteristics of any treatment program will depend largely upon the historical and institutional context in which it was developed and implemented. The definition of "treatment" itself is highly variable, and may include such terms as "resocialization", "reintegration", "reeducation", "reinsertion", or "social reincorporation".

This broad range of approaches to the treatment of drug dependence is also a function of the diverse origin of the various programs and is found when comparing the care provided not only in different countries, but also within a single country. In some cases, drug dependence treatment may have developed from the general public health-care system, or more specifically the mental health system; in others, it may arise from community-based movements, such as the social welfare system.

1.4 The role of Governments and the treatment of drug dependence

Within the CARICOM region, with respect to the treatment of drug dependence, there appears to be a trend toward greater government responsibility in terms of providing the necessary resources and establishing harmonized standards and regulations for treatment programs.

National Drug Councils, play a critical role in coordinating prevention and treatment strategies and programmes. Through these public sector agencies, governments play an essential role as bridges between treatment systems, justice and security and other critical areas.

It is important for countries to monitor standards of care in the treatment of drug dependence within the context of their national legislation. These generic standards must be developed with the recognition that each nation state may make adjustments to suit national needs and relevant legislation. They are developed through a process of discovery and consensus which is often a challenging approach to regional efforts.

In the CARICOM region, the area of standard setting is assuming greater importance. Standards relating to accessibility or availability of services, quality of care, efficiency, effectiveness and patients' charters are being developed across the region. However, because of the complexity of substance abuse treatment and rehabilitation, indicators commonly used to evaluate health-care services are difficult to apply to establishments for the treatment of drug dependence. This document benefits from international experience and provides a sound template on which to build. It adds to current efforts to document standards across the region.

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Chapter 2

Adapted: Organization of the American States/Inter-American Drug Abuse Control Commission Standards of Care in the Treatment of Dependence: Experience in the Americas (2000). Washington: Author.

The ideal treatment model blends the current concepts of the drug use and dependence problem, as well as the objectives established in the treatment program. It provides a pattern or guide to be followed in conducting treatment activities and a basis for establishing standards and thus permitting evaluation.

The development of an effective treatment system that comprehensively addresses the problem of drug use and dependence requires a body of minimum standards to be applied on a uniform basis employed by various treatment services as part of a national treatment system.

In constructing an ideal treatment model, various aspects of particular importance are taken into account:

The development of an effective treatment system that comprehensively addresses the problem of drug use and dependence requires a body of minimum standards to be applied on a uniform basis employed by various treatment services as part of a national treatment system.

2.1 THE TIMING OF THERAPEUTIC INTERVENTION

The process of treatment or therapeutic intervention includes a series of events that begin when persons using or dependent on psychoactive substances establish contact with a health-care establishment or other community service, and continues with actions of various kinds for the purpose of "identification, assistance, health care, and social integration", in an effort to promote the greatest degree of health and well being possible (WHO, 1998).

It must be determined whether the establishment attends to the users at various points in the development of the drug dependence disorder or is specialized in a particular phase of that development.

In an "ideal treatment system", the subsequent components of treatment can be identified according to the point in the evolution of the illness at which the intervention takes place:

2.1.1 IMMEDIATE ATTENTION

Emergency intervention/the treatment of acute cases

- To correct psycho-physiological disorders directly connected with the use or absolute or relative withdrawal from a drug.

- To attend to physical, psychiatric, or psychosocial complications resulting from drug use.

These interventions are carried out mainly by professional specialized teams, which can be supplemented with support from nonprofessional personnel or self-help groups, depending on the evaluation of the disorder and the risk to the life of the user or third person (WHO, 1998). They include treatment for:

- Acute intoxication or overdose.
- Acute withdrawal syndrome.
- Acute physical, psychiatric, or psychosocial complications.

Investigation or identification of probable cases

This includes presumptive diagnostic activities for disorders related to drug use, which can be conducted on an active basis through the application of tracking or interview procedures conducted in health-care or other types of establishments. Such as, the workplace, schools, sports or cultural organizations, etc., for persons displaying indicators suggesting the existence of such disorders. The following activities are included:

- Initial evaluation
- Presumptive diagnoses
- Guidance and referral

2.1.2 TREATMENT FOR DEPENDENCE

This refers to all activities designed to reduce the degree of dependence on drugs and the related complications, which include psychosocial and behavioral interventions for the purpose of restoring a life free from the use of these substances or, failing that, reducing the harm associated with such use.

The main activities in this area include:

- A therapeutic induction or motivation for treatment.
- Diagnostic evaluation.
- Prolonged abstinence or treatment per se.

2.1.3 MONITORING

Monitoring consists of all measures conducive to prolonged abstinence from drugs, through the prevention of relapses as well as the consolidation of improvements achieved in the individual's psychosocial functioning through treatment for the resulting disabilities, so as to diminish their impact on the quality of life. Activities in this area include the following:

- Prevention of relapses
- Social integration
- Treatment for consequences and support for disabilities.

2.2 ACCESS TO TREATMENT

The evaluation of access to treatment consists of studying the possibilities available to a potential service user to actually receive service. This relates to the following aspects:

2.2.1 ACCESSIBILITY

The opportunities for access and patterns for entering into a treatment system largely determine the socio demographic composition or profile of the users, and also influence the content of the therapeutic program. They depend on:

The quantitative and qualitative adequacy of the services offered
Geographical location
The cost to the user

2.2.2 AVAILABILITY OF SERVICES

This pertains to the relationship that exists between demand for drug dependence treatment and the supply of treatment programs. It may refer to a specific geographic area.

2.2.3 REFERRAL SOURCES

The source of referrals itself can influence the nature of treatment by generating expectations about the therapeutic setting, but also about the admission modality, because it presupposes certain physical, psychological, or social characteristics about the persons seeking service that modify the conditions of treatment. The configuration of a program is different for users under court order than for those referred by a psychiatrist. It is therefore very useful to know the main institutional sources of demand for treatment. The most relevant of these include:

- The general or mental health systems
- The judicial system
- Other sources: social services or employee care services

2.3 SERVICE USER PROFILE

Motivation for seeking treatment
The client's motivation and willingness to undergo treatment can vary according to the type of referral concerned. In most Caribbean countries, voluntary self referral is encouraged or explicitly required by some programmes. In some cases, various levels of family pressure or legally based coercion are involved. Such circumstances will make a difference as to the conditions under which the intervention will be carried out and the characteristics of the treatment regime.

The user profile for drug dependence treatment services reflects many of the characteristics of the treatment program. This profile consists of:

- Socio-demographic characteristics
- Type of substance involved
- Pattern of use
- Treatment for co-morbidity
- Special treatment for particularly vulnerable groups (e.g. prison inmates, children and adolescents, women, pregnant women, or juvenile delinquents).

Treatment for alcohol and other drugs, which traditionally have been handled separately, has begun to be merged in many programs in response to the so-called "crossed dependencies" and greater recognition of the similarities between dependencies on different drugs.

It is very important to develop treatment programs for special populations, such as those with other concomitant health disorders, minor children, women, or prison inmates.

2.4 EVALUATION OF THE PATIENT

The therapeutic approach applied in an establishment is determined by individualized diagnosis of the user's pathological conditions and disorders. A precise and comprehensive evaluation of persons seeking treatment makes it possible to plan treatment and adapt it to the particular needs of each subject.

Comprehensive evaluation includes:

- Physical, psychiatric, and social evaluation
- General and specific laboratory tests (toxicological)
- Recording and diagnosis
- Treatment plan

The diagnostic evaluation defines possible clinical conditions according to ICD-10:

- Acute intoxication
- Harmful use
- Dependence syndrome
- Withdrawal
- Psychiatric co-morbidity
- Somatic co-morbidity
- Chronic disabilities

2.4 .1 NATURE AND ORGANIZATION OF TREATMENT PROVIDED: T HERAPEUTIC SETTING

Treatment starts from the time the drug user arrives at a care providing institution, whether it is a health-care establishment or any other type of community service.

Treatment includes diagnosis, medical-care, and assistance in reintegrating the affected persons into society, with the aim of improving their health and quality of life by reducing drug dependence, morbidity, and mortality, maximizing the use of treatment capacity, access to services, and opportunities, and promoting full social integration.
(WHO, 1998)

In the treatment of drug dependence, the variability of therapeutic interventions becomes the norm. Consideration must be given to the many possible approaches, their different orientations and scientific foundations.

Both within a country and between different countries, the comparison of treatments is hampered by the absence of common criteria with which to classify the various interventions.

Organization of Services

The way in which treatment services are organized will ultimately determine who will benefit, what the treatment will consist of, and how effective it will be.

Consideration must be given to how the treatment program is structured internally, with its various components, as well as how it interacts with its environment. Reference is made here to the therapeutic setting, including type of treatment, characteristics of the establishment and composition of the teams.

Type of treatment

In studying the type of treatment, the following fundamental aspects are considered:

- The character of the intervention
- The therapeutic strategy
- The therapeutic goals
- The treatment philosophy

Predominant character of the intervention:

THIS REFERS TO THE OBJECT OF THE INTERVENTION, WHETHER LIMITED TO THE USER ALONE OR INCLUDING HIS ENVIRONMENT.

INTERVENTION TARGETING THE USER

- Biophysical: use all the physical, non-pharmacological intervention (e.g. massages, acupuncture, electrotherapy etc).
- Pharmacological: administration of substances with pharmacological effects (e.g. methadone, disulfiram).
- Psychological: individual or group psychotherapeutic intervention.

INTERVENTION TARGETING THE USER AND HIS/HER ENVIRONMENT

- Sociocultural: approach consisting of interventions designed to modify the user's sociocultural environment (e.g. Therapeutic Communities).

COMBINED INTERVENTION

- COMBINATION OF THE PRECEDING APPROACHES.

Therapeutic strategy

Strategies for intervention are classified into three main groups, which can be combined simultaneously or consecutively:

- Professional treatment (requiring specialized training).
- Nonprofessional support structures.
- Mutual assistance and self-help activities.

By way of example, currently used therapeutic strategy alternatives include:

- "12-step" programs: sequential programs used by Alcoholics Anonymous (AA) and other mutual assistance organizations.
- Aversion therapy: triggering an unpleasant response to use of the substance through conditioning.
- Psychology: the use of psychological methods to solve problems related to dependence, such as psychotherapy, psychoanalysis,cognitive-behavioral therapy or motivation enhancement therapy.

Therapeutic goals or objectives:
This refers to the goal to be achieved through treatment, including:

- **Reduction of use:** the aim is to reduce the dependence and morbidity/mortality associated with drug use through its reduction or elimination.
- **Modification of the causes of use:** measures targeting the historic causes of drug use.
- **Limitation of the consequences of drug use:** efforts to modify the consequences of drug use.

Philosophy of treatment

This refers to the ideological foundation and theoretical assumptions upon which the structure of the treatment program is based. This covers:

- **Moral.-**This approach emphasizes the "sinful" character of drug use and the rehabilitative benefit of guilt.
- **Spiritual.-**Emphasis is placed on the transcendence of human existence, spirituality, and religious belief as therapeutic alternatives.
- **Biological.-**Drug dependence is interpreted as a manifestation of metabolic or physiological abnormality, which can have a genetic character.
- **Psychological.-**Drug dependence is viewed as the result of psychogenetic determinants, a manifestation of conflict or emotional dysfunction.
- **Sociocultural.-** Drug dependence as a reflection of an alteration in the subject's socialization process.
- **Integrative, multifactor.-** Combination of the various approaches, in which drug dependence is conceived as the result of interaction among multiple factors.

Characteristics of Caribbean based establishments that specialize in the treatment of drug dependence

- **Residential**
  - Short stay (days).- Short-term residential programs generally for the immediate treatment of critical situations, for example: detoxification units, initial treatment facilities.

- Intermediate stay (weeks).-Residential programs for maintaining and prolonging absti nence, with precise and limited objectives. Such establishments can serve to supplement other interventions.
- Long stay (months or years).- Long-term residential programs, generally in the Therapeutic Community modality, which often includes social reintegration activities.

- **Nonresidential**
  - Out-patient.- Nonresidential programs ranging from individual consultations to group treatment with a large number of structured activities.
  - Partial hospitalization.-Programs combining aspects of residential treatment with those of ambulatory treatment, alternating periods of stay within the institutions, during the day, night, weekends, or other critical periods, with extra institutional activities, generally in t he employment or academic areas.
  - Drop In centres-Programmes that provide meals, clothing and sanitary conveniences for itinerant substance abusers and/or the mentally ill.

Establishments not specialized in the treatment of drug dependence

- General public or private health-care establishments.
- Community mental health institutions.
- Other social service professional consultancies.
- Prisons.
- Voluntary support networks composed of self-help and mutual assistance groups, such as Alcoholics Anonymous and Narcotics Anonymous.

THE THERAPEUTIC TEAM

As part of the organization of treatment programs for drug dependence, the formation of a therapeutic team plays a fundamental role. Uniform guidelines and basic intervention techniques must be defined for the treatment of persons with drug use problems.

The treatment of drug dependence is carried out by mixed teams composed of persons with different levels of education and training, which is determined by such disparate elements as the philosophy of the establishment or the conditions for financing the program.

The relationship that exists between staff characteristics and the quality of treatment services has not been well researched, and reports on the comparative effectiveness of programs led by rehabilitated vs. non-rehabilitated or professional vs. nonprofessional teams are not conclusive (Gerstein & Harwood, 1990).

The following are basic factors in defining a strategy for the formation of drug dependence treatment teams:

(a) Protocols for the selection and recruitment of staff, scientifically grounded and regularly reviewed and updated.

(b) Training and refresher training activities on:
- Therapeutic procedures in general
- Matters pertaining to the particular treatment establishment or program concerned.
- Treatment for special population groups (minors, women, HIV positive).

- Official recognition or accreditation of training.

Human resource training for the treatment of drug dependence should give priority to the following groups:

- Workers in the general health care sector, social services, correctional services or other sectors.
- Workers in establishments for detection and short-term treatment or orientation in respect of drug abuse problems.
- Persons working or planning to work in the specialized treatment of drug dependence, rehabilitation, or social reintegration services.

THE ECOLOGY

This refers to the social, cultural, political, and economic characteristics of the surrounding environment and the relationship between these characteristics and the treatment program. These environmental factors include:

Financial variables

- The economic situation of the country or locality.
- The budget allocated to drug dependence treatment programs.
- The establishment's financing.

Social and community values

- Acceptance of, and social value assigned to, treatment.
- Community commitment to therapeutic activities.

Political and administrative regulations

- The legislation governing treatment

Public private mix

- The configuration of the system of public and private treatment services for drug dependence may be:
  - (a) Separate or independent facilities
  - (b) Integrated within:
    - Health-care systems:
      - General
    - Specialized in dependence
    - Social security systems
    - Other systems

Activities to coordinate networks of drug dependence treatment establishments should aim for a central repository for admission and monitoring records.

During the evaluation process, it must be determined whether the services are offered separately and independently or as part of a planned system providing for the treatment of different stages in the evolution of the addictive disorder.

Socio-demographic and epidemiological aspects

- Profile of the establishment's users.
- Demand for treatment.
- Need for treatment.

Providing integrated treatment, through an inter-programmatic network with a functional referral system, helps to optimize clinical management and the cost-benefit ratio.

2.5 PATIENT RIGHTS

Minimum standards in the treatment of drug dependence must include provisions to safeguard the fundamental rights of persons seeking treatment, in accordance with the Universal Declaration of Human Rights, adopted and proclaimed by the United Nations General Assembly in its resolution 217a (III) of 10 December 1948.

Consideration must be given to all matters connected with protecting the anonymity of persons receiving treatment, therapeutic progress, and the patient's awareness of, and informed consent to, the interventions forming part of the treatment.

This standard should include provisions with respect to images, audio recordings or other similar materials obtained from patients, which must be authorized by the patients and be used solely for the purposes indicated to the patients.

Other important aspects relate to the conditions of stay in the treatment establishment, the prohibition of physical coercion, continued compulsory subjection to treatment, and contact with family or relatives, which must be duly justified and in accordance with prevailing legal provisions.

2.6 EXIT, MONITORING, AND REFERRAL OF CASES.

Standards are required for the client's leaving treatment, either upon completion of treatment, suspension of treatment, or referral to another establishment. Successful completion of treatment of treatment must be defined by set criteria. Minimum standards must specify criteria for expulsion, involuntary retention, recovery and improvement, and alternatives to be pursued in the case of therapeutic failure or complications.

Special attention must be given to the activities conducted subsequent to treatment per se, when the patient is either discharged following a period of internment or is shifted from ambulatory care to a lower intensity phase, or the so-called "monitoring" phase.

It is at this point that activities are conducted for relapse prevention, social reintegration, treatment for consequences, and support for disabilities. These activities can be conducted directly by the establishment or with the support of an inter-institutional or community services network.

2.7 EVALUATING TREATMENT

Therapeutic interventions are evaluated in two main ways:

1. Utility and effectiveness of the treatment
2. On the basis of economic criteria (costs and benefits)

It is necessary to compare the various therapeutic options, ranging from "non-intervention", to self-help groups, to community services, professional intervention, or other options.

2.8 EVALUATING EFFECTIVENESS

Effectiveness is evaluated on the basis of evidence obtained from several sources:

- Subjective anecdotal evidence, the opinions of specialists, expert committees.
- Systematic studies of the results of treatment, observation, and monitoring.
- Controlled tests.
- Multiple random clinical trials.

When conducting evaluations, the greatest weight will be given to arguments based on the most reliable techniques. Random clinical trials are considered to be the most solid method for evaluating treatment.

Interventions commonly used in treatment programs, those with demonstrated effectiveness based on controlled tests, and those considered essential in the treatment of drug dependence can be distinguished from other interventions, whose effectiveness is doubtful or questionable.
"Predictive" organizational factors in successful drug dependence therapy are very useful in determining success:

- An appropriate therapeutic team
- Efforts to ensure quality of service
- User follow-up
- Factors in the selection of users

The appropriateness of the therapeutic team depends in particular on its adaptation to the type of users to be treated and the specific training its members have received for the treatment of drug dependence. Ensuring the quality of a program's service requires systematic evaluation, staff with up-to-date training, and the observance of current treatment protocols. The selection of users, including comprehensive evaluation and therapeutic induction, as well as follow-up for the prevention of relapses, is fundamental to "ensuring" successful treatment.

2.9 ECONOMIC EVALUATION

In evaluating the economic aspects of a program, costs -- i.e. all costs directly or indirectly associated with the program -- are compared with the positive effects of the program, both for the individual and in terms of reduced problems for society. This comparison includes:

- **COST-BENEFIT EVALUATION.-** A comparison of all costs and benefits resulting from treatment with those that would have been incurred without treatment.
- **COST-UTILITY EVALUATION.-** An assessment of the benefits to the individual in terms of duration and quality of life.
- **COST-EFFECTIVENESS.-** The quantifiable, significant results obtained from the interventions.
- **COST RECOVERY.-** A comparison between the cost of treatment and the savings in health-care and other related institutional costs.ource: WHO, 1995

2.10 PHYSICAL INFRASTRUCTURE OF TREATMENT FACILITIES

The physical setting provided by establishments for the treatment of drug dependence must meet minimum requirements ensuring:

- Achieving of therapeutic objectives
- The patient's well-being
- Security for patients and their belongings

It is fundamental to ensure privacy and access to recreational areas, particularly in the case of residential treatment modalities. The aspects to be taken into account in facility standards for drug dependence treatment centres include:

Architectural aspects

- Type of construction, area of the property and construction per se, materials used.

Services

- Drinking water
- Sewage disposal
- Power sources
- Telecommunications
- Security

Functional areas

- Administrative
- Therapeutic (Consultation and group therapy rooms)
- Recreation and sports (Sports fields, gymnasium, game room, meeting rooms)
- Teaching and productive activity facilities (Classrooms, workshops, library, garden, etc.)
- Residential (Kitchen, dining room, bedrooms, bathrooms, storage, laundry, maintenance workshop)

Equipment available

- Clinical activity: medical diagnostic and treatment equipment
- Administrative: computers, typewriters
- Residential: stove, oven, refrigerators, washing machine, dryer, TV, VCR
- Teaching: audiovisual equipment, workshop machines

Other approaches

The National Quality Forum (2007) provides a concise example of consensus standards for the treatment of substance use conditions: Evidence-Based treatment practices as Appendix VII and a sample standard from Trinidad and Tobago in Appendix V.

Chapter 3

DEVELOPMENT OF A PROGRAMME FOR ASSESSING STANDARDS OF CARE IN THE TREATMENT OF DRUG DEPENDENCE

3.1 ADVANTAGES OF A SYSTEM FOR MONITORING STANDARDS OF CARE AND TREATMENT OF DRUG DEPENDENCE

Substance use conditions have substantial negative and destructive impact on health and society in the CARICOM region. Scientific knowledge has increased regarding the use of effective evidence based treatment for substance abusers. Furthermore, there is growing recognition that dependence and addiction are chronic conditions that must be managed through long term integrated and coordinated care. The biological, psychological and social components of the illness require various types of responses and support systems to be effective. With respect to the treatment of drug use and dependence, however, the task has not been simple because of the complexity of the problem and the innovative and diverse therapeutic approaches taken. As a result, many of the indicators commonly used to evaluate health-care services are difficult to apply to establishments for the treatment of drug dependence.

There is growing recognition that dependence and addiction are chronic conditions that must be managed through long term integrated and coordinated care.

However, there is a vast array of evidence based approaches to treatment with associated standards. The Caribbean region may adapt some of these standards in culturally sensitive ways as well as develop evidence based practices derived from the Caribbean experience. In evaluating the quality of care provided by treatment programs, the World Health Organization — with the participation of a group of scientists and clinicians — has developed a methodology. It is based on an instrument for executing the treatment monitoring program, verifying compliance with guidelines, analyzing deficiencies, and making appropriate recommendations to correct them with a view to ensuring effective care.

The methodology proposed by the WHO for evaluating the quality of care has provided a model for the development and updating of standards in several countries. Technical and economic cooperation has been provided by PAHO/WHO and CICAD/OAS for the organization of national workshops, with the participation of the National Commissions, Ministries of Health, government agencies, and non-governmental treatment organizations in CARICOM countries.

In order to develop a system for assessing standards of care in the treatment of drug dependence, updated information is required on:

- The various issues at stake in connection with alcohol and drug use.
- The needs of the services.
- The level of demand for treatment in relation to existing services.
- Distribution of the services.

- The availability of human and material resources.
- The composition of the teams providing treatment.
- The cost and effectiveness of the interventions.
- The existence of an ideal model for service delivery.
- Possibilities for human resource training.
- The research, coordination, and administration activities conducted.
- Awareness of the advantages of treatment.

Three phases can be distinguished in the process of implementing a program to monitor and assess standards of care in the treatment of drug dependence:

3.2 PHASE I: PREPARATION

In this phase, a diagnostic assessment of the care being provided is conducted and minimum standards for care and evaluation are defined.

The **situation assessment** includes:

- An analysis of drug use and its consequences (magnitude and characteristics).
- A description of the population affected (sociodemographic characteristics, profile of persons using treatment establishments, potential users).
- The resources available for care, including those specialized in drug dependence as well as within the general health system (quantity, quality, distribution).
- The review of existing laws, standards, and regulations pertaining to the delivery of treatment services in connection with drug use and dependence.

The ideal model for care and the instrument used for its evaluation consists of the minimum essential criteria for care defined locally with the support of a team of experts. As well as through seminars or workshops with the participation of representatives of the sectors and institutions involved in its application.

The model serves as a framework for comparison in evaluation, so it is important that it be adapted to local conditions and circumstances at various points in time. In defining the ideal model for care, consideration must be given to:

- The particular characteristics of the general health care system.
- The relevant legal provisions.
- The resources available for care.
- Specific treatment situations, such as:
    - The type of substance involved.
    - The current stage in the development of the clinical disorder and its complications.
    - The socio demographic characteristics of the users.
    - The intervention modality employed.
    - The type of institution.

3.3 PHASE II: MOTIVATION AND COMMITMENT

This phase consists of national workshops on the assessment of standards of care in the treatment of drug dependence, intended for government and private-sector policymakers concerned with treatment, as well as for those responsible for administering and executing the programs.

The objective of this activity is:

- To provide relevant information about the advantages of a national system for assessing the treatment of drug problems and the requirements for its implementation.
- To permit integration between public and private agencies and the various sectors concerned.
- To lay the groundwork for implementing the evaluation system, so as to ensure that the various stakeholders involved will be committed to it.

This activity can be coordinated by the health sector, in view of its prior experience in monitoring and evaluating establishments, with the participation of experts in the field, as well as government treatment agencies, community therapeutic associations, scientific societies, and industry associations.

3.4 PHASE III: ASSESSMENT OF THE TREATMENT AND CARE PROVIDED

This phase consists of comparing the ideal treatment model developed in the earlier phases with the actual situation in the country by applying the appropriate instrument.

The first step is to conduct trials of the assessment instrument. This activity is extremely helpful and must include the greatest possible variety of establishments in various localities. This will permit practical verification of the usefulness of the evaluation instrument and will provide an opportunity to make necessary adjustments.

The aim in applying the assessment instrument is:

- To detect local needs for care.
- To study the causes of the deficiencies encountered.
- To propose means for correcting those deficiencies.

As part of the strategy for establishing the program to assess standards of care in the treatment of drug dependence, it is necessary to define:

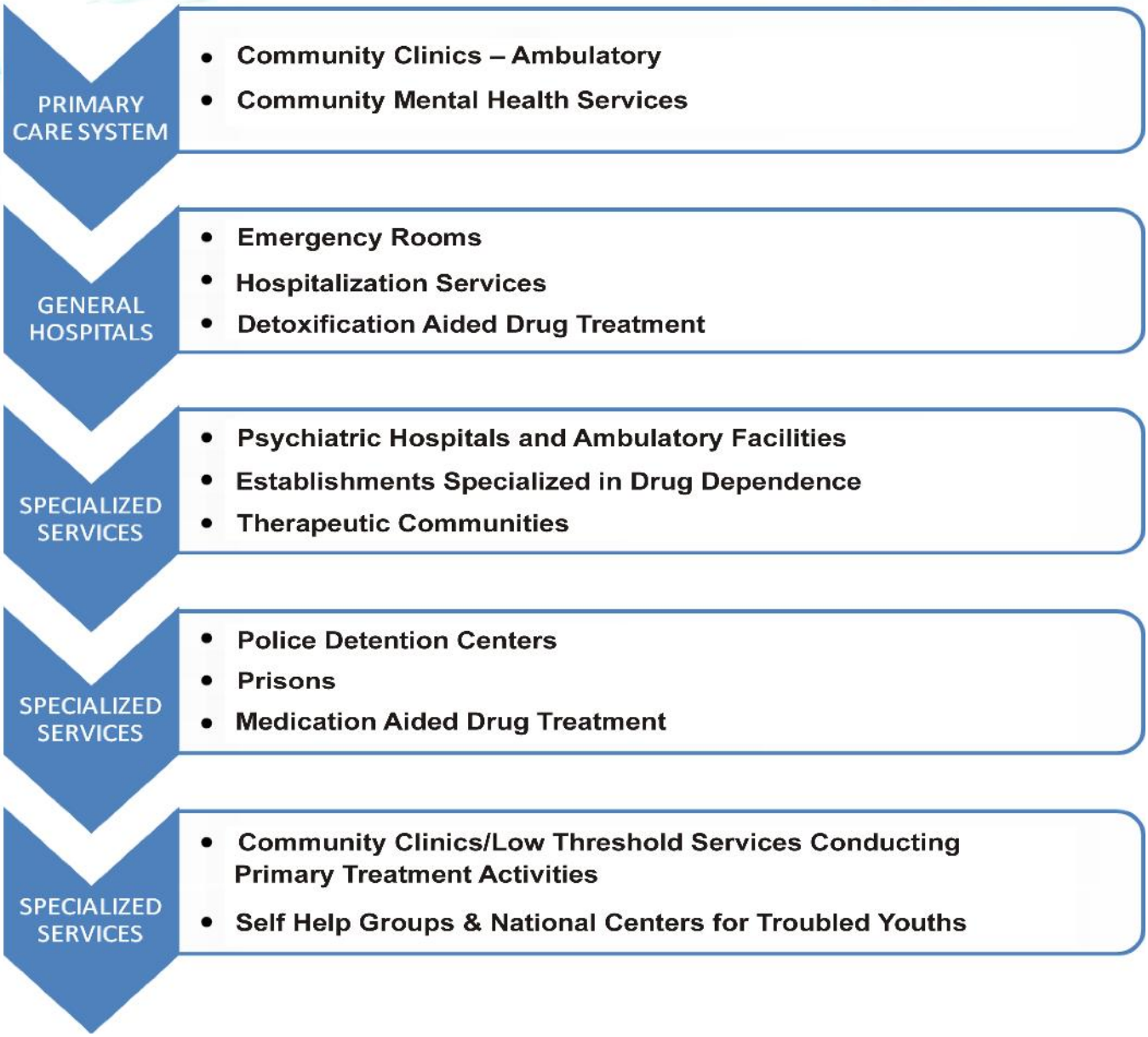
- Responsibilities for program development and application.
- The intervals for and scope of application of the instrument

Responsibility for developing and applying the evaluation program must be defined in the legal framework, specifying the role to be played by the various sectors, and in particular health, justice, public prosecution, and commissions against drug use.

The team of experts responsible for developing and adapting the instrument at the national level must participate in the trial phase as well as in the training of national teams, as observers or supervisors.

The scope and frequency of evaluation will depend on local conditions, the availability of resources for evaluation, and identified needs. A reasonable proposal for application would entail frequency of at least once a year and include the greatest possible number and variety of establishments within the public as well as private sectors.

Figure 1 below is a graphic representation of the spectrum of services that can be subjected to assessment.



Teams are set up with expert support according to a defined profile in conjunction with the definition of the objectives of supervision and the evaluation instrument.

In the selection and training of these teams, consideration is given first to expertise with respect to drug use and dependence, as well as in the practice of treatment activities.

Training covers the specific evaluation methodology, the objectives of the monitoring system, and the evaluation instruments, as well as supervised practical training in the field.

Chapter 4

INSTRUMENT FOR ASSESSING THE STANDARDS OF CARE IN SUBSTANCE ABUSE TREATMENT

4. 1 INSTRUMENT FOR ASSESSING THE STANDARDS OF CARE IN SUBSTANCE ABUSE TREATMENT .

(WORLD HEALTH ORGANIZATION, 1994, ABRIDGED).

The instrument proposed by the WHO Substance Abuse Program for **Assessing the Standards of Care in Substance Abuse Treatment** is used to determine the degree to which the treatment needs of the population are being satisfied. Its use depends on local circumstances and adaptability to particular political, health, and legal conditions, as well as to changes over time. The instrument provides guidelines for the evaluation of existing services and for the development of treatment standards by:

*The instrument for **Assessing the Standards of Care in Substance Abuse Treatment** is used to determine the degree to which the treatment needs of the population are being satisfied.*

Defining the ideal treatment situation.

Comparing this treatment ideal with the treatment actually provided at the local level.

The instrument covers six areas, which are arranged vertically, as listed below:

- Acute intoxication
- Withdrawal syndrome
- Dependence
- Physical co-morbidity
- Psychiatric co-morbidity
- Psychosocial co-morbidity

Standards of care for each area are arranged horizontally. These are possible standards that must be vetted and set by each country to identify those that apply to local settings. Some of these standards will be more important than others, some may be essential while others may be advisable while not essential to good care. Local adaptation may require the modification of some of the six (6) items above to be more specific and relevant. Therefore, the standards may be modified to meet local needs.

The standards are explained below:

A. Standards of access, availability, and admission criteria

This refers to the possibility for the population to receive treatment, in terms of the proximity of treatment services, hours of operation, options available, and admission requirements.

B. Standards on patient assessment
These standards specify the characteristics of patient evaluation, with emphasis on comprehensiveness, relationship with the treatment to be received, and the use of supplemental diagnostic procedures. Such as laboratory tests, psychological tests or other explorations, as well as diagnostic record keeping and classification based on established systems.

C. Standards on treatment content, provision and organization
This refers to the characteristics of therapeutic intervention, the basis for such intervention, the ways in which various aspects of treatment are structured, and the manner in which treatment is applied.

D. Standards on discharge, aftercare and referral
This refers to the criteria for discontinuing treatment, including the concept of therapeutic success or failure, outcome measures, follow-up activities subsequent to treatment, and the procedure for referral and derivation of cases.

E. Standards on outreach and early intervention
These standards pertain to the definition of the coverage of treatment, activities designed to satisfy the needs of the population for immediate attention on a timely basis, promotion of the treatment program among its potential users, and the structuring of treatment networks.

F. Standards on patients' rights
These standards are designed to ensure respect for the human rights of persons in treatment in accordance with the Universal Declaration of Human Rights. With emphasis on those circumstances that are intrinsic to treatment, such as confidentiality, anonymity, and informed consent in respect of the interventions.

G. Standards on physical aspects related to the treatment setting
These standards are intended to ensure that the institutions used for the purposes of treatment are suitable in terms of the technical specifications for health establishments.

H. Standards on staffing
These standards pertain to the profile of treatment service providers, their selection, the description of their responsibilities and functions, the implementation of training activities, the evaluation of performance, and refresher training programs.

APPLICATION METHODOLOGY

There is a sequence of steps that should be followed in the process of completing the schedules.

In the first phase, the relevance of applying each of these standards are evaluated with respect to different treatment settings and different levels of operation (national, regional, local, or within the establishment itself). The standards are classified as essential, advisable, or not indicated, as appropriate in each case.

- Essential (E)
- Advisable (ADV)
- Not indicated (NI)

In the second phase, the degree to which standards classified as essential or advisable are fulfilled is evaluated as satisfactory, unsatisfactory, or not in compliance at all.

- Satisfactory (S)
- Unsatisfactory (U)
- Not in compliance (N)

With respect to these last two options, the reasons for the situation and possible alternatives for correcting the deficiencies are indicated.

In the third phase of the process, it is necessary to indicate for each that is inadequately met or not met:

- Why this is the case, and
- How it is proposed to rectify the situation

Please record the country, region, parish and service that is being assessed, the date of the assessment as well as the name and position of the person(s) completing the assessment. This will assist others later who may wish to repeat, interpret the results of the exercise or use the information in other ways.

In Appendix VI, an inventory questionnaire developed by Day/Kohler (2000), provides a supplementary approach to gathering information on Street/Community Based Intervention Programmes (SCBIP).

A. STANDARDS OF ACCESS, AVAILABILITY AND ADMISSION CRITERIA

ASSESSMENT TOOL

The assessment instrument below is laid out for ease of use in a user-friendly way. Please place an X in the appropriate box as you proceed

STEP 1: Indicate if the standard is : Essential (E) Advisable (AV) Not Indicated (NI)	STEP 2: Indicate if the standard is: Adequately Met (AM) Inadequately Met (IM) Not Met at All (NM)																	*Step 3: For standards that are either Inadequately Met (IM) or Not Met (NM): Indicate why this is the case and how it is proposed to rectify the situation*
STANDARD		Management of Acute Intoxication			Management of Acute Withdrawal			Management of Drug Dependence			Management of Physical Conditions			Management of Psychiatric Disorders			Management of Psychosocial Disability			
A. STANDARDS OF ACCESS, AVAILABILITY AND ADMISSION CRITERIA																				
A 1. Services are easily assessable with regard to location, travelling time and transportation		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
A 2. Scheduled services are obtainable without restrictions on time or day		E	AV	NI	E	AV	NI	NOT APPLICABLE												
		AM	I	NM	AM	I	NM													
A 3. Necessary treatment is available without delay(s) which might lead to worsening of the condition		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
A 4. A variety of treatment modalities and therapeutic options are available (in-patient, out-patient and daily care)		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
A 5. Care is available without the need for routine laboratory tests, for instance for the detection of HIV.		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
A 6. Care is available to all potential patients irrespective of age and sex.		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
A.7 Care is available to all potential patients irrespective of their race, ethnicity, culture, ideology, political or religious beliefs.		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
A 8. Care is available to all potential patients irrespective of the substance or drug in question, how it is administered (e.g. intravenously or orally), or whether it is legal or illegal.		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
A 9. Patients can continue a prior treatment for other medical conditions without prejudice to their access to this type of treatment		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	

STEP 1: Indicate if the standard is : Essential (E) Advisable (AV) Not Indicated (NI)	STEP 2: Indicate if the standard is: Adequately Met (AM) Inadequately Met (IM) Not Met at All (NM)																	*Step 3:* *For standards that are either Inadequately Met (IM) or Not Met (NM):* *Indicate why this is the case and how it is proposed to rectify the situation*
STANDARD		Management of Acute Intoxication			Management of Acute Withdrawal			Management of Drug Dependence			Management of Physical Conditions			Management of Psychiatric Disorders			Management of Psychosocial Disability			
A 10. Care is available, as established by programme guidelines, irrespective of a patient's other physical or psychiatric conditions (including HIV)		E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	
A 11. Care is available irrespective of the patient's legal situation and whether or not he/she has been prosecuted (including for the use of drugs).		E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	
A 12. Care is available irrespective of the patient's financial means or professional or socioeconomic situation.		E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	
A 13. Care is available in guarded environments (e.g. police cells, prisons).		E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	
A 14. Care is available whether or not patients continue to use drugs.					NOT APPLICABLE						E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	
A 15. Care is available irrespective of the patient's treatment history.		E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	
A 16. There is established contact between drug-related treatment centers and general services (e.g. general hospitals, police, judicial system, social services), permitting the referral of cases when appropriate and enabling the specialized centers to consult with the general services.		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	

B. STANDARDS OF PATIENT EVALUATION

STEP 1: Indicate if the standard is : Essential (E) Advisable (AV) Not Indicated (NI)	STEP 2: Indicate if the standard is: Adequately Met (AM) Inadequately Met (IM) Not Met at All (NM																	Step 3: For standards that are either inadequately met (IM) or Not Met (NM): Indicate Why this is the case and How it is proposed to rectify the situation
STANDARD		Management of Acute Intoxication			Management of Acute Withdrawal			Management of Drug Dependence			Management of Physical Conditions			Management of Psychiatric Disorders			Management of Psychosocial Disability			
B. STANDARDS ON PATIENT EVALUATION																				
B 1. An initial evaluation is conducted in order to establish the priority of interventions according to a coordinated treatment plan.		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
B 2. An evaluation is conducted in order to detect physical and neurological complications		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
B 3. A psychiatric / psychological evaluation is conducted in order to detect complications (e.g. depression) that might influence the patient's treatment.		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
B 4. An initial evaluation is conducted in order to establish the priority of interventions according to a coordinated treatment plan.		NOT APPLICABLE			E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
					AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
B 5. There are methods for rapidly identifying the substances used, either through laboratory tests (e.g. urine or blood analysis) or other procedures.		E	AV	NI	NOT APPLICABLE															
		AM	I	NM																
B 6. Laboratory or other facilities are available to facilitate evaluation of the patient's physical and psychiatric/psychological condition.		E	AV	NI	E	AV	NI	E	AV	NI	NOT APPLICABLE									
		AM	I	NM	AM	I	NM	AM	I	NM										
B 7. Laboratory tests are used to determine biochemical, metabolic, immunological, and biological parameters.		NOT APPLICABLE						E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
								AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	

STEP 1: Indicate if the standard is : Essential (E) Advisable (AV) Not Indicated (NI)	STEP 2: Indicate if the standard is: Adequately Met (AM) Inadequately Met (IM) Not Met at All (NM																	*Step 3: For standards that are either Inadequately Met (IM) or Not Met (NM): Indicate why this is the case and how it is proposed to rectify the situation*
STANDARD		Management of Acute Intoxication			Management of Acute Withdrawal			Management of Drug Dependence			Management of Physical Conditions			Management of Psychiatric Disorders			Management of Psychosocial Disability			
B 8. Laboratory tests are used to determine biochemical and metabolic alterations associated with the psychiatric comorbidity.		NOT APPLICABLE						E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	
B 9. There are methods to determine the quantities of absorbed substances.		E AM	AV I	NI NM	NOT APPLICABLE			E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	
B 10. Laboratory facilities are available to identify drugs of abuse or dependence or other toxic substances present in body fluids (urine, blood)		E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	
B 11 Patients are evaluated using standardized instruments and procedures and an established classification system (e.g. the ICD-10).		E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	NOT APPLICABLE			
B 12. Registration of patients upon Admission is properly Administered.		E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	E AM	AV I	NI NM	

C. NATURE AND ORGANIZATION OF TREATMENT PROVIDED

STEP 1: Indicate if the standard is : Essential (E) Advisable (AV) Not Indicated (NI)	STEP 2: Indicate if the standard is: Adequately Met (AM) Inadequately Met (IM) Not Met at All (NM															Step 3: For standards that are either inadequately met (IM) or Not Met (NM): Indicate Why this is the case and How it is proposed to rectify the situation
STANDARD		Management of Acute Intoxication			Management of Acute Withdrawal			Management of Drug Dependence			Management of Physical Conditions			Management of Psychiatric Disorders			Management of Psychosocial Disability			
C. NATURE AND ORGANIZATION OF TREATMENT PROVIDED																				
C 1. Patient treatment records are maintained, indicating progress and referrals to other services; records are updated regularly (to the extent possible) to ensure the continuity of clinical care.		E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	NOT APPLICABLE			
C 2. The treatment or treatments are selected according to the drug or drugs used and the intensity of use, degree of dependence, physical and mental condition of the patient, and his/her social situation.		E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	NOT APPLICABLE			E / AM	AV / I	NI / NM	NOT APPLICABLE			
C 3. The treatment or treatments are selected according to the nature of the physical disorder, taking into account the means of drug Administration used, the presence of other physical and psychiatric conditions and the socio cultural background of the patient		NOT APPLICABLE			NOT APPLICABLE			E / AM	AV / I	NI / NM	NOT APPLICABLE			E / AM	AV / I	NI / NM	NOT APPLICABLE			
C 4. The treatment or treatments are selected according to the characteristics of the psychiatric disorder (symptoms, severity, time it started) and the specific condition of the patient (physical condition, age and social situation		NOT APPLICABLE			NOT APPLICABLE			E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	
C 5. The treatment or treatments are selected according to the psychosocial impediments, taking into account other physical and/or psychiatric conditions and the social situation of the patient		NOT APPLICABLE			NOT APPLICABLE			E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	
C 6. The medical staff examines and modifies the treatments in contact with the patient to ensure effective care		E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	
C 7. There are clearly defined protocols for writing prescriptions and other appropriate interventions according to the specific condition of the patient and the drugs concerned		E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	E / AM	AV / I	NI / NM	NOT APPLICABLE			
C 8. The protocols are firmly based, to the extent possible, on the results of research. When this is not possible, they are in conformity with accepted practice.		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	

STEP 1: Indicate if the standard is : Essential (E) Advisable (AV) Not Indicated (NI)	STEP 2: Indicate if the standard is: Adequately Met (AM) Inadequately Met (IM) Not Met at All (NM																		Step 3: For standards that are either inadequately met (IM) or Not Met (NM): Indicate Why this is the case and How it is proposed to rectify the situation
STANDARD	Management of Acute Intoxication			Management of Acute Withdrawal			Management of Drug Dependence			Management of Physical Conditions			Management of Psychiatric Disorders			Management of Psychosocial Disability			
C 9. The various therapeutic options possible are described to the patient.	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
C 10. Laboratory and other facilities are available for monitoring progress and observing the treatment being Administered.	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
C 11. Access to self-help and other support groups is available	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
C 12. Whether or not the objective of the treatment is abstinence, measures are taken to reduce the harm resulting from continued drug use by the patient (e.g. Administration of vitamins, instructions on disinfecting injection utensils).	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
C 13. When a procedure entailing known risks is being considered, a risk-benefit evaluation is conducted of alternatives and the least risky procedure is selected.	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
C 14. Treatment is provided in the home through regular contact with trained staff to initiate treatment and supervise progress.	E	AV	NI	E	AV	NI	NOT APPLICABLE			NOT APPLICABLE			NOT APPLICABLE			NOT APPLICABLE			
	AM	I	NM	AM	I	NM													
C 15. Patients receiving ambulatory treatment or treatment in the home are informed about 24-hour emergency services.	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
C 16. A mechanism is in place to ensure the continuity of care provided to patients.	E	AV	NI	E	AV	NI	NOT APPLICABLE			E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM				AM	I	NM	AM	I	NM	AM	I	NM	
C 17. A regular evaluation is conducted of the results of services to determine general effectiveness and efficiency (in other words, an evaluation of the program).	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
C 18. There are links between the drug dependence treatment program and other services to facilitate interventions on behalf ot the drug user s children and other family members, who have suffered psychologically or socially.	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
C 19. An emergency support service (or appropriate means of transport) is in place for cases where there is danger of drug-use-related death. These services are available	E	AV	NI	E	AV	NI	NOT APPLICABLE												
	AM	I	NM	AM	I	NM													

D. STANDARDS WITH RESPECT TO THE DISCHARGE OF IN-PATIENTS, FOLLOW-UP CARE, AND REFERRAL OF CASES

STEP 1: Indicate if the standard is : Essential (E) Advisable (AV) Not Indicated (NI)	STEP 2: Indicate if the standard is: Adequately Met (AM) Inadequately Met (IM) Not Met at All (NM)																	Step 3: For standards that are either inadequately met (IM) or Not Met (NM): Indicate Why this is the case and How it is proposed to rectify the situation
STANDARD		Management of Acute Intoxication			Management of Acute Withdrawal			Management of Drug Dependence			Management of Physical Conditions			Management of Psychiatric Disorders			Management of Psychosocial Disability			
D. STANDARDS WITH RESPECT TO THE DISCHARGE OF IN-PATIENTS, FOLLOW-UP CARE, AND REFERRAL OF CASES																		
D 1 There are defined criteria for sanctions or expelling patients for violations of treatment service rules, violence, continued use of unprescribed drugs, etc		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
D 2. There are defined criteria for retaining patients (e.g. intoxication, attempted suicide).		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
D 3. Internment is discontinued on the basis of a prior determination with respect to the patient s degree of recovery		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
D 4. Attention is given to subsequent treatment and support (e.g. family, social) considered necessary based on diagnostic assessment, objectives and the patient s resources		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
D 5. Consideration is given to treatment plans outlining possible alternatives in the event of partial or total failure of the initial plan, or expulsion of the patient from treatment for problems associated with psychoactive substance use.		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
D 6. Individuals displaying signs of imminent withdrawal syndrome during treatment are provided access to treatment for that syndrome.		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
D 7. There are links (e.g. a directory, regular communication) with specialized drug abuse treatment services for the referral of cases.		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
D 8. Patients who have obtained the maximum possible benefit of treatment, but who are still not self-sufficient, have access to treatment in controlled environments.		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	

E. STANDARDS ON OUTREACH AND RAPID INTERVENTION

STEP 1: Indicate if the standard is : Essential (E) Advisable (AV) Not Indicated (NI)	STEP 2: Indicate if the standard is: Adequately Met (AM) Inadequately Met (IM) Not Met at All (NM																		Step 3: For standards that are either inadequately met (IM) or Not Met (NM): Indicate Why this is the case and How it is proposed to rectify the situation
STANDARD		Management of Acute Intoxication			Management of Acute Withdrawal			Management of Drug Dependence			Management of Physical Conditions			Management of Psychiatric Disorders			Management of Psychosocial Disability			
E. STANDARDS ON OUTREACH AND RAPID INTERVENTION																			
E 1. Intoxicated persons in public places in need of treatment for intoxication and withdrawal syndrome are detected	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
E 2. There are agreements and active cooperation between health-care staff and law enforcement officers to ensure that there are drug-use-related services in detention and other controlled facilities.	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
E 3. Voluntary interrogations are regularly conducted in general health services in order to detect cases of drug dependence and excessive use.	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
E 4. Efforts are made to promote rapid intervention in the event of drug-use-related problems.	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
E 5. Rapid intervention is also promoted in environments other than health services (e.g. the workplace, schools, etc.)	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
E 6. Efforts are made to promote rapid intervention within specific population subgroups (e.g. pregnant women, prostitutes, students and children at risk, homeless persons).	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
E 8. Efforts are made to promote voluntary submission to treatment for drug-related problems.	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
E 9. Information on evaluation procedures and treatment resources are distributed to the initial contact persons for the potential patients.	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
E 10. Efforts are made to facilitate counseling for families, employers, and others seeking treatment assistance for a drug user.	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
E 11. A register of case referrals is kept to ensure the continuity of clinical care.	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
E 12. As part of their training, primary and other health-care staff, social workers, and police officers receive instruction in the recognition of, and basic treatment for, persons with drug-related disabilities and in the referral of such cases for treatment.	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	

F. STANDARDS ON PATIENT RIGHTS

STEP 1: Indicate if the standard is : Essential (E) Advisable (AV) Not Indicated (NI)	STEP 2: Indicate if the standard is: Adequately Met (AM) Inadequately Met (IM) Not Met at All (NM)																		Step 3: For standards that are either inadequately met (IM) or Not Met (NM): Indicate Why this is the case and How it is proposed to rectify the situation
STANDARD		Management of Acute Intoxication			Management of Acute Withdrawal			Management of Drug Dependence			Management of Physical Conditions			Management of Psychiatric Disorders			Management of Psychosocial Disability			
F. PATIENT RIGHTS																			
F 1. The human rights of patients are protected (see the Universal Declaration of Human Rights).		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
F 2. Information on patient progress or participation in treatment is not revealed to any individual or authority without the patient s prior consent, except in the case if subpoenas or in matters related to suicidal or homicidal patients.		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
F 3. Patients are fully informed as to the nature and content of the treatment, as well as the expected risks and benefits.		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
F 4. The patient s prior informed consent is obtained with respect to the content, conditions and restrictions of treatment (if the patient has legal capacity).		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
F 5. No photographs or audio, video or other similar recordings of the patient are taken without his prior informed consent, obtained after explaining the purpose of such photographs or recordings (e.g. training, research, public dissemination).		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
F 6. The patient has the right to maintain contact with, and receive visits from, his/her family and other persons (e.g. teachers, employers, religious leaders).		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
F 7. The provisions of resolution 45.35 of the World Health Assembly, recognizing as groundless, from the point of view of public health, measures imposing compulsory HIV detection, are accepted.		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
F 8. There is no use of physical coercion to detain or confine patients with legal capacity against their will.		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
F 9. A documented complaint procedure is in place, and patients and/or their families are informed about it.		E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
		AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	

G. STANDARDS ON THE PHYSICAL ASPECTS OF THE TREATMENT SITE

STEP 1: Indicate if the standard is : Essential (E) Advisable (AV) Not Indicated (NI)	STEP 2: Indicate if the standard is: Adequately Met (AM) Inadequately Met (IM) Not Met at All (NM																		Step 3: For standards that are either inadequately met (IM) or Not Met (NM): Indicate Why this is the case and How it is proposed to rectify the situation
STANDARD		Management of Acute Intoxication			Management of Acute Withdrawal			Management of Drug Dependence			Management of Physical Conditions			Management of Psychiatric Disorders			Management of Psychosocial Disability			
G. PHYSICAL ASPECTS OF THE TREATMENT SITE																			
G 1. The physical environment of the services is properly adapted to the protection of patient well-being (e.g. hygiene, building security, and protection against possible injury, self-inflicted or otherwise).	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
G 2. In-patients are provided with space for safekeeping of their personal effects.	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
G 3. In-patients have the possibility to avoid being bothered.	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	
G 4. In-patients have access to recreational facilities.	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	E	AV	NI	
	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	AM	I	NM	

H. STANDARDS ON STAFFING

STEP 1: Indicate if the standard is : Essential (E) Advisable (AV) Not Indicated (NI)	STEP 2: Indicate if the standard is: adequately Met (AM) Inadequately Met (IM) Not Met at All (NM)						Step 3: For standards that are either inadequately met (IM) or Not Met (NM): Indicate Why this is the case and How it is proposed to rectify the situation
STANDARD		Management of Acute Intoxication	Management of Acute Withdrawal	Management of Drug Dependence	Management of Physical Conditions	Management of Psychiatric Disorders	Management of Psychosocial Disability	
A. STAFFING								
H 1. Qualified staff is available, either within the treatment facility itself, or on 24-hour standby, during treatment.	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	
H 2. New staff (specialized as well as general health-care personnel) are trained in the recognition of drug-abuse-related problems and methods for handling them.	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	
H 3. Staff (specialized as well as general health-care personnel) are provided with regular refresher training.	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	
H 4. In determining the composition of service staff, consideration is given to the characteristics (sex, race, ethnicity,) of the population with access to the services.	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	
H 5. Additional support staff is in place to handle violent patients, and thus ensure the safety of other patients and staff.	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	
H 6. More than one staff member is on duty during the hours of treatment program activity.	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	
H 7. To maintain the quality of service, staff receives regular supervision from senior staff, and peer evaluations and case conferences are conducted.	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	
H 8. A regular evaluation is conducted of workflow in the service and the proportion between staff and patients.	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	E AV NI / AM I NM	

Conclusion

The relationship between mental illness and drug abuse is complex. Drug dependence, intoxication and withdrawal constitute psychiatric illness in the classification of mental disorders.

There is an overlap of delinquents, and non-specific abnormal personalities among the population of drug abusers who present with a variety of psychiatric disabilities. In the effort to manage psychiatric co-morbidity, it is necessary that attention is given to the basic pathological habit of drug abuse. Effective therapy may require input from psychiatric, medical, social services and at times law enforcement agencies. Staff involved with treatment and management of those with complications of drug abuse need to take cognizance of the natural course of drug dependence. This is especially important for the emergency room staff in general hospitals. In this regard, due consideration must be given to the training of all such personnel.

Whether psychiatric co-morbidity is primary or secondary to drug abuse, it requires prompt attention to avoid complications. Long-term out-patient follow ups and adequate rehabilitation offering training in social skills, occupation, followed by employment where necessary may prove to be useful.

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Appendix

ANNEX 1: RECOMMENDATIONS OF THE EXPERT GROUP ON DEMAND REDUCTION OF THE INTER-AMERICAN DRUG ABUSE CONTROL OF THE ORGANIZATION OF AMERICAN STATES (CICAD/OAS)

With respect to national strategies for the implementation of a program to monitor standards of care in the treatment of drug dependence, the Expert Group on Demand Reduction of the Inter-American Drug Abuse Control Commission of the Organization of American States (CICAD/OAS) has made the following recommendations:

- States should take steps to incorporate within their juridical systems standards for the appropriate, accessible, and effective treatment of persons with disorders related to the use of psychoactive substances.

- Determine the availability and capacity of treatment, rehabilitation, and social reintegration services and decide on the types of services that should be subject to treatment standards.

- Promote and recognize the role of self-help groups as supplemental support services for persons with drug problems; self-help groups are by definition voluntary, anonymous, and free of charge.

- Promote the creation of mechanisms for eliciting the participation of those involved in the supply of drug dependence treatment and rehabilitation services (government, health-care establishments, professionals, users) in developing standards of care and ensuring the participation necessary and consensus required for the Adoption of such standards.

- Facilitate the dissemination of information to the general public on the availability of drug dependence treatment and rehabilitation services and promote the acceptance and use of such services.

- Establish mechanisms for training, in cooperation with the establishments concerned, to Address problems that hinder effective compliance with standards.

- Establish mechanisms to ensure regular and continuous evaluation.

April 23, 2010, Lugo, Spain

DECLARATION OF LUGO ON THE PREVENTION AND TREATMENT OF DRUG USE AND DEPENDENCE

We, European, Latin American and Caribbean city mayors, national policy-makers and experts, meeting in Lugo, Spain in the context of the "EU-LAC City Partnerships in Drug Treatment", recognize that drug demand reduction policies and programs should be comprehensive and long-term, and should be geared to promoting healthy lifestyles, preventing drug use and abuse, providing treatment and rehabilitation for drug-dependent persons, and offering recovery support services in the community.

We have focused our efforts for the last three years on improving drug abuse prevention and treatment policies and programs in our cities.

We have shared out municipal plans for preventing drug and alcohol use, particularly among young people, with community support.

We have also seen the importance of providing in the cities treatment and rehabilitation for drug-dependent individuals.

We have learned, through the assessments we have conducted of the status of drug treatment in our cities that our drug treatment services and our human resources training can be improved through the exchange of good practices and information among experts from both sides of the Atlantic.

We are most grateful to the European Union for its support and financing of the EU-LAC Drug Treatment City Partnerships over the last three years.

We are also most grateful to the Inter-American Drug Abuse Control Commission (CICAD), Secretariat for Multidimensional Security of the Organization of American States for its leadership in organizing and carrying out this initiative.

We have concluded that drug policies must be based on scientific evidence. This evidence shows us that drug dependence is a chronic relapsing disease that needs professional health care, and the support of local social and welfare services made available by cities.

It is necessary to remove the stigma and social exclusion that are still associated with drug users and drug-dependent people and that impede their recovery and full participation as productive members of the community.

We recognize that since the reasons for drug dependence are complex, therapy and recovery must necessarily also be complex and many-layered.

We are convinced that helping people recover from their illness of drug dependence means drawing on many government and community resources, particularly health care, social welfare, housing, employment and education.

Resources invested in recovery services translate into benefits for society as a whole by reducing the costs associated with dependence.

We agree that drug policy works best when it is part of overall social policies, with drug treatment and rehabilitation working hand in hand with social services. An integrated health response to addiction requires a full partnership of government and civil society, in the common mission of improving the lives of every individual and their families.

We are also convinced that cooperation, communication and clear roles for different agencies are key to success in treating drug dependence, whether locally or in the central government.

We welcome the full cooperation of civil society organizations and the private sector in providing and supporting drug abuse prevention and treatment services for our citizens.

We express our support for international initiatives that build cooperation and exchanges of good practices among the local agencies and individuals, since it is they who work most closely with the people of our cities. We therefore propose to our national Governments that they ensure that their drug policies, particularly in demand reduction, include the promotion and continuation of initiatives such as the EU-LAC City Partnership in Drug Treatment that has brought us together in Lugo.

On behalf of the more than forty cities that have committed to this multilateral City Partnerships initiative in recent years, we express our thanks to the City of Lugo and to its citizens for their work in bringing together the peoples of Europe, Latin America and the Caribbean.

We are committed to translating our transatlantic exchanges of experiences into concrete plans and actions for the future.

We therefore declare that we are formally establishing the EU-LAC City Partnership in Drug Demand Reduction, that will be signed in Coimbra, Portugal in September 2010, geared to promoting public policies, plans and actions to prevent drug and alcohol use and to provide treatment and recovery support services for drug-dependent persons. This EU-LAC Partnership is committed to exchanges of evidence based experiences in demand reduction, and to the protection of human rights.

Done in Lugo, Spain, April 23, 2010

UNIVERSAL DECLARATION OF HUMAN RIGHTS

Adopted and proclaimed by General Assembly Resolution 217 A (III) on 10 December, 1948

PREAMBLE

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.

Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and what has been proclaimed as the highest aspiration of the common people,

Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law,

Whereas it is essential to promote the development of friendly relations between nations,

Whereas the people of the United Nations (UN) have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in cooperation with the United Nations, the promotion of universal respect for an observance of human rights and fundamental freedoms,

Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge,

Now, therefore,

The General Assembly,

*P*roclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States, themselves and among the peoples of territories under their jurisdiction.

Article 1

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3

Everyone has the right to life, liberty and security of person.

Article 4

No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6

Everyone has the right to recognition everywhere as a person before the law.

Article 7

All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8

Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 9

No one shall be subjected to arbitrary arrest, detection or exile.

Article 10

Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Article 11

1. Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has all the guarantees necessary for his defence.
2. No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13

1. Everyone has the right to freedom of movement and residence within the borders of each State.
2. Everyone has the right to leave any country, including his own, and to return to his country.

Article 14

1. Everyone has the right to seek and to enjoy in other countries asylum from persecution.
2. This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15

1. Everyone has the right to a nationality.
2. No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16

1. Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.
2. Marriage shall be entered into only with the free and full consent of the intending spouses.
3. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17

1. Everyone has the right to own property alone as well as in association with others.
2. No one shall be arbitrarily deprived of his property.

Article 18

Everyone has the right to freedom of thought, conscience and religion; his right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impact information and ideas through any media and regardless of frontiers.

Article 20

1. Everyone has the right to freedom of peaceful assembly and association.
2. No one may be compelled to belong to an association.

Article 21

1. Everyone has the right to take part in the government of his country directly through freely chosen representatives.
2. Everyone has the right to equal access to public service in his country.

3. The will of the people shall be the basis of the authority of government; this will be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22

Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international cooperation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23

1. Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.
2. Everyone, without and discrimination, has the right to equal pay for equal work.
3. Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity and supplemented, if necessary, by other means of social protection.
4. Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Article 26

1. Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.
2. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.
3. Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27

1. Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.
2. Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29

1. Everyone has duties to the community in which alone the free and full development of his personality is possible.
2. In the exercise of their rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.
3. These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30

Nothing in this declaration may be interpreted as implying for any state, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

Caribbean Adaptation- Assessing standards of care in substance abuse treatment (WHO)

1. SHOULD THE INCLUDED STANDARDS BE RETAINED (YES), REMOVED (NO)? WHAT ADDITIONAL AREAS SHOULD BE INCLUDED IN THE CARIBBEAN VERSION?

Area	Yes	No
A. Standards on access, availability and admission criteria		
B. Standards on assessment		
C. Standards on treatment content provision and organization		
D. Standards on discharge, aftercare and referral		
E. Standards on outreach and early intervention		
F. Standards on patients' rights		
G.. Standards on physical aspects of the treatment setting		
H. Standards on staffing		
Additional Areas:		
Tele-counselling, computer mediated counselling		
Others		

2. WOULD YOU RETAIN THE FOLLOWING MARKERS FOR ASSIGNING STATUS THROUGHOUT THE DOCUMENT?

Status Marker	Yes	No	If no, I suggest
Essential (E)			
Advisable (AV)			
Not Indicated (NI)			
Inadequately met (IM)			
Adequately met (AM)			
Not met at all (NM)			

3. ADJUSTMENT/RETENTION OF STATEMENTS ASSOCIATED WITH STANDARDS OF CARE.

What statements would you retain (yes), remove (no) or include?

Standard	**A. Standards on Access, Availability and Admission criteria**				
Assciated Statements	**Yes**	**No**	**Assciated Statements**	**Yes**	**No**
A1			A9		
A2			A10		
A3			A11		
A4			A12		
A5			A13		
A6			A14		
A7			A15		
A8			A16		
Other associated statements					

Standard	B. Standards on Assessment				
Assciated Statements	**Yes**	**No**	**Assciated Statements**	**Yes**	**No**
B1			B7		
B2			B8		
B3			B9		
B4			B10		
B5			B11		
B6			B12		
Other associated statements					

Standard	C. Standards on Treatment Content Provision and Organization				
Assciated Statements	**Yes**	**No**	**Assciated Statements**	**Yes**	**No**
C1			C11		
C2			C12		
C3			C13		
C4			C14		
C5			C15		
C6			C16		
C7			C17		
C8			C18		
C9			C19		
C10					
Other associated statements					

What statements would you retain (yes), remove (no) or include?

Standard	**D. Standards on Discharge, Aftercare and Referral**				
Assciated Statements	**Yes**	**No**	**Assciated Statements**	**Yes**	**No**
D1			D5		
D2			D6		
D3			D7		
D4			D8		
Other associated statements					

Standard	E. Standards on Outreach and Early Intervention				
Assciated Statements	**Yes**	**No**	**Assciated Statements**	**Yes**	**No**
E1			E7		
E2			E8		
E3			E9		
E4			E10		
E5			E11		
E6					
Other associated statements					

Standard	F. Standards on Patients' Rights				
Assciated Statements	**Yes**	**No**	**Assciated Statements**	**Yes**	**No**
F1			F7		
F2			F8		
F3			F9		
F4			F10		
F5			E11		
F6					
Other associated statements					

Standard	G. Standards on Physical Aspects of the Treatment Setting				
Assciated Statements	**Yes**	**No**	**Assciated Statements**	**Yes**	**No**
G1			G4		
G2			G4		
Other associated statements					

What statements would you retain (yes), remove (no) or include?

Standard	D. Standards on Discharge, Aftercare and Referral				
Assciated Statements	**Yes**	**No**	**Assciated Statements**	**Yes**	**No**
H1			H5		
H2			H6		
H3			H7		
H4			H8		
Other associated statements					
New Standard					
Associated Statement					

ANNEX V - DRAFT STANDARDS FOR NON- GOVERNMENTAL ORGANIZATIONS PROVIDING SERVICES AFFECTED BY ALCOHOL AND OTHER DRUGS OF ABUSE (TRINIDAD AND TOBAGO)

OBJECTIVE:

The following guidelines have been developed in order to provide basic standards for Non-Governmental Organizations providing services for clients affected by alcohol and drug abuse. This is to ensure that these organizations provide services of an acceptable standard. The guidelines describe the essential components of a treatment service and are not intended to indicate the particular treatment philosophy of a programme. Thus, the application of these guidelines may vary according to the philosophy, goals and objectives of each organization. It is recognised that the standards established by these guidelines may not exist at the onset of a programme. However, in all cases a time frame should be determined as to when a particular facility will meet these guidelines.

The document has been organized under the following sections:

(1) Definitions
(2) Staffing, Management and Administration
(3) Admission and Registration of Patients
(4) Accommodation
(5) Treatment of Patients
(6) Inspection of Centres by Government Officers
(7) Monitoring of Operation by Government

1. DEFINITIONS:

Client: (residential, patient, members or customer) – The person served or members of that person's family legally acting on his/her behalf, i.e. the client's legal representative.

DETOXIFICATION SERVICES

This service assists the individual to withdraw from an alcohol or other drug induced state and to attain an acceptable level of physical, psychological and social functioning. This is often the initial phase of a continuum of care and must therefore be linked to other components of the treatment and rehabilitation process. Facilities located outside of a medical institution must have immediate 24 hour access to an emergency medical service.

RESIDENTAIL (IN-PATIENT) TREATMENT:

These services include programmes offering patients treatment in a residential facility for periods varying from 1 to 3 months or for longer periods. The services provided include assessment and treatment involving a multi-disciplinary approach and aftercare. They provide a full range of therapeutic modalities which address the biological, psychological, spiritual and social needs of the addicted individual.

NON-RESIDENTIAL

These services are non-residential programmes which range from those offering aftercare for patients discharged from residential programmes to those offering all the elements of a comprehensive rehabilitation service. This includes detoxification, rehabilitation and follow-up.

DROP-IN CENTRES:
A service offering advice, referral and support to addicts and their families or any concerned individual.

HALF-WAY HOUSE:
A half-way house is an intermediate facility which offers support while promoting and developing independence. These programmes attempt to combine the advantages of residential treatment and ambulatory treatment. Patients live at the facility but are allowed to leave during the day and sometimes on the weekends. Half-Way house frequently serves as a transition facility from a residential programme to a full independent functioning in the community. Length of stay may range from 1 month to 1 year.

HARM REDUCTION:
Programmes and policies which attempt to reduce drug related harm.

2. **STAFFING, MANAGEMENT AND ADMINISTRATION:**

The operations of the facility must be clearly stated and there should be documentation of services which would include:

(1) Philosophy and objectives
(2) Policies and procedures
(3) Administrative organization
(4) Staff responsibilities
(5) Sources of funding and financial policies
(6) Liaison with other community services
(7) Assessment and treatment
(8) Programme evaluation procedures

The composition of staff should reflect the services offered by a particular facility. Thus, a comprehensive out-patient programme would require a multi-disciplinary staff, whereas a Half-Way House may only require modified supervision with backup from community services.

Staff should be carefully selected especially regarding level of education, experience and attitudes to addiction and addicts.

There must be competent, trained persons designated for supervising, counselling and other specialised functions. Opportunities must exist within the organization for upgrading the knowledge and skills of all members of staff on a regular and continuous basis.

3. ADMISSION AND REGISTRATION OF PATIENTS:
There must be clearly defined statements on the admission and registration of patients. The statement should cover the following areas:

a. Admission criteria
b. Evaluation process
c. Admission procedures
d. Registration process and record keeping

Admission criteria should be developed to describe the population likely to benefit from the particular programme. The evaluation process should link behaviour, personal history/drug use and interpersonal

relationships to develop a profile of the person's past and present state and his likely prognosis and course of management.

Admission procedure should describe method of referral and rules and regulations governing participation in the programme as well as discharge and after care.

A register of all patients must be kept with the following demographic information:

1. Name, age, sex, usual place of abode, next of kin/significant other, marital status.
2. Date of admission and date of discharge from facility.
3. Evaluation record and diagnosis/presenting problems.
4. Progress notes
5. Discharge summary and aftercare arrangements.
6. Any other illness/dysfunction/injury
7. Referral source/contact (phone number and address)

Adequate arrangement must be in place to ensure documentation and the safe keeping and confidentiality of records.

4. ACCOMMODATION:

Regulations regarding accommodation for residential programmes should be as follows:

(a) In every room that is to be occupied by more than two patients the space per bed should not be less than 80 sq. ft.

(b) Every room in which not more than two patients are to be accommodated should not be less than 90 sq. ft.

(c) All bedspreads, springs, mattresses, pillows, sheets, pillow slips and bedcovers should be maintained in good repair and in a clean and insect free condition.

(d) The water supply of the facility should be of potable quality and under sufficient pressure to serve all parts of the facility

(e) There should not be less than one toilet and one wash basin for every six patients (at least one each for paraplegics).

(f) Where male and female patients are accommodated on the same floor of the facility, there should be separate toilets and wash basins for each gender.

(g) Where possible, toilet facility for male patients should be at one end of the floor and for female patients at the other end.

(h) Where bath or showers are not provided in every room, there should be at least two baths or two showers on each floor.

(i) All plumbing fixtures should be kept in good repair and the rooms and conveniences maintained in a sanitary condition. There must be no unsecured electrical fittings/wires etc.

(j) Every facility should be equipped with adequate lighting at all times in all halls, stairways, passages and closet compartments.

(k) All floors, walls and ceiling surfaces should be kept in a state of good repair and in a clean condition at all times. Cellars and basements should be clean of waste and combustible materials.

(l) The premises should be kept free of rodents, lice, bedbugs, cockroaches, flies and other pests. Every yard, area, forecourt or other open space with its cartilage should at all times be kept in a thoroughly clean condition with no overgrowth and weeds.

(m) All facilities should meet the requirements of the Chief Fire Officer regarding means of escape, fire fighting equipment and material to be used in the case of fire.

5. TREATMENT OF PATIENTS:

Successful outcome necessitates the development of a range of treatment services in order to provide a continuum of care for the addicted individual and his family. Each individual component of this service may provide a comprehensive range of ongoing recovery oriented activities (as in the case of multi-programme rehabilitation services offering detoxification, in-patient rehabilitation and aftercare). Or they may offer partial services (as in the case of Half-Way Houses and Detoxification Centres). However, all facilities are required to have clear, written policies outlining their particular treatment programme. This should include all the elements necessary to increase the likelihood of the addicted individual achieving the stated objectives of that particular facility.

The following will apply to in-and out-patient programmes:

(a) These programmes must comprise of various treatment modalities incorporating a multi-disciplinary approach. The attending team should comprise mental health personnel, recovering addicts/alcoholics and or other personnel trained in the requisite discipline.

(b) Treatment methods must include activities such as group and individual counselling, didactic sessions on addictions, occupational therapy, liaising with self help groups, spiritual counselling, etc.

(c) There should be close co-operation and consultation (where necessary) with the wider therapeutic community of specialist institutions. These include Alcoholics Anonymous, Narcotics Anonymous, Social Service Agencies and Public Health facilities.

6. INSPECTION OF CENTRES BY GOVERNMENT OFFICERS:

All enterprises and programmes that fall under the purview of these guidelines must have their physical facility, registers and other records with the exception of confidential case histories, open to inspection. This is to be done by persons appointed by the Minister of Health or other relevant state agency. These facilities must be inspected at intervals of not more than twice per year or at any frequency determined by the Minister of Health.

7. MONITORING OF OPERATIONS BY GOVERNMENT OFFICIALS

All facilities and programmes that fall under the purview of these guidelines must allow monitoring by Government officials to ensure that programme objectives are being achieved. In this regard, the following will apply:

(1) Programme objectives must be clearly defined in such a manner as to allow evaluation to be conducted;

(2) Adequate records must be maintained for the purpose of the programme;

(3) Evaluation exercise by a duly constituted committee of the Ministry of Health must be conducted at a frequency that will allow for the maintenance of an effective programme.

(4) Copies of policies, procedures, codes and so on should be submitted to the regulatory body at registration and in the event of subsequent change by the institution to these documents.

(5) Treatment and Rehabilitation Institutions must be accredited or licensed every three years, subject to compliance with these standards.

ANNEX VI - SAMPLE INSTRUMENT FOR CENTRES PROVIDING STREET/COMMUNITY BASED INTERVENTION PROGRAMMES (SCBIP) – KOHLER/DAY (2000)

Date: _____

Name of Centre: Address _____

Phone: _____ Fax _____ Email _____

Name of Director: _____

Name of person completing this questionnaire: _____

Capacity for treatment (how many places): _____

Current occupancy of in-patient treatment: _____

Gender distribution: _____

Number of males: _____

Number of females: _____

Current annual operating budget: _____

Current exchange rate to the US Dollar: _____

Where do these funds come from? _____

Government subvention: _____

Private sector contributions _____

Self generated funds from client fees: _____

Other self generated funds from: _____

Fund raising: _____

Sustainable income generating: _____

Is there a deficit? _____

If so, how is the deficit made up? _____

1. STREET/COMMUNITY BASED INTERVENTION PROGRAMME (SCBIP)

1.1	Does your organization maintain a SCBIP? Name of the SCBIP: Location of the SCBIP:	Yes	No
1.2	Is the SCBIP located in a neighbourhood where drug use is prevalent?	Yes	No
1.3	Does the SCBIP provide low-threshold and early access for both current drug users and potential drug users? If no, why not? _____	Yes	No
1.4	Does the SCBIP provide the individual and/or groups with information and support to minimize the potential damage that may be caused by hazardous and compulsive drug use? If no, why not? _____	Yes	No
1.5	Is the SCBIP a safe place for individuals/groups to congregate and socialize? If no, why not? _____	Yes	No
1.6	Does the SCBIP provide family counselling? If no, why not? _____	Yes	No
1.7	Is there social support through trained counsellors and peer counsellors? If no, why not? _____	Yes	No

HEALTH SERVICES

1.8	Does the SCBIP provide health counselling? If no, why not? _____	Yes	No
1.9	Does the SCBIP provide adequate medical facilities and staff trained in dealing with common infections and diseases? If no, why not? _____	Yes	No
1.10	Is there a physician or nurse available to the centre on a regular basis? If no, why not? _____	Yes	No

1.11	Is there a physician or nurse available to the centre on call? If no, why not?_____	Yes	No
1.12	Is there a referral system to appropriate medical clinics and hospitals if and when needed? If no, why not?_____	Yes	No
1.13	Does the SCBIP maintain a sound, working relationship with these service providers? If no, why not?_____	Yes	No
1.14	Does the SCBIP provide out-patient treatment facilities with qualified staff, doctors or nurses? If no, why not?_____	Yes	No
1.15	Has the SCBIP developed an appropriate out-patient treatment strategy? If no, why not?_____	Yes	No
1.16	Has the SCBIP developed an appropriate out-patient treatment programme? If no, why not? _____	Yes	No

LEGAL SERVICES

1.17	Does the SCBIP provide law and order assistance or referrals? If no, why not? _____	Yes	No

REFERRAL SERVICES

1.18	Does the SCBIP provide referral services for residential treatment if the client desires? If no, why not?_____	Yes	No
1.19	Does the SCBIP provide follow-up aftercare for an individual discharged from in-residence treatment period? If no, why not?_____	Yes	No

ADVOCACY SERVICES

1.20	Does the SCBIP provide advocacy for drug users needing support either with:	Yes	No
1.21	Employment relations If, no why not?_____		
1.22	Job placement If no, why not?_____		
1.23	Legal issues If no, why not?_____		
1.24	Does the SCBIP maintain contact with persons having been discharged from residential treatment facilities irrespective of their drug-use status? If no, why not? _____		

BASIC NEEDS

1.25	Does the SCBIP maintain a shelter facility for homeless drug users? If no, why not?_____	Yes	No
1.26	Does the SCBIP provide services to meet the basic biological needs of the client such as: If no, why not?_____		
1.27	A well-balanced meal If no, why not? _____		
1.28	If yes, is there a fee charged? How Much? _____		
1.29	Replacement clothing If no, why not?_____		
1.30	If yes, is there a fee charged? How Much?_____		
1.31	A place to bathe If no, why not?_____		
1.32	If yes, is there a fee charged? How Much? _____		

DATA COLLECTION

1.33	Does the SCBIP gather information in order to detect new drug using trends and understand the magnitude in regard to the local drug use situation? If no, why not?_____	Yes	No
1.34	Is this information shared with the governmental authorities? If no, why not? _____ If yes, is the information collected in a formal or informal manner?	Yes	No
1.35	Does the government provide forms which they use to collect data?	Yes	No

2. RESIDENTIAL TREATMENT AND REHABILITATION (T&R) SERVICES

		Yes	No
2.1	Does your organization maintain a T&R service?		
2.2	How many separate T&R Centres are maintained? Male _____ Female _____ Both _____		
2.3	Current population Male _____ Female _____ Both _____		
2.4	Name of the T&R Centre:		
2.5	Location of the T&R Centre:		
2.6	Is the T&R Centre located in a neighbourhood where drug use is prevalent?		
2.7.	Does the T&R Centre provide the client with information and support to minimize the potential damage that may be caused by hazardous and compulsive drug use? If no, why not? _____		

COUNSELLING SERVICES

		Yes	No
2.8.	Does the T&R Centre provide family counselling? If no, why not? _____		
2.9	Is there support through trained counsellors and peer counsellors? If no, why not? _____		
2.10	Check the appropriate services provided: Group Therapy Individual Therapy 12 Step Meetings Other, please explain: _____		

HEALTH SERVICES

		Yes	No
2.11	Does the T&R Centre provide health counselling? If no, why not? _____		
2.12	Does the T&R Centre provide adequate medical facilities and staff trained in dealing with common infections and diseases? If no, why not? _____		
2.13	Is there a physician or nurse available to the centre on a regular schedule? If no, why not? _____		
2.14	Is there a physician or nurse available to the centre on call? If no, why not? _____		

HEALTH SERVICES

		Yes	No
2.15	Is there a referral system to appropriate medical clinics and hospitals if and when needed? If no, why not?_____		
2.16	Does the T&R Centre maintain a sound, working relationship with these service providers? If no, why not?_____		
2.17	Does the T&R Centre provide out- patient treatment facilities with qualified staff, doctors or nurses? If no, why not? _____		
2.18	Does the T&R Centre provide in-house detox services? If no, why not? _____		
2.19	Has the T&R Centre developed an appropriate out-patient treatment programme? If no, why not? _____		

LEGAL SERVICES

2.20	Does the T&R Centre provide law and order assistance or referrals? If no, why not? _____	Yes	No

AFTER CARE SERVICES

2.21	Does the T&R Centre provide follow-up aftercare for a discharged individual? If no, why not?_____	Yes	No

ADVOCACY SERVICES

		Yes	No
2.22	Does the T&R Centre provide advocacy for drug users needing support with: Legal issues If no, why not? _____		
2.23	Does the T&R Centre maintain contact with persons having been discharged from the facility irrespective of their drug-use status? If no, why not? _____		

DATA COLLECTION

		Yes	No
2.24	Does the T&R Centre gather information in order to detect new drug using trends and understand the magnitude in regard to the local drug use situation? If no, why not? _____		
2.25	Is this information shared with the governmental authorities? If no, why not? _____		
2.26	If yes, is the information collected in a formal or informal manner?		
2.27	Does the government provide forms which they use to collect data?		

EMPLOYMENT

	Yes	No
2.28 Does the T&R Centre have an in-house vocational skills training programme for the residents? If no, why not?_____ If yes, please list the type of skills the resident can learn:		
2.29 Does the programme provide the individual with skills that have the potential for income earning possibilities after discharge from the residential period? If no, why not?_____		
2.30 Does the T&R Centre provide assistance with job placement? If no, why not? _____		
2.31 Does the T&R Centre engage in income generating activities in order to provide income for the Centre? If no, why not?_____		
2.32 For the residents? If no, why not? _____		

		Yes	No
2.33	Does the Centre have written and defined exit strategies with the individual client related to his/her medical, social and economic well being after discharge from the facility? If no, why not?_____		
2.34	Does the T&R Centre have an operation manual that clearly defines the following: Complaint Procedures Code of Ethics Medical / Infectious Disease Protocols Rules on Client confidentiality Programme Procedures, Conflict Resolution.		

3. AFTER-CARE SERVICE

Rationale:

It is essential that a person leaving a residential centre have a supportive environment to return to after an in-patient period. To some extent clients may feel or sense de-skilled after the discharge, as they have un-learned the street survival skills and adopted new social skills during their residential period in a centre. In many cases, the individual's family or community remains suspicious of the client as to how much he/she has really changed. The client often finds himself/herself without an ally or significant reference point/ person. A residential period without significant after-care service and support is doomed to failure in most cases and often leads to an individual's increased sense of hopelessness and mental self-degrading. Aftercare service and support must form an integral part of any in-resident treatment facility in order to do justice to its purpose. Halfway facilities are necessary where a client can benefit from the daily social support of peers while engaging with a society often hostile to the individual in recovery. The halfway facility may be a rented accommodation whereby the rent and utilities should be covered to some extent by the income generated by the residents. In order for a halfway facility to meet the needs of the client, certain aspects must be attended to in the service provision:

3.1	**On-going medical support:** regular health checks etc. In the best cases, doctors and nurses are on call for emergencies.
3.2	**Social support** through living in a community, common activities and individual support through formal counselling where needed and through informal peer counselling. It would be important that some of the income generated by the resident is channeled to his/her family.
3.3	**Support for employment** and job-placement development: a Centre should develop a pool of businesses willing to accept residents for employment. Staff of residential services should place importance in assisting clients in employment relations.
3.4	**Self-management training:** assisting the resident to learn time-management, personal budgeting, recreation time, relationship management and other areas which may need development on an individual basis.
3.5	Development of a market-let enterprise attached to the residence, in which residents can implement and develop their skills.

4. TRAINING OF SERVICE PROVIDERS

Rationale:

Ongoing training is essential for service providers to respond adequately to the changes and demands coming from drug use related damage. Training also inhibits the 'burn-out' among staff, as training helps provide coping and management skills. Training occurs in two main ways, formal training and informal "in service training" by 'learning through doing'. One method through which the latter is best facilitated is staff exchanges with other organizations.

4.1	**Weekly staff and management meetings** in which day-to-day operation of the service providers are discussed including case management.
4.2	**Development and/or revision of staff manuals** and procedures, development of service standards inclusive of complaint procedures etc.
4.3	**Clinical staff supervision on a regular basis.**
4.4.	**In-service training through staff exchange** with other service providers.
4.4.1	**Development of a 'resource-map':** identification of other agencies willing to cooperate in staff exchanges.
4.4.2	**Development a roster for staff exchanges.** Determining the timing and frequency of exchanges.
4.4.3	**Securing financial resources** (if needed).
4.5.	Formal training.
4.5.1	**Identification of appropriate training courses.**
4.5.2	**Identification of learning/training potential** through conferences, training workshops, seminars etc.
4.5.3	**Developing clear guidelines** regarding whom, how and when staff or management will and should benefit from training.
4.5.4	**Lobbying** and securing fellowships or sponsorships

5. NETWORKING

Rationale:.

Networking is one of the most crucial aspects in service provision. The benefits from the networking process are multiple. Such as, early detection of new trends, innovative responses in service intervention, sharing of know-how resources, lobbying and advocacy, development of best practices, common responses etc.

The common objective in the networking process must be to provide a better and more appropriate service to the drug user. Networks or network-bodies cannot be political or an avenue of funding, otherwise they will become partisan and thereby useless for the end-beneficiary, the drug user. Networks must be developed on a voluntary basis and cannot be coercive. Networking needs to be established on a local, regional and inter-regional basis and will include:

5.1	**Establishing local partners**/partnerships willing and interested in networking
5.2	**Development of a resource-map** including possible members to the network
5.3	**Establishing a framework of cooperation**, including objectives and mechanisms of working together, frequency of meeting, responsibilities
5.4	**Development of links** with other service providers on a regional basis
5.5	**Mapping resources existing within the region**
5.6	Establishing framework of regional and inter-regional cooperation
5.7	**Establishing an agreed Code of Ethics, Standards of Service**
5.8	**Analysis of the needs** for service provision within the region and the establishment of a framework to address these needs

6. COMMUNICATION AND DATA COLLECTION/ANALYSIS

6.1 Rationale:

Inter-agency communication is the foundation to any networking and development process for service providers involved in the drug field. For data to be of value it must be compared, comparison is only then possible when communication exists. It is of fundamental importance that service providers compare the outcome of their service provision with similar organizations. In the analysis, this will provide the reference needed to make an informed assessment.

Present day technology especially in computer technology is offering an inexpensive avenue of communication. Access to email facilities and the internet is no longer a luxury but an essential tool for communication. The access needs to exist:

6.1. Locally: access to other local organizations
6.2. Regionally: access to service providers
6.3. Inter-regionally: to provide a global picture of service provision and needs

Data Collection and Analysis

6.4. Locally: to provide an oversight in service outcomes and needs, establishing trends and appropriate responses
6.4. Regionally: for comparison
6.5. Inter-regionally: in order to obtain a global sense/understanding of both needs and provisions

It is important that mechanisms for collecting data are universal in order to allow comparison. The universality can only be established through communications and networking, considering present existing mechanisms and developing an agreed format.

Identification of Substance Use Conditions

Screening [1] and Case Finding

1. During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use

2. Healthcare providers should employ a systematic method to identify patients who use drugs that consider epidemiologic and community factors and the potential health consequences of drug use for specific population

Diagnosis and Assessment

3. Patients who have a positive screen for an indication of a substance use problem or illness should receive further assessment to confirm that a problem exists and determine a diagnosis. Patients diagnosed with a substance use illness should receive multidimensional bio-psycho-social assessment to guide patient centered treatment planning for substance use illness and any coexisting conditions

Initiation and Engagement in Treatment

Brief Intervention

4. All patients identified with alcohol use in excess of limits [2] and /or any tobacco use should receive a brief motivational counselling intervention by a healthcare worker trained in this technique.

Promoting Engagement in Treatment for Substance Use Illness

5. Healthcare providers should systematically promote patient initiation of care and engagement in ongoing treatment for substance use illness. Patients with substance use illness should receive supportive services to facilitate their participation in ongoing treatment

Withdrawal Management

6. Supportive pharmacotherapy should be available and provided to manage the symptoms and adverse consequences of withdrawal, based on a systematic assessment of the symptoms and risk. Withdrawal management alone does not constitute treatment for dependence and should be linked with ongoing treatment for substance use illness.

Therapeutic Interventions to Test Substance Use Illness

Psychosocial Interventions

7. Empirically validated psychosocial treatment interventions should be initiated for all patients with substance use illnesses

Pharmacotherapy

8. Pharmacotherapy should be recommended and available to all adult patients diagnosed with opioid dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support.

9. Pharmacotherapy should be offered and available to all adult patients diagnosed with alcohol dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support.

10. Pharmacotherapy should be offered and available to all adult patients diagnosed with nicotine dependence (including those with substance use conditions) and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with motivational counselling.

Continuing Care Management of Substance Use Illness

11. Patients with substance use illness should be offered long-term, coordinated care management of their substance use illness and any coexisting conditions, and this care management should be adapted based on ongoing monitoring of their programmes

1. Screening is the use of a standardized examination procedure or test with asymptomatic patients to identify the probable presence of a condition requiring further assessment

2. Maximum drinking limits: Healthy men up to age 65-No more than 4 drinks per day AND no more that 14 drinks per week. Healthy women (and healthy men over age 65)-No more than 3 drinks in a day AND no more than 7 drinks in a week. Recommend lower limits or abstinence as medically indicated; for example, for patients who take medications that interact with alcohol, have a health condition exacerbated by alcohol, or are pregnant (Advise abstinence). *National Institute on Alcohol Abuse and Alcoholism guidelines; Helping Patients Who Drink Too Much: A Clinician's Guide, 2005 Edition, Rockville, MD: NIAAA; 2005.*

INTOXICATION AND OVERDOSE

Standards of Care of the Treatment of Drug Dependence (2000) -the Organization of American Status/ Inter-American Drug Abuse Control Commission (OAS/CICAD) and the Pan American Health Organization (PAHO)

INTRODUCTION

Intoxication results from the intake of a quantity of a substance that exceeds the individual's tolerance and that will produce behavioural and or physical abnormalities. There is obviously an element of relativity in this definition. The term 'overdose' impose that the person has ingested a drug quantity that is higher than the recommended normal or therapeutic dose and that also exceeds his/her tolerance. The term is used here in a broader context, one that includes poisoning with substances that do not have therapeutic uses and therefore have no 'normal' dose (Devenyi, et. al, 1986).

Intoxication and withdrawal states are two of the organic brain syndromes in psychiatric diagnostics. There are many types of psychiatric disturbances associated with the abuse of drugs or substances. Those conditions may be the obvious causes for referring persons or their circumstances to seek help from the facilities. In this brief paper consideration is given to intoxication states, and the other conditions will be covered in other sections.

Every substance, in single or combination use, gives rise to a wide range of clinical symptoms. Manifestations of the symptoms or syndromes depend on many factors, for instance: pre-morbid personality, amount or doses of substance used, time limit, drug or substance type. A lot of substances cause psychiatric disorders, especially an intoxication state, as WHO mentions:

- Alcohol
- Tobacco
- Opioid
- Cannabinoid
- Sedative/hypnotics
- Cocaine
- Other stimulants, including caffeine
- Hallucinogens
- Solvents/inhalants

It is important to know that to detect an intoxication state, some resources can be helpful. Patients' clinical signs, physical and psychiatric examination, drug or substance finding by family/relative or circumstances and laboratory examination for the identification of drugs/substances in body fluid (e.g. urine, blood, saliva).

CLINICAL MANIFESTATION AND MANAGEMENT

The signs and symptoms that have been described (see chart) concerning the classes of psychoactive substances. The clinical manifestation of the intoxication states vary from mild to severe. If mild symptoms develop, the clinical picture can be expected to be limited and to clear with time alone.

General treatment focused on the life-threatening condition of the overdose patient, such as: disturbances in respiratory system, coma, or acidosis.

Specific treatment focused on the drug intoxication management for specific purposes, as the use of naloxone as opioid antagonist.

CONCLUSION

Treatment of overdose or intoxication in the patient is only the first step in the overall response to the problem of drug abuse. Full examination and assessment should be conducted and will assist in identification of other important health care needs, for which appropriate responses will be required.

REFERENCES

Devenyi, P. & Saunders, S. (1986) *Physicians Handbook for Medical Management of Alcohol-and Drug-related Problems*. Addiction Research Foundation, Toronto, Canada.
Schuckit, M.A. (1989) *Drug and Alcohol Abuse: A clinical guide to diagnosis and treatment*. Third edition, Plenum Publishing Corporation.

WITHDRAWAL SYNDROMES

INTRODUCTION

Withdrawal state is a variable group of symptoms of diverse degree occurring on absolute or relative withdrawal of a substance after repeated, and or high-dose use of that substance. In the case of opioids and Central Nervous System (CNS) depressants, long-term administration produces a 'latent counter-adaptation' in neural systems affected by the drugs. They become manifest in the form of rebound or overshoot phenomena when the drugs are stopped or when an antagonist is administered. The under activity of neural systems that often follows discontinuation of cocaine or amphetamine can also be viewed as a manifestation of latent counter-adaptation. Onset and course of the withdrawal state are time-limited and are related to the type of substance and dose being used immediately prior to abstinence. The most severe withdrawal syndromes occur with CNS depressants: alcohol, opioids and hypnotics-sedatives. A different type of withdrawal syndrome occurs with cocaine and other stimulants.

ALCOHOL

Signs and Symptoms

Whenever a patient presents any of the physical problems often associated with alcoholism or demonstrates a tremor and gives a history of alcohol misuse, the possibility of withdrawal must be carefully considered. Some 95 percent of alcoholics never evidence severe signs of withdrawal. Mild reactions, usually lasting up to 48 hours, consist of insomnia, irritability and tremor. More than one half of patients may evidence some level of autonomic nervous system dysfunction, including sweating, an increase in heart rate (100-120/min), increases in respiratory rate, mild elevations in temperature (372o – 37.8o C) and elevated blood pressure. One may also find signs of increased deep tendon reflex activity and tremor, irritability and anxiety. Other symptoms are anorexia or nausea and vomiting, emotional complaints including sadness and psychosomatic symptoms, headaches and illusions. The severity of the syndrome is related, among other things, to the intensity and duration of the most recent exposure to alcohol. In a more severe syndrome one may find a marked clouding of the sensorium and tremulousness. The most common of the more severe withdrawal symptoms is grand mal seizures. Delirium Tremens, characterized by severe autonomic nervous system (ANS) dysfunction, confusion and the possible concomitance of seizures, is reported for less than one percent of patients. Mortality rates are less than one in 500 patients during alcoholic withdrawal.

The psychological picture consists of nervousness, a feeling of decreased self-worth, and a high drive to continue drinking. For five percent of the cases it can include an obvious organic brain syndrome (OBS) or hallucinations.

Onset, evolution and critical periods

Alcohol is a CNS depressant with a relatively short half-life. The acute and usually mild withdrawal syndrome begins within 12 hours or less of the decrease in blood-alcohol levels, in an individual who has been drinking for days, weeks or months. Symptoms are likely to peak in intensity by 48-72 hours, and are usually greatly reduced by 4-5 days. Seizures may occur from 18 to 48 hours after the last alcohol ingestion. Mild levels of anxiety, insomnia and perhaps ANS dysfunction, are likely to continue for many months. Occasionally, the onset of withdrawal may not occur until three or more days after the last drink.

Management

Many patients with mild withdrawal can be managed safely and effectively at home or in non-medical detoxification centres. In such cases, treatment should include thiamine and diazepam in low doses, if possible, a relative or friend should be enlisted to watch the patient during the withdrawal phase. The treatment of the alcoholic patient is carried out in several stages and includes interventions directed toward life support, prevention of central nervous system damage, control of various medical complications of the condition, and recovery from the alcohol dependent itself. (5)

Physical examination placing emphasis on searching for evidence of cardiac arrhythmias or heart failure. Upper or lower gastro intestinal (GI) bleeding, infections including pneumonia, signs of liver failure, and neurological impairment including peripheral neuropathies.

Oral multiple vitamins given for a period of weeks, making sure that folic acid and thiamine are included. It would be better if those vitamins also contained zinc and magnesium, because some alcoholics might develop deficiencies in those minerals. Hydration may be required, although in milder withdrawal, over-hydration is more typical.

Reality orientation techniques are useful particularly for patients showing mild levels of confusion. An opportunity to sleep, adequate nutrition, reassurance, supportive nursing care, as well as a dimly lit, quiet, single room should be provided.

Medication is used to decrease overall symptoms, increase levels of comfort and decrease the risk for convulsions and delirium tremens (DTs). Almost all reviews of alcoholic withdrawal agree that the optimal medicinal treatment utilizes the benzodiazepines. Among them, a longer-acting drug such as diazepam or chlordiazepoxide is of choice; the reason is that they allow a relatively smooth withdrawal due to their long half-life. The dangers of the longer-acting drugs include the problem of exaggerated drug accumulation which, in patients with liver impairment could lead to lethargy, drowsiness and ataxia. On the other hand, the inconvenience of the shorter-acting drugs is that doses must be given every four hours for fear that falling blood levels might add to the pre-existing alcoholic withdrawal syndrome, and even precipitate seizures. The needed dose should be determined on day one, and then decreased by 20 percent for each day, stopping the drug by day four or five. An important safeguard is to skip the dose when the patient is lethargic or asleep. (1)

Treatment of delirium tremens includes a thorough physical examination and then supportive measures intravenous fluids (IV fluids if there is objective evidence of dehydration) as well as the prescription of multiple vitamins including thiamine and folic acid. Some clinicians recommend benzodiazepines sometimes in high doses; others argue in favour of antipsychotic drugs such as haloperidol, but the latter group of medication might actually lower the seizure threshold.

The routine administration of phenytoin is not necessary. However, patients with a history of pre-existing convulsive disorder unrelated to alcoholism should be continued on anticonvulsive medication during withdrawal or started on anticonvulsive regimen. (50 Magnesium sulfate is indicated if the patient has had a recent seizure or has a history of previous seizures. (4)

OPIOIDS

Signs and symptoms

Even though there is a lot of variability, some generalizations can be made for heroin and morphine. In the case of methadone, the development of symptoms is slower, the clinical picture is less intense and the persistence of acute problems could last for more than three weeks. Dilated pupils are small during withdrawal; there are muscle twitching and only mild gastrointestinal complaints. With codeine there is a tendency to have only mild symptoms. (1)

The usual heroin or morphine withdrawal consists of physical discomfort, tearing of the eyes, runny nose, sweating and yawning. Within 12-14 hours, and peaking on the second or third day, the patient moves into a restless sleep and other symptoms begin to appear. Such as, dilated pupils, loss of appetite, gooseflesh, back pain and a tremor; insomnia, incessant yawning, a flu-like syndrome consisting of weakness, gastrointestinal upset, chills and flushing, muscle spasm, ejaculation and abdominal pain. Other symptoms are restlessness, depression, weakness, nausea and vomiting and joint aches.

There are also very important psychological symptoms, among them a strong craving and emotional irritability.

Onset, evolution and critical periods
Signs and symptoms may appear after the sudden interruption of opioids, after one or two weeks or continued administration. The acute withdrawal usually begins at the time of the next dose, four to six hours for heroin and morphine, and a day or more for methadone. The intensity of the syndrome increases directly with the dose, duration of use and the time the dose is postponed, and inversely with the healthiness of the abuser.

The physical discomfort begins within the first 12 hours and in the acute phases of withdrawal, gets to the peak on the second or third day, the syndrome decreases in intensity and is usually greatly reduced by the fifth day, disappearing in one week to ten days.

Management
A good medical examination is the first step. There should be a physician-patient rapport and an estimation of the probable degree of dependence. The patient should be aware of the symptoms he can expect and that they cannot be totally eliminated.

One treatment approach begins with the administration of an opiate to the point at which symptoms are greatly reduced, after which the drug dose is slowly decreased over a period of 5-14 days. Oral methadone is recommended, and 1 mg of methadone roughly equals 2 mg of heroin or 20 mg of meperidine. Most addicts have some comfort at doses of 20 mg of methadone the first day. The necessary drug is then divided into twice daily doses, with daily decreases of 10-20 percent of the first day's dose, depending on the development of symptomatology. (1)

An alternate approach is to administer 10 mg of methadone 1M and observe the effects. The patient should be re-examined in eight hours to estimate the amount of drug needed to control the symptoms in the first 24 hours. After which the doses can be given orally two or three times a day and decreased as described before. (1)

Another scheme is based on the use of clonidine, beginning with .2 mg PO stat., .1 mg PO Q4H (10 doses)., .1 mg PO Q6H (four doses), and then slowly diminish the dose in six or more days.

CANNABIS

It is not certain whether any form of withdrawal of critical significance occurs with marijuana and hashish. If symptoms develop, the picture can be expected to be limited and to clear with time alone. (1)

Signs and symptoms
The signs and symptoms that have been described as a cannabis withdrawal syndrome are: nausea, loss of appetite, moderate anxiety, increase in REM, insomnia, moderate elevation of temperature. (1) Other authors add to the preceding: irritability, restlessness, sweating, vomiting, diarrhoea and loss of weight. (7)

HYPNOTICS

The patient usually develops a fine tremor, gastrointestinal upset, muscle aches, and problems of the autonomic nervous system, (eg. increased pulse and respiration rates, a fever and a labile blood pressure).

Others are nausea and vomiting, weakness, irritability, agitation, restlessness, dysphoria, depression, perceptual changes and insomnia. Atypical syndromes may include headache, malaise, and abrupt weight loss. Especially with barbiturates, between 5 and 20 percent of individuals will develop grand mal convulsions, in which cases it is a major withdrawal syndrome. They usually appear between the second and the third day, but they can still happen in the seventh or eighth day. There are also moderate to high levels of anxiety and a strong drive to obtain the drug. Between 5 and 15 percent of individuals develop an organic brain syndrome and/or hallucination-delirium state.

Onset, evolution and critical periods

The depressant withdrawal syndrome consists of a constellation of symptoms that might develop in an individual taking any of these drugs daily in excessive doses. The clinical picture is usually a mixture of any or all the possible symptoms, running a time-course that tends to last 3-7 days for the short-acting drugs, but may be longer for longer-acting drugs like diazepam (7-10 days). There is evidence that when administration of benzodiazepines is continued for more than a month or so, even at doses in the therapeutic range, mild but disturbing withdrawal symptoms are likely to be seen. Physical withdrawal has been reported with diazepam in clinical dose ranges (eg. 10-20 mg/day), as well as alprazolam or lorazepam (4mg/day or less) when taken over a period of weeks to months. When two to three times the normal maximal doses are ingested, physical dependence can probably be included in a matter of days to weeks. The syndrome begins slowly over a period of hours and may not peak until day two or three for alcohol and day seven for short to intermediate-half-life Bz's. The symptoms begin within a half day of stopping or decreasing the medications, a peak intensity at 24-72 hours, and disappearance of acute symptoms some time before day seven. The time course of withdrawal is probably a good deal longer for the longer acting barbiturates and the anti-anxiety drugs. Such as chlordiazepoxide (Librium), for which it has been reported that seizures and delirium can begin as late as day seven or eight, and last for 7 to 14 days. Secondary abstinence symptoms of lesser severity may continue for months.

Severe and prolonged depressive illness following benzodiazepine withdrawal has been reported, as well as severe delusional depression during the syndrome. (3)

Management

An adequate physical examination and all baseline laboratory tests should be carried out. General supportive car care should be instituted and the safest approach is to place the patient in a hospital setting, due to the possibility of convulsions. The patient should be provided with good nutrition, rest and multivitamins. Treatment of withdrawal itself comprises the following steps: The pentobarbital method (for short to intermediate-acting barbiturates) consists of a test close of 200 mg. If the patient falls asleep, no further treatment is needed. If no reaction, repeat dose every two hours in order to determine dose for 24 hours. Give the drug in divided doses (QID) through the day, stabilize for two days and decrease by 100 mg/day. The Phenobarbital method consists of 32 mg of Phenobarbital for each 100 mg of estimated abused barbiturate (eg. pentobarbital or equivalent). For each 250 mg of a drug like glutethimide (doriden), for each 400 mg of meprobamate (equanil), for each 5 mg of diazepam (valium), or for each 25 mg of chlordiazepoxide (Librium). Stabilize for two days, give QID and decrease by 30 mg/day. If needed, Phenobarbital can be used intravenously. If the patient demonstrates signs of withdrawal, extra doses should be given. If the patient looks sleepy or confused, the next dose should be withheld until he clears. Other authors suggest that one might use the drug of abuse itself as an appropriate withdrawal agent, gradually tapering the doses over an approximate eight-week period. (1)

COCAINE

Signs and symptoms

In the early phase, the abuser experiences intense agitation, feelings of depression (which can be of substantial nature), a decrease in appetite that then gives way to fatigue with associated insomnia, continued depression, and a decrease in craving. All of which result in a final experience of exhaustion, a rebound in appetite, and a need to sleep. In the second phase sleep patterns begin to normalize, the craving is relatively low, and the mood is fairly normal, but this soon progresses into a recurrence of fatigue, anxiety, and associated anhedonia.

Onset, evolution and critical periods

The withdrawal syndrome may begin insidiously, with the patient having no idea why he is depressed, lethargic, or irritable, or it may have a more dramatic onset. During the first 9 hours to 14 days, the craving is intense and so is the cocaine-seeking behaviour. This acute phase is followed over the next 1-10 weeks of withdrawal. Usually symptoms peak between the second and the fourth day, but depression and irritability can last several months. (1)

Management

Treatment is simply addressing the symptoms, as the acute syndrome tends to dissipate within days on its own. It is recommended to carry out withdrawal in an in-patient setting in order to offer maximal support, but there are also out-patient approaches. To begin with, there should be a careful neurological and physical examination. The clinician should look for concomitant use of other drugs. A history of the drug abuse pattern and prior psychiatric disorders must be obtained. The patient should be placed in quiet surroundings and allowed to sleep. Preliminary reports suggest that the use of bromocriptine 0.625 and 2.5 mg per day in divided doses may result in diminution of depression, sleep disturbance, and loss of energy, and is likely to report reduced craving for cocaine. (1) The use of hydroxyzine is recommended to control anxiety, from 300 mg/day down to 50 mg/day on the fifth or sixth day.

OTHER STIMULANTS

Signs and symptoms

As for cocaine abusers, there is usually no specific pathology present, other than the usual type of medical problems seen in any abuser. The withdrawal syndrome is similar to that of cocaine, with an early phase of agitation, depression and loss of appetite, followed by fatigue, insomnia or hypersomnia, depression, irritability and a decrease in craving, and then exhaustion, a rebound in appetite, and a need to sleep. There can also be paranoid and suicide ideas. Withdrawal effects are highly variable from person to person; some patients show severe transitory depression or paranoia, while others do not. Stimulation of the cardiovascular system may provoke headache, tachycardia, palpitations, and even cardiac arrhythmias. Both hypertension and hypotension have been reported. Excessive sweating may occur. Abdominal cramps, nausea and vomiting, and diarrhoea have been reported. (4) The caffeine withdrawal syndrome resembles an anxiety neurosis; restlessness, irritability, headaches and agitation. (7)

Onset, evolution and critical periods

The withdrawal syndrome can begin while the individual continues to take stimulants as tolerance develops, and it may include a variety of non specific muscular aches and pains. The same characteristics of cocaine withdrawal apply for amphetamines and other CNS stimulants. The symptomatology peaks between the second and fourth day and usually resolves without any medication. Depression and irritability can last several months.

Management
The same measures taken for cocaine apply for other stimulants. In general, allowing the person several days to recover and having him sleep and eat as much as he needs to will usually result in the diminution of all symptoms. (1)

HALLUCINOGENS

No clinically significant withdrawal picture is known for the hallucinogens. (1) Drugs like LSD, PCP and mescaline, which have 'psychedelic' or hallucinogenic effects, produce more than toxicological emergencies, both during intake and after sudden withdrawal. (6)

Signs and symptoms
Some authors have reported a clinical picture similar to the alcohol or opioid withdrawal. (1) In the case of PCP, whenever a withdrawal syndrome appears, it is relatively mild; tremor, facial muscle contracture (tics) and feelings of anxiety and fear.

Management
Quiet reassurance is very effective, better if provided by friends or relatives. An accurate history of the drugs ingested should be taken, a complete physical examination and a close control of vital signs. If medication is necessary, give diazepam 920 mg p.o. or 10 mg iv) or haloperidol (2.5 mg p.o.or i.m). Repeat every one to two hours if required. (6) Other authors recommend tricyclic antidepressants such as desipramine; 50-100 mg as the initial dose, and down in two weeks. (1)

INHALANTS (volatile substance abuse)

No clinical relevant withdrawal syndrome from solvents has been described. (1) Occasionally, the chronic abusers of toluene have experienced severe symptoms very similar to those of delirium tremens in alcoholics; anxiety, agitation and intense fear.

MULTIPLE DRUG USE

The most common withdrawal pictures are those seen following the concomitant abuse of multiple depressants, depressants and stimulants, or multiple addictions to opiates and depressant drugs. (1)

Signs and symptoms
The withdrawal from depressants and stimulants more closely follows the CNS-depressant withdrawal paradigm, but probably includes greater levels of sadness, paranoia, and lethargy than would be expected with depressants alone. The withdrawal from depressants and opiates usually demonstrates an opiate type syndrome, along with heightened levels of insomnia and anxiety and a depressant related risk for convulsions and confusion. (1)

Onset, evolution and critical periods
A higher incidence of convulsions is seen with benzodiazepines or barbiturates than with alcohol. The range of onset and the length of the acute withdrawal roughly parallel the half-life of the drugs. (1)

Management

It is probably safer to treat withdrawal from the longer-acting drug most aggressively, assuming that the second depressant will be adequately 'taken care of'. The guidelines mentioned for hypnotics are valid for multiple depressants. When we are facing a withdrawal syndrome of depressants and stimulants, we have to pay special attention to the depressant syndrome, since it is the one that produces the greatest discomfort and is the most life threatening. In the case of addiction to depressants and opiates, it is advisable to administer both an opiate and a CNS depressant until the symptoms have been abolished or greatly decreased. Most authors then recommend stabilization with the opiate, while the depressant is withdrawn at 10 percent a day. After the depressant withdrawal is completed, opiate withdrawal can then proceed. As a general principle, if two or more drugs have been significantly abused, it is recommended to withdraw one at a time, the first being the one that potentially represent the most problems. There are no firm rules to cover all eventualities.

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INTRODUCTION

Psychiatric disorder may be the initial presentation and reason for referral of a person who is abusing drugs. Sometimes, however, psychiatric co-morbidity in drug abuse can be ascertained only after a careful psychiatric examination and or laboratory investigations. The diagnosis may be missed particularly if the symptoms are less severe or there is no concomitant gross abnormal behavior. Similarly, drug abuse may be missed in patients suffering from psychiatric disabilities. In the United Kingdom, in a psychiatric emergency clinic, Jones (1979) found a high rate of missed diagnosis of alcoholism amongst patients subsequently admitted. In the developing countries with limited resources, many such cases may be missed or not seen at all.

The physical disability that complicates the abuse of drugs can be readily appreciated. However, the psychiatric complications usually tend to be a source of debate as to whether psychiatric co-morbidity is a cause or effect of the drug abused. Some believe that drug abuse is symptomatic; for example, that alcoholism is symptomatic (Freed 1970) and therefore treat the patients for the diagnosed primary condition. Others postulate an underlying biological basis. Winokur, et al, hypothesized a generic entity depressive spectrum disease which express itself as early onset depression in women and alcoholism in men. Kraus (1981) wrote that where juvenile delinquency and drug abuse coexist, the former precedes the later. Though anxiety and phobic systems are common in alcoholics, it is not clear whether neurotic illness and high neuroticism predispose to alcohol abuse. Mullan, et al (1986) suggest that clinically neurotic illness and high neuroticism are more often a consequence than cause of alcoholism.

If psychiatric co-morbidity is secondary to drugs abused then the pharmacological properties of the drugs should cause direct psychiatric condition or their effect on social functioning should be so negative as to lead to psychiatric problems. The latter is somewhat true in chronic drug users incapacitated physically or socially as to affect their self esteem and cause a severe psychiatric illness like depression.

According to the particular drug, its pattern of use, and the personal and social characteristics of the drug-taker and the society in which he/she exists, psychiatric manifestations may or may not be present, and may or may not be identified. Sometimes mention is made of predisposition to psychiatric illness where it is believed that the person has some vulnerability to become mentally ill and that psychiatric illness is made manifest by the use of drugs.

Bell and Champion (1979) wrote that drug abuse both licit and illicit was more extensive among those who suffered parental depression, psychiatric illness and those who had committed antisocial acts.

It may be important to know whether the psychiatric co-morbidity is primary or secondary; however, it can be extremely difficult sometimes to make this distinction. Once the person with a psychiatric disorder abuse drugs, problems related to the abuse becomes more dominant and may affect his or her social behavior. From clinical experience, many acute psychiatric systems resulting from the use drugs may disappear when the use of the offensive drug is stopped.

PRIMARY PSYCHOLOGICAL/PSYCHIATRIC CONDITION AND DRUG ABUSE

Low self-esteem has been implicated as etiological or contributory factor in depression (Beck. 1967), drug abuse (Brehm & Back, 1968) and alcohol abuse (McCord & McCord 1960) Depressive illness is considered as a primary cause for many types of drug abuse. The brief alteration of depressed mood for happiness by some drugs, and the feeling of being on top of the world will influence some people with depressive conditions to use drugs.

Many authors have discussed the relationship between alcohol dependence and depression. Schuckit, et al, (1969) indicated that there is a close relationship between these two diseases in a certain proportion of female alcoholics. Weissman, et al, (1980) observed that some alcohol dependent patients had a history of depression. Winokur, et al, (1970) reported that a certain percentage of relatives of alcohol dependent people themselves presented with depression. However, Schlesser, with Winokur (1980) reported, using the dexamethazone suppression test, that depression observed among the relatives of alcoholics was not primary affective disorder. At the time researchers then became more doubtful about the link between primary affective disorder and alcoholism.

Meanwhile, some researchers insisted that a relationship exists between antisocial personality and alcohol dependence. Some insist that antisocial personality is a baseline characteristic of an alcoholic personality (McCord, W. et al, 1962). Nevertheless, after observing boys that came from a confused family situation which included an alcoholic father in a pathological role, this finding is believed to warrant further research. In recent times, more refined studies have revealed that the relationship between antisocial personality and alcohol dependence is so clear. In an investigation of college freshmen, Kammeier, et al (1973) found that those students who went on the become alcoholic had, at college, notable levels of high impulsivity, were clearly rebellious against authority figures, and tended to form a clique. However, they could not be defined as' antisocial'. Cadoret, et al (1987) investigated adoptees, some of whose biological fathers were antisocial, and some alcoholic. They concluded that there are two different cross-generational routes for these two clinical disorders (alcoholism and antisocial personality disorder).

With respect to the pre-morbid features alcoholism, some researchers have pointed out the importance of the hyperactive tendency among some children of alcoholics. Begleiter, et al (1984) disorder frontal lobe dysfunction in sons of alcoholics. Schuckit (1989) suggest some biochemical hypothesis, indicating some vulnerability among alcoholics' sons. To date, there is no definite conclusion concerning the presence of genetic markers of either alcoholism or drug abuse.

As to the relationship between alcohol dependence and schizophrenia, Free (1975) reviewed several reports concerning the overlay of these two diseases, and found that the ratio varies from 6 to 63 percent. This continues to be a difficult problem in determining treatment guidelines.

Social phobia manifesting in over-shyness and inability to talk in public may be the primary cause of drug abuse. Drugs are used in these situations as reinforcers. Mullaney and Trippett (1979) wrote that the more common sequence is for the development of phobia some years before the attachment of alcohol problems. Reich, et al (1974) found that almost half of their manic in-patient group had consumed alcohol prior to admission. They thought that patients had used alcohol to diminish symptoms. However they did not rule out the possibility of alcohol precipitating mania in most of the cases.

SOME COMMON DRUGS ABUSED AND PSYCHIATRIC COMPLICATIONS

There are many types of psychiatric disturbances associated with the abuse of drugs. Acute confusional states, schizophrenic-like psychoses, neurotic symptoms, depression and dementia have been encountered. However, with the exception of a few syndromes like delirium tremens and alcoholic hallucinosis, there are no specific psychiatric conditions related to a particular drug abuse. However, some drugs may provoke a variety of psychiatric conditions. Coexisting psychiatric disorder may determine treatment programme and prognosis.

ABUSE OF AMPHETAMINE AND ITS DERIVATIVES

Drug abusers who have consumed heavy doses of amphetamines and amphetamines-like drugs on a regular basis tend to develop a psychosis. The psychosis manifests usually as idea of reference, delusions of persecution, auditory and visual hallucinations (Connell, 1958). The psychotic episode is schizophrenic-like. Acute episodes are characterized by excitement, restlessness, over-activity and outbursts of aggressiveness. Chronic users may present with depressive illness. Apathy, lethargy, anxiety and sleep disturbances may be observed.

COCAINE

Cocaine can cause paranoid psychosis. In practice, conditions similar to hypomania have been observed characterized by symptoms like euphoria, feeling of confidence, grandiose and talkativeness. Anorexia, apathy and profound withdrawal from society mimicking depressive illness have been reported in chronic users. Tactile hallucinations 'cocaine bug' may be associated with chronic cocaine abuse.

Delirium may occur. The essential features of delirium are reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli, and disorganized thinking. The syndrome also involves a reduced level of consciousness, sensory misperception, disturbances of the sleep-wake cycle and level of psychomotor activity, disorientation to time, place or person, and memory impairment. The onset is relatively rapid, and the course typically fluctuates. The total duration is usually brief. Perceptual disturbances are common and result in various misinterpretations, illusions and hallucinations.

The sleep-wake cycle is almost invariably disturbed and vivid dreams and nightmares are common and may merge with hallucinations. Disorientation to time and place is common; disorientation to person is uncommon. A memory disturbance, particularly of recent memory, is commonly present.

HALLUCINOGENIC DRUGS

These drugs have as their main property, the ability to reduce severe perceptual disturbances. LSD (lysergic acid diethylamide), psilocybin and mescaline are among this group.

Acute episodes may manifest as delirium, feeling of altered manifesting as depersonalization and derealization, hallucinations and bizarre changes in quality of perception.

Chronic users may present with emotional changes ranging from euphoria to a profound feeling of despair, anxiety or doom. Schizophrenic-like reactions may be present but are self-limiting. Severe depression has been thought to be the cause of homicidal and suicidal behavior.

FLASHBACK

This is a phenomenon, which is found in chronic LSD users who stop using the drug. It has also been found that other drugs trigger flashbacks.

Feeling of paranoia, unreality and estrangement are often experienced in the flashbacks along distorted visual perceptions. Flashbacks are episodic and can last from a few minutes to several hours. Three kinds of flashbacks have been described; perceptual, somatic and emotional.

- The perceptual type involves visual and auditory experiences similar to the original experience.
- Somatic type involves experiencing tingling sensations. Palpitation, etc.
- Emotional type involves reliving of depressive, anxious or otherwise emotional thoughts that might have been triggered by the initial use of the drugs.

The persistent feeling of fear, remorse, loneliness or other emotions that occur may lead to extreme depression or suicide.

Differential diagnosis – depressive illness, schizophrenia, anxiety neurosis.

TOLUENE AND OTHER SOLVENTS INCLUDING ADHESIVES AND PETROL SNIFFING

Press and Done (1967), wrote that the effects of solvent abuse are greater than those of alcohol and closer to the effect of LSD. Lawton and Malmquist reported hallucinations in petrol sniffers. Evans and Raistick (1987), reported that the various clinical features of solvent intoxication are similar to alcohol intoxication with initial stimulation followed by depression. Euphoria, feeling of omnipotence, impaired judgment and visual hallucinations may occur.

Acute cases may present with delirious states with clouding of consciousness. Chronic users may have a toxic psychosis with affective components (Skuse and Burrel, 1982).

Toluene, like alcohol and other related substances produces an excitatory effect on the central nervous system, followed by depressive state. Features of acute intoxication include physical symptoms like coughing, nausea and vomiting, diarrhoea, diffuse pains, tremor and epileptic seizures. Visual and less commonly auditory hallucinations may occur.

Zur (1983) found depression to be significantly common in toluene abusers than in young delinquents. Care, however, has to be taken not to confuse withdrawal symptoms with depressive illness. Hypomania and schizophrenia have to be excluded.

CANNABIS SATIVA

There is some evidence that cannabis can give rise to an acute but short-lived psychotic illness, Weil (1970), Meyer (1976), Edwards (1982). In practice acute psychosis among chronic users of cannabis without previous history of psychiatric disturbance is common in those who use large amounts of the drug. There are cases of acute psychotic episodes manifesting after the use of cannabis.

Anxiety, suspiciousness and paranoid ideas with ideas of reference, persecutory delusions and auditory hallucinations have been observed in some users of cannabis (Thacore, (1975, 1976). The psychosis associated with cannabis abuse tends to be schizophrenic-like (Knight, 1976) Spencer 1971). The affected tend to demonstrate aggression, anxiety and other bizarre behaviours. Occasionally a picture similar to a toxic confusional state may be observed.

Cannabis Intoxication

Occasionally when cannabis is taken in unusual amounts or by naïve persons they may become overwhelmed by the experiences like fear of becoming 'mad', persecutory ideas and a feeling of loss of control. This feeling usually acts as an aversion to further cannabis abuse.

It is thought that this condition is dose related but small doses of cannabis may produce intoxication in individuals with certain organic conditions. Disinhibitions caused by some social events can also produce acute intoxication, following a small dose of cannabis. This condition is usually associated with aggressive outburst and agitation.

Amotivational Syndrome

This syndrome which is not accepted by some workers is characterized by progressive loss of energy and drive, apathy, inactivity and self-neglect. This syndrome represents the effect of chronic use of certain drugs including cannabis. Memory impairment and poverty of ideas may form part of the condition. Differential diagnosis cannabis-related psychotic problems include schizophrenia and mania.

ALCOHOL ABUSE

Alcohol abuse produces a variety of psychiatric problems. Below are some of the complications:

Pathological Intoxication

This condition manifests as a sudden outburst of violent behaviour after using relatively small quantities of alcohol. This behaviour is out of keeping with the personality of the affected person.

Alcohol Withdrawal Phenomena

Alcohol withdrawal phenomena occur when the blood level of alcohol falls in an alcohol dependent person. The onset and duration are dose-related. They are usually relieved by further alcohol use by the alcohol abuser. Symptoms include tremors of the whole body, face and hands. Panic, guilt, depression, nausea and visual hallucination may be expressed. This presents as an acute condition which requires early intervention.

Delirium Tremens
It occurs in long-term heavy drinkers who abstain abruptly. Occasionally, it may occur in episodes of heavy drinking. Symptoms include clouding of consciousness, confusion, tremors, vivid hallucinations and illusions affecting all sensory modalities. Autonomic overactivity may be observed. It usually presents as an acute medical or psychiatric emergency requiring prompt attention.

Alcoholic Hallucinations
This condition occurs during or after alcohol abuse. It is characterized by vivid hallucinations, ideas of reference, and delusions of paranoid or persecutory type occurring in clear consciousness or mild clouding without confusion. This condition is short-lived and will usually resolve within six months of abstinence. Hallucinations may disappear on withdrawal from alcohol and reappear if drinking resumes. Differential diagnosis includes schizophrenia.

Affective Disorder
There is more evidence to show a two-way relationship. Depressive feeling or depressive illness can be the basis for drug-abuse (Winokur, et al, 1971). It should be noted however, that simple withdrawal states may have effective components. Social problems associated with alcohol abuse may plunge the affected into deep depression. Heavy drinking may precede attempted suicide (Patel, et al 1972). Excessive alcohol abuse may be used to mask a bipolar affective illness.

Anxiety States
Alcohol may be used to suppress anxiety symptoms. Alcohol, however, may induce phobic states in chronic users.

Pathological Jealousy
Pathological or morbid jealousy is a belief that a spouse is not faithful which can be delusional intensity. This state may form part of a functional psychosis or induced by a drug, particularly alcohol. It may occur in the abuse of drugs like amphetamine and cocaine. This condition is more common in men than in women.

Sedatives or Hypnotics
These drugs rarely present with psychiatric co-morbidity except in acute chronic intoxication and withdrawal which have been dealt with elsewhere.

Chronic use of barbiturates may present with sluggishness difficulties in thinking, slowness of speech and comprehension. Defective judgment, emotional lability and reduced attention span may accompany chronic use.

These drugs are commonly used in parasuicide and suicidal behaviour. It is important to exclude depressive illness in users.

Opiates
These substances also rarely present with psychiatric conditions unless in chronic intoxication and withdrawal. Severe depressive illness resulting in suicide has been found in chronic opiate user.

MANAGEMENT

In management of psychiatric co-morbidity, careful and detailed clinical history and mental state examination are required. Attention should be given to physical and social complications which by themselves can cause or complicate psychiatry co-morbidity.

The psychiatric and physical examinations should be supported by laboratory investigations. It is therefore desirable that laboratory facilities be available for simple urine or blood screening tested for drug abuse.

Treatment Setting

It has to be decided whether treatment can be carried out at home, out-patients' departments, self-help group, general hospital or in specialist units. Motivation, for treatment and abstinence, severity for the condition, adequate social support and presence of physical complications are factors to be considered in selecting treatment setting.

Treatment

Management of intoxication, withdrawal and dependence are provided elsewhere. Treatment of psychiatric co-morbidity involves largely pharmacological intervention for psychotic and other severe psychiatric conditions in the short term. There is a wide range of anti-psychotic drugs, anti-depressants and minor tranquilizers which can be used. For psychotic conditions, drugs like chlorpromazine, thioridazine, trifluoperazine, haloperidol, fluphenazine are useful.

Tricyclic anti-depressants like imipramine and amitriptyline, are also used for depressive conditions. Lithium carbonate is used for bipolar and unipolar affective psychosis. Minor tranquilizers like diazepam, clordiazepoxide and lorazepam are useful for anxiety states and mild neurotic conditions. However, they should be used with care so as not to cause dependency.

Some psychiatric complications of drug abuse will disappear a couple of days or weeks after the person had stopped using the drugs.

It is important that other measures are put in place to maintain abstinence. Social group support, counselling behavioural techniques and skilled psychotherapy may be applied.

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