

ASSESSING STANDARDS OF CARE FOR THE TREATMENT AND REHABILITATION OF SUBSTANCE ABUSERS IN THE CARIBBEAN

*Guidelines and criteria for the
development of programmes to
assess standards of care in the
treatment of substance abusers*

FUNDS FOR THE DEVELOPMENT OF THIS MANUAL WERE DERIVED FROM THE 9TH EUROPEAN DEVELOPMENT FUND.

ACKNOWLEDGEMENT

It has become clear that the development of standards and a regime for assessment is necessary in the Caribbean. The knowledge of what is appropriate treatment and care and means of assessment has grown. However, this knowledge is not consistently applied across the spectrum of providers in this region.

This publication draws on seminal publications in the area of assessing standards of care while distilling the recommendations of CARICOM providers of treatment and care for substance abusers. We thank them all for their enthusiastic participation in the meeting convened in Montego Bay by the CARICOM Secretariat in Montego Bay. Then, we pursued ideas and reached substantial consensus through a process of discovery.

We acknowledge the contribution of all authors, editors and publishers of the two base documents on which this volume is built. These are **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). CARICOM also made available the document titled, **“Assessing the Standards of Care in Substance Abuse Treatment”** (WHO, 1994). This formed the basis for the major assessment section included in the document.

The feedback and background information provided by Dr. Marcus Day gave added value to the document. The contribution of other members of the Technical Advisory Body (TAB) to CARICOM was useful in setting the scope of the publication. We thank Dr. Anna Chisman of the OAS office in Washington for constructive and encouraging feedback.

We acknowledge the commitment of Beverley Reynolds of the CARICOM Secretariat who had the foresight to identify this opportunity for regional capacity building presented by the project. Arnulfo Kantum of the CARICOM Secretariat guided the process of accessing funding and coordinated the feedback and review process over the three (3) month period. The Executive Director of the National Council on Drug Abuse (NCDA), Michael Tucker, played a pivotal role in ensuring that the link between national and regional parties remained active and productive. The creative talent of Paulette Spencer Smith, Human Resources Manager of the NCDA, is evident in the design of this document. We hope that it becomes a useful guide for treatment providers, managers and policy makers who are involved in the treatment and care of substance abusers.

Ellen Campbell Grizzle, PhD, Director, Information and Research, NCDA. June 2009.

SCOPE OF THE DOCUMENT

The purpose of this publication is to develop and provide basic guidelines and criteria for the development of programmes to assess standards of care in the treatment of substance abusers in the CARICOM region.

This handbook is adapted from the *Standards of Care of the Treatment of Drug Dependence* prepared in 2000 by the Organization of American States/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.

According to Klein, Day, Harriott and Oppenheimer (2001), guidelines for “standards and care”, accompanied by a system of regular inspections to ensure high quality of care, are needed in all CARICOM members states. In the report by Klein et.al., submitted to and endorsed by the 5th Council on Human and Social Development (COHSOD), it was acknowledged that insufficient progress had been made in the provision of treatment and rehabilitation services by CARICOM member states. Additionally, the existing regime regulating facilities to oversee the existing, primarily residential, treatment and rehabilitation centres, was described as “rudimentary”.

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. Caribbean based demand reduction specialists have expressed the need for standards to govern treatment and rehabilitation facilities and services. In seeking to address this problem, the CARICOM Secretariat determined that a handbook would be a useful tool to guide the fledgling but diverse treatment and rehabilitation sector in the region. This handbook should contain a set of standards that are relevant and appropriate for CARICOM countries and which complies with international standards for safety and efficacy. CARICOM demand reduction experts have agreed that, prior to the anticipated increase in treatment and rehabilitation services across the Caribbean, it was an opportune time to generate a handbook.

GLOSSARY OF TERMS

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.”

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.

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).

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."

RECREATIONAL USE

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

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."

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 neuroadaptation 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."

DELIRIUM TREMENS

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

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."

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."

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."

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."

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."

RELAPSE

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

TABLE OF CONTENTS

| | |
|--|-----------|
| ACKNOWLEDGEMENTS | 2 |
| SCOPE OF THE DOCUMENT | 3 |
| GLOSSARY OF TERMS | 4 |
| CHAPTER 1: THE TREATMENT OF PROBLEMS RELATED TO DRUG DEPENDENCE | 10 |
| 1.1 DRUG USE AND DEPENDENCE AS A PUBLIC HEALTH AND SOCIO-ECONOMIC PROBLEM..... | 10 |
| 1.2 HISTORICAL TRENDS IN DRUG USE AND TRAFFICKING IN THE REGION..... | 10 |
| 1.3 MODELS FOR THE TREATMENT OF DRUG DEPENDENCE..... | 12 |
| 1.4 THE ROLE OF GOVERNMENTS AND THE TREATMENT OF DRUG DEPENDENCE..... | 13 |
| CHAPTER 2 TOWARDS A CARIBBEAN STANDARDS OF CARE..... | 15 |
| 2.1 THE TIMING OF THERAPEUTIC INTERVENTION..... | 15 |
| 2.1.1 IMMEDIATE ATTENTION | 16 |
| 2.1.2 TREATMENT FOR DEPENDENCE | 16 |
| 2.1.3 MONITORING | 17 |
| 2.2 ACCESS TO TREATMENT | 17 |
| 2.2.1 ACCESSIBILITY..... | 17 |
| 2.2.2 AVAILABILITY OF SERVICES..... | 17 |
| 2.2.3 REFERRAL SOURCES:..... | 18 |
| 2.3 SERVICE USER PROFILE | 18 |
| MOTIVATION FOR SEEKING TREATMENT | 18 |
| 2.4 EVALUATION OF THE PATIENT..... | 19 |
| 2.4.1 NATURE AND ORGANIZATION OF TREATMENT PROVIDED: THERAPEUTIC SETTING..... | 19 |
| THE THERAPEUTIC TEAM..... | 23 |
| THE ECOLOGY..... | 24 |
| 2.5 PATIENT RIGHTS..... | 25 |
| 2.6 EXIT, MONITORING, AND REFERRAL OF CASES..... | 26 |
| 2.7 EVALUATING TREATMENT..... | 26 |
| 2.8 EVALUATING EFFECTIVENESS..... | 26 |

| | |
|---|------------|
| 2.9 ECONOMIC EVALUATION | 27 |
| 2.10 PHYSICAL INFRASTRUCTURE OF TREATMENT FACILITIES | 28 |
| CHAPTER 3: DEVELOPMENT OF A PROGRAMME FOR ASSESSING STANDARDS OF CARE IN THE TREATMENT OF DRUG DEPENDENCE | 30 |
| 3.1 ADVANTAGES OF A SYSTEM FOR MONITORING STANDARDS OF CARE AND TREATMENT OF DRUG DEPENDENCE | 30 |
| 3.2 PHASE I: PREPARATION..... | 31 |
| 3.3 PHASE II: MOTIVATION AND COMMITMENT..... | 32 |
| 3.4 PHASE III:ASSESSMENT OF THE TREATMENT AND CARE PROVIDED..... | 32 |
| CHAPTER 4: INSTRUMENT FOR ASSESSING THE STANDARDS OF CARE IN SUBSTANCE ABUSE TREATMENT | 36 |
| 4. 1 INSTRUMENT FOR ASSESSING THE STANDARDS OF CARE IN SUBSTANCE ABUSE TREATMENT (WORLD HEALTH ORGANIZATION, 1994, ABRIDGED). | 36 |
| APPLICATION METHODOLOGY | 38 |
| ASSESSMENT TOOL | 40 |
| APPENDIX | I |
| 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) | I |
| ANNEX 11- CARIBBEAN COOPERATION IN HEALTH..... | II |
| ANNEX 111- INTERNATIONAL DECLARATIONS | VII |
| UNIVERSAL DECLARATION OF HUMAN RIGHTS | VII |
| AVOIDANCE OF DISCRIMINATION | XII |
| ANNEX 1V - SAMPLE INSTRUMENT OF DISCOVERY USED IN ADAPTATION OF THESE STANDARDS | XV |
| ANNEX V- DRAFT STANDARDS FOR NON GOVERNMENTAL ORGANIZATIONS PROVIDING SERVICES AFFECTED BY ALCOHOL AND OTHER DRUGS OF ABUSE (TRINIDAD AND TOBAGO)..... | XXII |
| ANNEX V1- SAMPLE INSTRUMENT FOR CENTERS PROVIDING STREET/COMMUNITY BASED INTERVENTION PROGRAMMES (SCBIP) – KOHLER/DAY (2000)..... | XXVIII |
| ANNEX V11 – STANDARDS FOR THE TREATMENT OF SUNSTANCE USE CONDITIONS:EVIDENCE-BASED TREATMENT PRACTICES (NATIONAL QUALITY FORUM (NQF) 2007 | XLIII |
| ANNEX V111- INTOXICATION AND OVERDOSE | XLV |
| ANNEX 1x – PSYCHIATRIC COMORBIDTY OF DRUG ABUSE | LIX |
| ANNEX – LIST OF DELEGATES - REGIONAL WORKSHOP ON STANDARDS OF CARE AND TREATMENT FOR REHABILITATION FACILITIES FOR SUBSTANCE ABUSE, MONTEGO BAY, JAMAICA..... | LXXII |

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.

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 UNODC report (2001) estimated that 60% of these drugs land in the region enroute 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, weather East Indian of 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 transshipment 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 transshipment 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 nongovernmental 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. Though 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.

References:

Archer, C. (2003). Bahamian alcoholism and other drugs, 1955-2003. Nassau, Bahamas: COLMAR Publications

Griffith, I. L. (2004). Caribbean security in the age of terror . (pp.117-175). Kingston, Jamaica: Ian Randle.

Platzer, M., Mirella, F. & Nestares, C. R. (2004) Illicit Drug Markets in the Caribbean.
In A. Klein, M. Day, A. Harriott. (Eds.), Caribbean drugs: from criminalization to harm reduction (pp. 189-223). Kingston, Jamaica: Ian Randle

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.

United Nations Office on Drugs and Crime. (2001). World Report. Vienna: Author

CHAPTER 2



TOWARD A CARIBBEAN STANDARDS OF CARE

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:

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

This refers to all procedures or interventions whose objectives are:

- 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 comorbidity
- Somatic comorbidity
- Chronic disabilities

2.4 .1 NATURE AND ORGANIZATION OF TREATMENT PROVIDED: THERAPEUTIC SETTING

Treatment starts from the time the drug user arrives at a care providing institution, whether it be 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).
- 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

- Socio cultural: approach consisting of interventions designed to modify the user's socio cultural 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 abstinence, 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**
 - Outpatient.- 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 extrainstitutional activities, generally in the 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 a 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.

Sociodemographic and epidemiological aspects

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

Providing integrated treatment, through an interprogrammatic 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 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 "nonintervention", 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, are 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.

Source: 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:

- The 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 centers** 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 V11 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.

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 -- have developed a methodology 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 nongovernmental 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 that 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

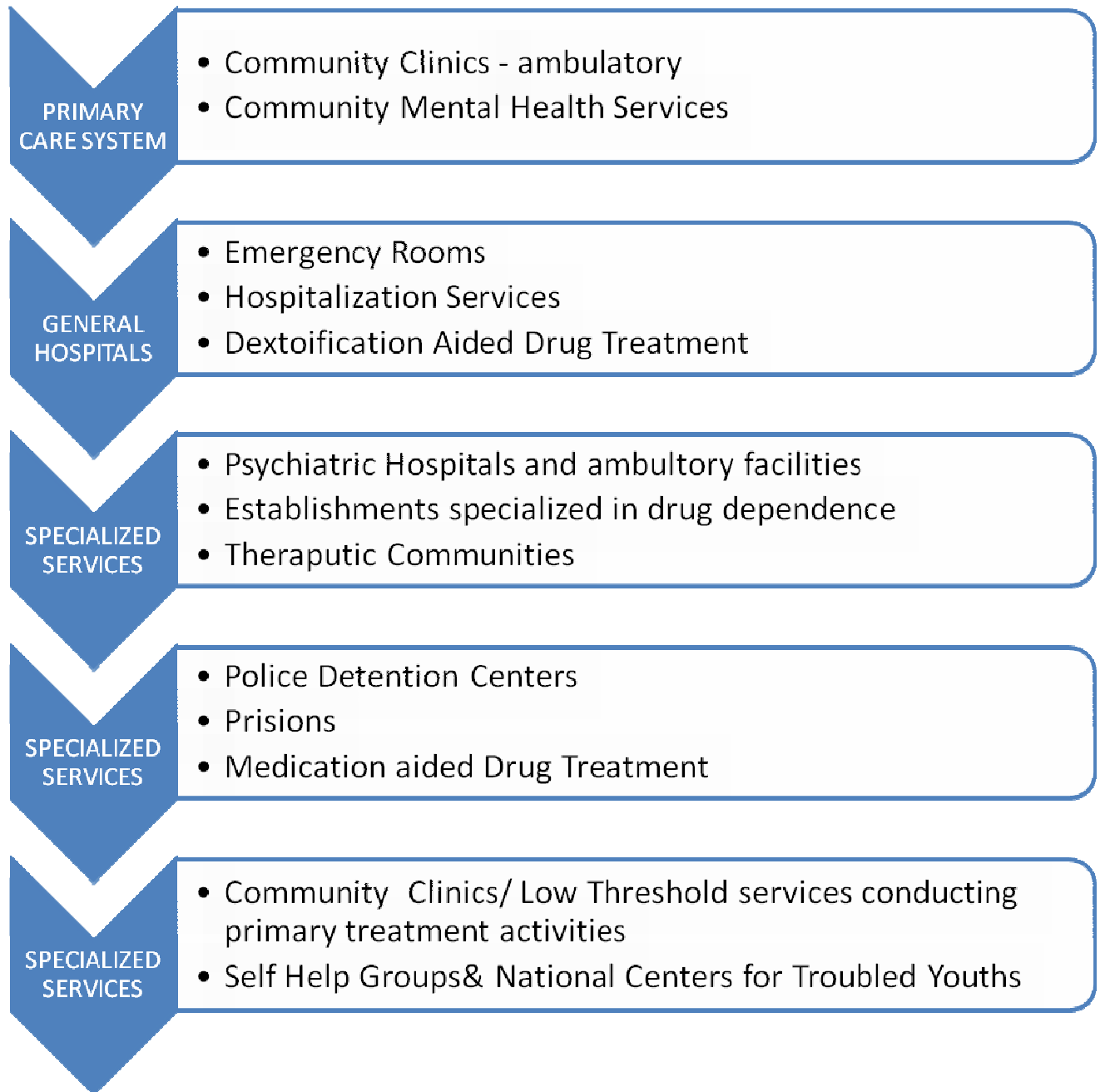
Responsibility for developing and applying the evaluation program must be defined in the legal framework, specifying the role to be played by the various sectors, and in particular health, justice, public prosecution, and commissions against drug use.

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.

Figure 1. Spectrum of services to be considered in national assessments.



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:

- 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 comorbidity
- Psychiatric comorbidity
- Psychosocial comorbidity

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

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

In a 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 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, and 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) | | | | | | | <i>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</i> | | | | | | | | | | | |
|--|--|--------------------------------|-------------------------------|-----------------------------------|-------------------------------------|---------------------------------------|----------------|---|----------|---------|---------|----------|---------|---------|----------|---------|---------|----------|--|
| 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 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 2. Scheduled services are obtainable without restrictions on time or day | E AM | AV I | NI NM | E AM | AV I | NI NM | NOT APPLICABLE | | | | | | | | | | | | |
| A 3. Necessary treatment is available without delay(s) which might leave to worsening of the condition | 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 4. A variety of treatment modalities and therapeutic options are available (in-patient, outpatient and daily 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 | |
| A 5. Care is available without the need for routine laboratory tests, for instance for the detection of 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 | |

| 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) | | | | | | | | | | | | | | | | | | | <i>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</i> | | |
|---|--|----------------------------------|----|----|--------------------------------|----|----|-------------------------------|----|----|-----------------------------------|----|----|-------------------------------------|----|----|---------------------------------------|----|----|---|----|--|
| 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 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 | E | AV | NI | |
| | AM | I | NM | 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, or political, or religious beliefs. | E | AV | NI | 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 | 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 | E | AV | NI | |
| | AM | I | NM | 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 | E | AV | NI | |
| | AM | I | NM | AM | I | NM | AM | I | NM | AM | I | NM | AM | I | NM | AM | I | NM | AM | I | NM | |
| A 10. Care is available, as established by programme guidelines, irrespective of a patient's other physical or psychiatric conditions (including HIV) | E | AV | NI | 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 | AM | I | 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 | E | AV | NI | 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 | 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) | | | | | | | | | | | | | | | | | | | <i>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</i> |
|---|--|----|----|--------------------------------|----|----|-------------------------------|----|----|-----------------------------------|----|----|-------------------------------------|----|----|---------------------------------------|----|----|--|---|
| 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 | | | | |
| use of drugs). | | | | | | | | | | | | | | | | | | | | |
| A 12. Care is available irrespective of the patient's financial means or professional or socioeconomic situation. | 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 13. Care is available in guarded environments (e.g. police cells, prisons). | 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 14. Care is available whether or not patients continue to use drugs. | 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 | AM | I | NM | | |
| A 15. Care is available irrespective of the patient's treatment history. | 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 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 | | |
| | AM | I | NM | AM | I | NM | AM | I | NM | AM | I | NM | AM | I | NM | AM | I | NM | | |

B. STANDARDS ON 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) | | | | | | | | <i>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</i> | | | | | | | | | | |
|---|--|----------------------------------|--------------------------------|-------------------------------|-----------------------------------|-------------------------------------|---------------------------------------|----|---|----|----|----|----|----|----|----|----|----|--|
| 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 | 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 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 | | | | |
| B 8. Laboratory tests are used to determine biochemical and metabolic alterations associated with the psychiatric co morbidity. | 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 | | | | |
| B 9. There are methods to determine the quantities of absorbed substances. | E | AV | NI | 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 | AM | I | 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 | 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 | | |
| B 11 Patients are evaluated using standardized instruments and procedures and an established classification system (e.g. the ICD-10). | E | AV | NI | E | AV | NI | E | AV | NI | E | AV | NI | E | AV | NI | NOT APPLICABLE | | | |
| | AM | I | NM | AM | I | NM | AM | I | NM | AM | I | NM | AM | I | NM | | | | |
| B 12. Registration of patients upon Admission is properly 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 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 | E | AV | NI | E | AV | NI | E | AV | NI | E | AV | NI | E | AV | NI | NOT APPLICABLE | | | |
| | 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 | | | | | |
| services; records are updated regularly (to the extent possible) to ensure the continuity of clinical care. | | | | | | | | | | | | | | | | | | | | | | |
| 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 | AV | NI | E | AV | NI | E | AV | NI | NOT APPLICABLE | | | E | AV | NI | NOT APPLICABLE | | | | | |
| | | AM | I | NM | AM | I | NM | AM | I | NM | | | | AM | I | NM | | | | | | |
| 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 | AV | NI | NOT APPLICABLE | | | E | AV | NI | NOT APPLICABLE | | | | | |
| | | | | | | | | AM | I | NM | | | | AM | I | NM | | | | | | |
| 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 | 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 | | |
| 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 AV NI | E AV NI | E AV NI | E AV NI | | |
| | | | AM I NM | AM I NM | AM I NM | AM I NM | | |
| C 6. The medical staff examines and modifies the treatments in contact with the patient to ensure effective 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 | | |
| 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 AV NI | E AV NI | E AV NI | E AV NI | E AV NI | NOT APPLICABLE | | |
| | AM I NM | AM I NM | AM I NM | AM I NM | AM I NM | | | |
| 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 | | |
| | AM I NM | AM I NM | AM I NM | AM I NM | AM I NM | AM I NM | | |
| 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 | | |

| 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 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 | | | | | | | | | | | | |
| | 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 | | | |
| 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 | | AM |
| 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 of 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 un prescribed 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 | |

| 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 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 | | |

| 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 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 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 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 | | 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 | | | |
| of treatment for intoxication and withdrawal syndrome are detected | | 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 | | 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 | | | |
| environments other than health services (e.g. the workplace, schools, etc.) | | 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 | |

| 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 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 | | |
| | AM | I | NM | AM | I | NM | AM | I | NM | AM | I | NM | AM | I | NM | AM | I | NM | | |

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 | |

| 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 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 |
| | 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 |
| | 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 |
| | 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 | E | AV | NI | E | AV | NI | E | AV | NI |
| | 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 | | | | | | | | | | | | | |
| detection, are accepted. | | | | | | | | | | | | | | | | | | | | |
| 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 | |

| 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 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 | E AV NI | E AV NI | E AV NI | E AV NI | 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 | AM I NM | AM I NM | AM I NM | AM I NM | 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 | | | | | | | | | | | |
| H. STAFFING | | | | | | | | | | | | | | | | | | |
| H 1. Qualified staff is available, either within | | E AV NI | E AV NI | E AV NI | E AV NI | E AV NI | E AV NI | E AV NI | E AV NI | E AV NI | E AV NI | 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 | |
| the treatment facility itself, or on 24-hour standby, during treatment. | AM | I | NM | AM | I | NM | AM | I | NM | AM | I | NM | AM | I | NM | AM | I | NM | 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 | 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 | AM | I | NM | | | | |
| H 3. Staff (specialized as well as general health-care personnel) are provided with regular refresher training. | E | AV | NI | 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 | AM | I | NM | | | | |
| H 4. In determining the composition of service staff, consideration is given to the characteristics (sex, race, ethnicity,) of the of the population with access to the services. | E | AV | NI | 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 | 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 | 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 | 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 | | | |
| H 6. More than one staff member is on duty during the hours of treatment program activity. | 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 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 | 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 8. A regular evaluation is conducted of workflow in the service and the proportion between staff and 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 | | |

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 (CICAV/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.

ANNEX 11- CARIBBEAN COOPERATION IN HEALTH

Countries in the Caribbean share a similar history in the development of their health systems. They have often cooperated to deal with many of the challenges to health which they have to confront. However, there is need for even greater collaboration and cooperation among the countries in the Region, given the increasing threats to the economies of these countries and the presence of newly emerging and re-emerging problems in the health sector. Efforts therefore have to be focused not only in the fight against disease, but in promoting healthy lifestyles, protecting the environment and increasing the capacity of the health sector to provide quality service and value for money.

The concept of the Caribbean Cooperation in Health Initiative (CCH) was introduced in 1984 at a meeting of the former CARICOM Conference of Ministers responsible for Health (CMH). The CMH saw this as a mechanism for health development through increasing collaboration and promoting technical cooperation among countries in the Caribbean. The initiative, in which seven priority areas were identified, was adopted by the CMH and approved by the Heads of Government in 1986. An evaluation of the Initiative (1992-1994), found that the priorities identified ensured that activities were focused in areas critical to improving health status in the region. Overall it was established that the Initiative was beneficial to Caribbean countries.

In 1996, the CMH mandated a re-definition and re-formulation of the CCH Initiative for the period 1997-2001. A wide cross section of national and regional professionals in health and planning from 19 member countries met in Port-of-Spain in July 1997 to reprogramme the initiative. The meeting selected eight(8) health priority areas, recommended strategies for implementation, and identified some areas of common concern which required joint action. The recommendations of that meeting were accepted by CMH in 1997.

Participating Countries

To date, the countries that have participated in the initiative include Antigua and Barbuda, Anguilla, The Bahamas, Barbados, Belize, Bermuda, The British Virgin Islands, the Caymans Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, Saint Lucia, St Vincent and the Grenadines, St Kitts and Nevis, Suriname, Trinidad and Tobago and the Turks and Caicos Islands. However, it is intended that the Initiative will become Caribbean in tandem with the integration movement.

Benefits of the New CCH Initiative

Countries in the region will be able to:

- Reduce costs associated with duplicating services or mobilizing extra-regional assistance;
- Access, mobilise and optimise national and external resources to address selected health issues;
- Identify and implement appropriate and suitable projects and programmes in collaboration with regional institutions;
- Share expertise and experience with other Caribbean countries especially in addressing similar problems. Professionals in any one country will be less isolated and will be better able to develop partnerships with colleagues in neighbouring countries;
- Create mechanisms for sustained involvement of relevant social partners, including the community, in all stages of programme development and execution;
- Participate in planning the future of regional health;
- Pool ideas and resources so that countries will benefit from economies of scale;
- Implement the policy of regional integration in a meaningful way in the health sector.

New Definition of CCH

The CCH is a mechanism through which Member States of the Caribbean Community:

- To collectively focus action and resources over a given period towards the achievement of agreed objectives in priority areas of common concern;
- To identify the approaches and activities for joint action and/or Technical Cooperation among Countries (TCC) in support of capacity building for the achievement of objectives.

Goal of CCH

To improve and sustain the health of the people of the Caribbean.

- 1) This goal will result in the following:
- 2) Adding years to life and life to years;
- 3) Increasing equity for health within and among countries;

- 4) Maintaining universal access to quality care for priority problems.

Purpose of CCH

To develop and implement programmes which focus action and resources on priority health issues of common concern to the Caribbean community, with particular consideration given to vulnerable groups. In other words, " Caribbean Countries helping themselves and one another to improve health in the Region."

Regional Health Priority Areas

- * Environmental Health;
- * Strengthening Health Systems;
- * Chronic Non-communicable Diseases;
- * Mental Health including Substance Abuse;
- * Family Health:
- * Prevention and Control of Communicable Diseases;
- * Food and Nutrition;
- * Human Resource Development.

Health Promotion

Health Promotion has become essential in the changing Caribbean. Over the last forty years non-communicable diseases, along with violence, new sexually transmitted diseases and environmental hazards, have gained priority over infectious diseases as the major causes of mortality in the Caribbean.

In times past, a focus on a curative approach to health care could be justified when infectious diseases were the major cause of mortality. Health technologies were either cheap(immunization) or yielded massive returns for the investment as in the case of pure water supply. The prevention and control of chronic diseases, on the other hand, has encountered massive difficulties. Prominent among them are the costs of medication, hospitalization and long term treatment with little and/or diminished potential. It has become evident that a preventive and broader approach to the problem of chronic disease and the protection of health is required.

Health promotion is the approach that best achieves this goal. In its widest perspective it treats health as a primary tool in human and economic development, focusing on public policies conducive to prevention of disease and promotion of well-being and productivity. On an individual and community level, dynamic health education in an inter sectoral approach enables people to originate initiatives to seek to control and modify personal practices and everyday living conditions that foster their health.

Planning Approach

Regional and national consultations were held to identify the priority issues related to each of the areas and to develop goals and objectives along with indicators for resolving them over the next five years. The goal and targets reflect improvement of improved health status and/or decrease health risks. Responding to the consensus that CCH should provide a framework/protocol to assist national planning, the objectives and indicators at that level are directional and indicate key achievements or strategic action required in the system to improve the situation.

The Logical Framework Approach to project design or "logframe" was applied by all the planning teams with the view to identifying clearly the outputs at the nation and regional levels required for improved health systems or situations. As far as possible available data from the Health Conditions of the Caribbean and Caribbean Regional Health Study guided the setting of realistic targets thereby increasing the probability of achievement within the time frame.

Management of CCH

The Administrative activities of the new initiative will be managed by a Secretariat comprising CARICOM Secretariat and PAHO to be known as the CCH Secretariat. Chief Medical Officers (CMOs) will be responsible for coordinating national activities. A broader steering group includes the Regional Health Institutions and the Regional Focal points for each priority area. The Secretariat will act as facilitator to ensure that the needs of countries are met and will also promote and facilitate technical cooperation among countries, agencies, institutions and organisations in the public, private and voluntary sectors. One of the key roles of the Secretariat will be resource mobilisation , monitoring and evaluation.

Critical Success Factors

Building on the experiences of CCH I and to ensure that countries and institutions in the Caribbean accept, own and operate the initiative as theirs, the following are deemed necessary for CCH to be successful and sustainable:

A proficient joint CCH Secretariat(PAHO/CPC and CARICOM Secretariat) to coordinate and , where necessary, undertake work in close collaboration with the CMOS (the CCH coordinators).

- Greater attention to communication through the implementation of a comprehensive Communications Strategy, upgrading existing systems where necessary, to facilitate communication between the Secretariat and countries.
- Ongoing monitoring and evaluation with timely reprogramming of objectives and /or strategies for implementation.

If the benefits of CCH II are to be realized, countries must be prepared to:

- Ensure that reliable data is collected and disseminated, and used in health planning nationally and regionally.
- Participate fully at all levels of CCH including policy formulation, needs identification, resource mobilisation and information sharing.
- Provide guidance, direction and relevant information to the CCH Secretariat.
- Maintain communication with key stakeholders, particularly the public, about CCH benefits.
- Support the CCH Coordinators(CMOs) in implementing the Initiative.
- Participate fully in all activities of CCH

The Future

The new CCH initiative, in addition to ensuring that activities are focused in areas critical to improving health status in the region, will also involve more actively all the countries of the Caribbean, as well as regional and international agencies, in a dynamic communications network dedicated to improving health in the region. Additionally, it will signal the redefinition and reorientation of health, seeking to expand the boundaries of health to include other sectors as participants and partners.

ANNEX 111- INTERNATIONAL DECLARATIONS

UNIVERSAL DECLARATION OF HUMAN RIGHTS

Adopted and proclaimed by General Assembly resolution 217 A (III) of 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 rights 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 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,

Proclaims 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 AV 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 of 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

Article 9

No one shall be subjected to arbitrary arrest, detention 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

1. 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 impart 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 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

1. 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, widowed, 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 his 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 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 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.

AVOIDANCE OF DISCRIMINATION

WHA41.24 the Forty-first World Health Assembly

Recalling resolution WHA40.26 on the global strategy for the prevention and control of AIDS, Economic and Social Council resolution 1987/75, and United Nations General Assembly resolution 42/8 on the prevention and control of AIDS.

Endorsing the London Declaration on AIDS Prevention unanimously AVopted on 28 January 1988 by the world summit of Ministers of Health on Programmes for AIDS Prevention;

Recognizing that AIDS is a global problem which poses a serious threat to humanity, and that urgent and worldwide action is required to implement WHO's global strategy to combat it;

Acknowledging with deep appreciation the work of WHO, through the Global Programme on AIDS, in directing and coordinating the global strategy;

Noting the medical, ethical, legal, socioeconomic, cultural and psychological implications of AIDS prevention and control programmes;

Recognizing the responsibility of Member States to safeguard the health of everyone and to control the spread of HIV infection through their national policies and programmes, taking into account their epidemiological situation, and in conformity with the global strategy;

Bearing in mind the responsibility of individuals not to put themselves or others at risk of infection with HIV;

Strongly convinced that respect for the human rights and dignity of HIV-infected people with AIDS, and of members of population groups, is vital to the success of national AIDS prevention and control programmes and of the global strategy;

1. URGES Member states, particularly in devising and carrying out national programmes for the prevention and control of HIV infections and AIDS.
 - (1) to foster a spirit of understanding and compassion for HIV-infected people and people with AIDS through information, education and social support programmes;
 - (2) to protect the human rights and dignity of HIV-infected people and people with AIDS, and members of population groups, and to avoid discriminatory action against and stigmatization of them in the provision of services, employment and travel;
 - (3) to ensure the confidentiality of HIV testing and to promote the availability of confidential counseling and other support services to HIV-infected people and people with AIDS;
 - (4) to include in any reports to WHO on national AIDS strategies information on measures being taken to protect the human rights and dignity of HIV-infected people and people with AIDS.

2. CALLS on all governmental, nongovernmental and international organizations and voluntary bodies engaged in AIDS control programmes to ensure that their programmes take fully into accounts the health needs of all people as well as the health needs and dignity of HIV-infected people and people with AIDS.

 3. REQUESTS the Director-General
 - (1) to take all measures necessary to Advocate the need to protect the human rights and dignity of HIV-infected people and people with AIDS, and members of population groups;

 - (2) to collaborate with all relevant governmental, non-governmental and international organizations and voluntary bodies in emphasizing the importance to the global strategy for the prevention and control of AIDS of avoiding discrimination against HIV-infected people and people with AVS.

 - (3) to stress to Member States and to all others concerned the dangers to the health of everyone of discriminatory action and stigmatization of HIV-infected people and people with AIDS, and members of population groups, by continuing to provide accurate information on AIDS and guidance on its prevention and control;

 - (4) to report annually to the health Assembly through the Executive Board on the implementation of this resolution.
-

ANNEX 1V - SAMPLE INSTRUMENT OF DISCOVERY USED IN ADAPTATION OF THESE STANDARDS

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 on 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 | | | | |
|----------|---|----|-----------------------|-----|----|
| | Yes | No | Associated statements | Yes | No |
| A1 | | | A9 | | |
| A2 | | | A10 | | |
| A3 | | | A11 | | |
| A4 | | | A12 | | |

| | | | | | |
|-----------------------------|----------------------------|----|-----------------------|-----|----|
| A5 | | | A13 | | |
| A6 | | | A14 | | |
| A7 | | | A15 | | |
| A8 | | | A15 | | |
| Other associated statements | | | | | |
| | | | | | |
| Standard | C. Standards on assessment | | | | |
| Associated statements | Yes | No | Associated statements | Yes | No |
| B1 | | | B7 | | |
| B2 | | | B8 | | |
| B3 | | | B9 | | |
| B4 | | | B10 | | |
| B5 | | | B11 | | |
| B6 | | | B12 | | |
| Other associated statements | | | | | |
| | | | | | |

| Standard | D. Standards on treatment content provision and organization | | | | |
|-----------------------------|--|----|-----------------------|-----|----|
| Associated statements | Yes | No | Associated 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 |
|-----------|---|

| Associated statements | Yes | No | Associated Statements | Yes | No |
|-----------------------------|---|----|-----------------------|-----|----|
| D1 | | | D5 | | |
| D2 | | | D6 | | |
| D3 | | | D7 | | |
| D4 | | | D8 | | |
| Other associated statements | | | | | |
| | | | | | |
| Standard | E. Standards on outreach and early intervention | | | | |
| Associated statements | Yes | No | Associated Statements | Yes | No |
| E1 | | | E7 | | |
| E2 | | | E8 | | |
| E3 | | | E9 | | |
| E4 | | | E10 | | |
| E5 | | | E11 | | |
| E6 | | | | | |
| Other associated | | | | | |

| | | | | | |
|-----------------------------|---|----|-----------------------|-----|----|
| statements | | | | | |
| | | | | | |
| Standard | F. Standards on patients' rights | | | | |
| Associated statements | Yes | No | Associated Statements | Yes | No |
| F1 | | | F5 | | |
| F2 | | | F6 | | |
| F3 | | | F7 | | |
| F4 | | | F8 | | |
| | | | F9 | | |
| Other associated statements | | | | | |
| | | | | | |
| Standard | G. Standards on physical aspects on the treatment setting | | | | |
| Associated statements | Yes | No | Associated Statements | Yes | No |
| G1 | | | G3 | | |
| G2 | | | G4 | | |
| Other Associated | | | | | |

| | | | | | |
|------------|--|--|--|--|--|
| statements | | | | | |
| | | | | | |

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

| Standard | H. Standards on staffing | | | | |
|-----------------------------|--------------------------|----|-----------------------|-----|----|
| Associated statements | Yes | No | Associated 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-Government Organizations providing services for clients affected by alcohol and drug abuse 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, but 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.

RESIDENTIAL (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 provide include assessment, 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 including 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 serve as a transition facility from a residential programme to 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 service which would include:

- (1) Philosophy and objectives
- (2) Policies and procedures
- (3) Administrative organisation
- (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 as regards level of education, experience and attitudes to Addiction and Addicts.

There must be competent, trained persons designated for supervising, counseling 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 as regards 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 be not less than one toilet and one wash basin for every six patient: (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 both sexes.
- (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 clean and 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 at all times be kept in a state of good repair and in a clean condition. 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 and every yard, area, forecourt or other open space with its cartilage should at all times be kept in a thoroughly clean and sanitary 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 orientated activities (as in the case of multi-programme rehabilitation services offering detoxification, inpatient 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 which 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 counseling etc.
- (c) There should be close co-operation and consultation (where necessary) with the wider therapeutic community of specialist institutions including 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, other than confidential case histories, open to inspection 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 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 purpose of 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 should be submitted to the regulatory body at registration and in 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 V1- SAMPLE INSTRUMENT FOR CENTERS 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? _____

STREET/COMMUNITY BASED INTERVENTION PROGRAMME (SCBIP)

| | YES | NO |
|---|-----|----|
| <p>Does your organization maintain a SCBIP?</p> <p>Name of the SCBIP: _____</p> <p>Location of the SCBIP: _____</p> | | |
| Is the SCBIP located in a neighbourhood where drug use is prevalent? | | |
| <p>Does the SCBIP provide low-threshold and early access for both current drug users and potential drug users?</p> <p>If No why not?</p> | | |
| <p>Does the SCBIP provide the individual and/or groups within information and support to minimize the potential damage that may be caused by hazardous and compulsive drug use?</p> <p>If no why not? _____</p> | | |
| <p>Is the SCBIP a safe place for individuals/groups to congregate and socialize?</p> <p>If no why not? _____</p> | | |

COUNSELLING SERVICES

| | YES | NO |
|--|-----|----|
| <p>Does the SCBIP provide family counselling?</p> <p>If no why not? _____</p> | | |
| <p>Is there social support through trained counsellors and peer counsellors?</p> <p>If no why not? _____</p> | | |

HEALTH SERVICES

| Does the SCBIP provide health counselling? If no why not? _____ | YES | NO |
|--|-----|----|
| Does the SCBIP provide adequate medical facilities and staff trained in dealing with common infections and diseases? If no why not? _____ | | |
| Is there a physician or nurse available to the centre in a regular basis? If no why not? _____ | | |
| Is there a physician or nurse available to the centre on call? If no why not? _____ | | |
| Is there a referral system to appropriate medical clinics and hospitals if and when needed? If no why not? _____ | | |
| Does the SCBIP maintain a sound working relationship with these service providers? If no why not? _____ | | |
| Does the SCBIP provide outpatient treatment facilities with qualified staff, doctors or nurses? Why not? _____ | | |
| Has the SCBIP developed an appropriate outpatient treatment strategy? Why not? _____ | | |
| Has the SCBIP developed an appropriate outpatient treatment programme? Why not? _____ | | |
| | | |

LEGAL SERVICES

| | YES | NO |
|--|-----|----|
| Does the SCBIP provide law and order assistance or referrals? If No why Not? | | |
| | | |

REFERRAL SERVICES

| | YES | NO |
|--|-----|----|
| Does the SCBIP provide referral services for residential treatment if the client desires? If no why not? _____ | | |
| Does the SCBIP provide follow-up after care for an individual discharged from in-residence treatment period? If no why not? _____ | | |

ADVOCACY SERVICES

| Does the SCBIP provide advocacy for drug users needing support either with: | YES | NO |
|--|-----|----|
| Employment relations If no why not? _____ | | |
| Job placement If no why not? _____ | | |
| Legal issues If no why not? _____ | | |
| 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

| | YES | NO |
|---|-----|----|
| Does the SCBIP maintain a shelter facility for homeless drug users? If no why not? _____ | | |
| Does the SCBIP provide services to meet the basic biological needs of the client such as: If no why not? _____ | | |
| A well-balanced meal If no why not? If yes is there a fee charged? If yes, How much | | |
| Replacement clothing? If no why not? If yes is there a fee charged? If yes, How much | | |
| A place to bathe? If no why not? If yes is there a fee charged? If yes, How much | | |
| | | |

DATA COLLECTION

| | YES | NO |
|--|-----|----|
| <p>Does the SCBIP gather information in order to detect new drug using trends and understanding the magnitude in regard to the local drug use situation?</p> <p>If no why not? _____</p> | | |
| <p>Is this information shared with the governmental authorities?</p> <p>If no why not? _</p> <p>If yes is the information collected in a formal or informal manner?</p> <p>Does the government provide forms which they collect data?</p> <p>_____</p> | | |

Residential Treatment and Rehabilitation (T&R) Services

| | YES | NO |
|--|-----|----|
| <p>Does your organization maintain a T&R service?</p> | | |
| <p>How many separate T&R centres are maintained?</p> <p>Male Female Both</p> | | |
| <p>Current population</p> <p>Male Female Both</p> | | |

Name of the T&R Centre: _____

Location of the T&R Centre: _____

Is the T&R located in a neighbourhood where drug use is prevalent? Yes No

Does the T&R provide the client with information and support to minimize the potential damage that may be caused by hazardous and compulsive drug use?

Yes No

If no why not? _____

COUNSELLING SERVICES

| | YES | NO |
|---|-----|----|
| Does the T&R provide family counselling? If no why not? _____ | | |
| Is there social support through trained counsellors and peer counsellors? If no why not? _____ | | |

Check the appropriate services provided

Group Therapy

Individual Therapy

12 step meetings

Other, please explain: _____

HEALTH SERVICES

| | YES | NO |
|--|------------|-----------|
| Does the SCBIP provide health counselling? If no why not? _____ | | |
| Does the T&R provide adequate medical facilities and staff trained in dealing with common infections and diseases? If no why not? _____ | | |
| Is there a physician or nurse available to the centre in a regular basis? If no why not? _____ | | |
| Is there a physician or nurse available to the centre on call? If no why not? _____ | | |
| Is there a referral system to appropriate medical clinics and hospitals if and when needed? If no why not? _____ | | |
| Does the T&R maintain a sound working relationship with these service providers? If no why not? _____ | | |
| Does the T&R provide in house detox services? Why not? _____ | | |
| Has the SCBIP developed an appropriate outpatient treatment strategy? Why not? _____ | | |
| Has the SCBIP developed an appropriate outpatient treatment programme? Why not? _____ | | |
| | | |

LEGAL SERVICES

| | YES | NO |
|--|-----|----|
| Does the SCBIP provide law and order assistance or referrals? If No why Not? | | |
| | | |

AFTER CARE SERVICES

| | YES | NO |
|---|-----|----|
| Does the T&R provide follow-up after care for a discharged individual? If No why Not? | | |
| | | |

ADVOCACY SERVICES

| | YES | NO |
|---|-----|----|
| Does the T&R provide Advocacy for drug users needing support either with: Legal issues If No why Not? | | |
| Does the T&R maintain contact with persons having been discharged from the facility irrespective of their drug-use status? If no why not? _____ | | |

DATA COLLECTION

| | YES | NO |
|---|-----|----|
| Does the T&R gather information in order to detect new drug using trends and understanding the magnitude in regard to the local drug use situation? | | |

| | | |
|---|--|--|
| If no why not? _____ | | |
| Is this information shared with the governmental authorities? If no why not? _ If yes is the information collected in a formal or informal manner? Does the government provide forms which they collect data? _____ | | |

EMPLOYMENT

| | YES | NO |
|---|-----|----|
| Does the T&R have an in house vocational skills training programme for the residents? If no why not? _____ If Yes Please list the types of skills the resident can learn: | | |
| Is this information shared with the governmental authorities? If no why not? _ If yes is the information collected in a formal or informal manner? Does the government provide forms which they collect data? _____ | | |
| 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? | | |
| Does the T&R Centre provide assistance with job placement? If no why not? | | |
| Does the T&R Centre engage in income generating activities in order to provide income for the Centre If no why not? | | |

| | | |
|-------------------|--|--|
| For the resident? | | |
| If no why not | | |

CLIENT / INSTITUTION RELATIONS

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?

Yes No

If no why not? _____

2.33 Does the T&R Centre have a operations 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 inpatient 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 really has changed. The client finds himself/herself often 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 client needs certain aspect must be attended to in the service provision:

- 3.1.Ongoing 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 community, common activities and individual support through formal counselling where needed and through the informal peer counselling. It would be important that some of the income generated by the resident is channelled 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 an 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 a individual basis.
- 3.5.Development of a market-let enterprise attached to the residence, in which residence can implement and develop their skills.

4. Training of Service Providers

Ongoing training is essential for service providers to respond Adequately to the changes and demands coming from drug use and 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 the latter is best facilitated is through 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 of a roaster 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 is multiple: 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 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 develop 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 need's for service provisions within the region and the establishment of a framework to Address these needs

6. Communication and Data collection/analysis

6.1Rationale:

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

organisations. This will provide in the analysis 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 organisations

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

Screening¹ 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 considers 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- or 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 centred 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 limits² 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 of serious Adverse consequences related to the withdrawal process. 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 management of their care for substance use illness and any coexisting conditions, and this care management should be AVapted 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/CICAV) 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 poisonings 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 fro 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. Manifestation 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 if 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 overdoses 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

1. Devenyi, P. & Saunders, S. (1986) *Physicians handbook for medical management of alcohol-and drug-related problems*. AVdiction Research Foundation, Toronto, CanAVa.
2. 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 CNS depressants, long-term Administration produces a 'latent counter-Adaptation' in neural systems affected by the drugs that becomes manifest in the form of rebound or overshoot phenomena when the drugs are stopped or when an antagonist is administered. The underactivity 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 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 (37.2o – 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 are grand mal seizures. Delirium Tremens, characterized by severe autonomic nervous system (ANS) dysfunction, confusion and the possible concomitance of seizures, is reported for fewer than one percent of patients. Mortality rates is 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 the 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 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, overhydration is more typical.

Reality orientation techniques are useful particularly for patients showing mild levels of confusion. An opportunity to sleep, an 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 being 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 (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, but 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. For dilated pupils are small during withdrawal, there is 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: 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 is 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 IM 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), 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 five 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 AVministration 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-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 antianxiety 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 seven to 14 days. Secondary abstinence symptoms of lesser severity may continue of months.

Severe and prolonged depressive illness following benzodiazepine withdrawal have 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 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 dose 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 give 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 nine 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 by 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 inpatient setting in order to offer maximal support, but there are also outpatient 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 nonspecific 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 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, PCO 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 po or 10 mg iv) or haloperidol (2.5 mg po or im). 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 parallels 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 represents the most problems. There are no firm rules to cover all eventualities.

REFERENCES

1. Schuckit, M.A. (1989) *Drug and Alcohol Abuse: A clinical guide to diagnosis and treatment. Third edition*, Plenum Publishing Corporation.
2. *Diagnostic and statistical manual of mental disorders. Third edition, revised* (1988). The American Psychiatric Association.
3. Keshavan, M.S., et al. (1988) Delusional depression following benzodiazepine withdrawal. *Canadian Journal of Psychiatry*, Vol. 33, October.
4. Arif, A. & Westermeyer, J. (1988) *Manual of drug and alcohol abuse*, Plenum Publishing Corporation.
5. Mandell, W. & Melisaratos, N. (1986) The psychopharmacology of alcoholism, In: Derogatis, Leonard R., *Clinical psychopharmacology*, AVdison-Wesley Publishing Company, inc.
6. Devenyi, p. & Saunders, S. (1986) *Physicians handbook for medical management of alcohol-and drug-related problems*. addiction Research Foundation, Toronto, Canada.
7. Madden, J.S. (1986) *Alcoholism y Farmacodependencia*. Editorial Moderno, Mexico.

ANNEX 1X – PSYCHIATRIC COMORBIDITY OF DRUG ABUSE

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

INTRODUCTION

Psychiatric disorder may be the initial presentation and reason for referral of a person who is abusing drugs. Sometimes, however, psychiatric comorbidity 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 comorbidity 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. Through anxiety and phobic systems are common in alcoholics, it is not clear whether neurotic illness and high neuroticism predispose to alcohol abuse. Mullan, et a (1986) suggest that clinically neurotic illness and high neuroticism are more often a consequence than cause of alcoholism.

If psychiatric comorbidity 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 drug-taker and the society in which he/she exists, psychiatric manifestations may/may not be present, and may/may not be identified. Sometimes mention is mAVE 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 comorbidity is primary or secondary; however, it can be extremely difficult sometimes to make this distinction. Once the person with a psychiatric disorder abuses drugs, problems related to the abuse become 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 add 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. Schucki, 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, Schlessner, 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 like 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 as 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 to 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 – 63 percent. This continues to be a difficult problem in determining treatment guidelines.

Social phobia manifesting in overshyness 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 inpatient group had consumed alcohol prior to admission. They thought that patient 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, overactivity 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 drug triggers flashbacks.

Feeling of paranoia, unreality and estrangement are often experienced in the flashbacks along distorted visual perceptions. Flashbacks are episodic and can last from 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 AVHESIVES 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 judgement 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 Burrell, 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.

CANNIBIS 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 'mAV', 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 feelings, 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 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 resumed. 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 drug, particularly alcohol. It may occur in the abuse of drug like amphetamine and cocaine. This condition is more common in men than in women.

Sedatives or hypnotics

These drugs rarely present with psychiatric comorbidity 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 have been found in chronic opiate user.

MANAGEMENT

In management of psychiatric comorbidity, 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 comorbidity.

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, outpatients' department, 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 comorbidity 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 counseling behavioural techniques and skilled psychotherapy may be applied.

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 comorbidity, it is necessary that attention is given to the basic pathological habit of drug abuse. Effective therapy may require inputs 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 comorbidity is primary or secondary to drug abuse, it requires prompt attention to avoid complications. Long-term outpatients follow ups and adequate rehabilitation offering training in social skills, occupation, followed by employment where necessary may prove to be useful.

References

1. Beck A.T. (1967) *Depression, clinical experimental and therapeutic aspects*, New York Harper and Row.
2. Begleiter, H. & Porjesz, B.; et al. (1984) Event-related brain potentials in boys at risk for alcoholism, *Science*, 225:1493-1496.
3. Brehm, M. & Black, W. (1968) Self-image and attitudes towards drugs, *Journal of Personality* 36, 299-314.
4. CAVoret, R.J., Troughton, E.O. & Gorman, T. (1987) Genetic and environmental factors in alcohol abuse and antisocial personality, *J. Study Alcohol*, 48, 1-8.
5. Connell, P.H. (1958). *Amphetamine psychosis*. Maudsley Monograph. Oxford, Oxford Univeristy Press.
6. Ewards, G. (1982). The question of psychiatric morbidity. In: *AVvisory Council on the Misuse of Drugs*. Report of the expert group on the effects of cannabis use. London Home Office, 34-39.

7. Evans, A.C. & Raistrick, D. (1987) Phenomenology of intoxication with toluene-base AVhesives and butane gas. *British Journal of Psychiatry*, 150, 769-773.
8. Freed, X. (1975) Alcoholism and manic depression disorders. Some perspectives. *Quarterly Journal of Studies on Alcohol*, 31, 62-69.
9. Freed, E.X. (1975) alcoholism and schizophrenia – the search for perspectives. *J. Stud. Alcohol*, 36, 853-888.
10. Freund, G. (1963) chronic central nervous system toxicity of alcohol. *Annual Review of Pharmacology*, 13, 217-227.
11. Jones, G. A. (1979) The recognition of alcoholism by psychiatrists in training. *Psychological Medicine*, 9, 789-791.
12. Kammeier, M.L., Hoffman, H & Loper, R.G. (1973) Personality characteristics of alcoholics as college freshmen and at times of treatment. *Quarts. J. Stud. Alcohol*, 34, 390-399.
13. Knight, F. (1976) *Role of cannabis on psychiatric disturbance*. *Ann. of the N.Y. AcAVemy of Sciences*, 282, 64-71.
14. Kraus, J. (1981). Juvenile drug abuse and delinquency: some differential association. *Brit. J. Psychiat.*, 139, 422-430.
15. Lawton, J.J. & Malmquist, C.P. (1961) Gasoline AVdiction in children. *Psychiatric quarterly* 35, 55-561.
16. Meyer, R.E. (1975) Psychiatric consequences of marijuana use. The state of the evidence. *Marijuana and health hazards*, Tinklenberg, J.R. (ed), New York AcAVemic Press, 133-152.
17. McCord, W. & McCord, J (1969) *Origins of alcoholism*, Standford, California, Standford University Press.
18. McCord, W. & McCord, J.A. (1962). A longitudinal study of the personality of alcoholics. In: (ed) D. J. Pittman, C.R. Snyder. *Society, culture and drinking*. New York, John Wiley & Sons.
19. Mullan, M. J. Curling, B.E. Oppenleim & R. M Murray (1986). The relationship between alcoholism and neurosis. Evidence from Twin study. *British Journal of Psychiatry* 148, 435-441.
20. Mullaney, J.A. & Tripett, C.J. (1979). Alcohol dependence and phobia. Clinical description and relevance. *British Journal of Psychiatry*, 135, 565-573.
21. Patel, A.R., Roy, M. & Wilson, G.M. (1972) Self-poisoning and alcohol, *Lancet* H., 1909-1102.
22. Press, E. & Done, A.K. (1967) Solvent sniffing. Physiological effects and community control measures for intoxication from the international inhalation of organic solvents. Parts I and II. *Paediatrics* 39:451-461, 611-622.
23. Reigh L.H., Davies, R. K. & Himmelhock J.M. (1974) Excessive alcohol use in manic-depressive illness. *American Journal of Psychiatry*, 131, 83-86.
24. Schlessor, M.A., Winokur, G. & Serman, B.M. (1980) Hypothalamic-pituitary-AVrenal axis activity in depressive illness. *Arch. Gen. Psychiatry*, 37, 737-743, 1980.

25. Schuckit, M., Pitts, F.N. & Reitch, T., Et al (1969) Alcoholism 1: two types of alcoholism in women. *Arch. Gen. Psychiatry*, 20, 301-306.
26. Skuse, D. & Burrell, S. (1982) A review of solvent abuses and their management of by a child psychiatric out-patient service. *Human Toxicology*, 1, 321-329.
27. Spencer, D.J. (197) Cannabis induced psychosis. *International journal of the AVdiction*, 11, 53-69.
28. Thacore, V.R. (1975) Bhang psychosis. *British Journal of Psychiatry*, 123, 225-229.
29. Thacore, V.R. (1976) Cannabis psychosis and paranoid schizophrena. *Archives of general psychiatry*, 33, 383-386.
30. Victor, M., AVams, R.R. & Collins, G.M. (1971). 'The Wernicke-Korsakoff Syndrome'. Oxford, Blackwell.
31. Weissman, M.M. (1980) Clinical depression in Alcoholism. *Am. J. Psychiatry*, 137, 372-373.
32. Weil, AT. (1970) AVverse reactions of marijuana, classification and suggested treatment. *New England Journal of Medicine* 282, 997-1000.
33. Winokur, G., CAVdret, R., Donzard 7 Baker. M. (1971) depressive disease. A genetic study. *Archives of general psychiatry*, 24, 135-144.
34. Winokur g., Reich, T. & Rimmer, J. et al (1970) Alcoholism 111: diagnosis and familial psychiatric illness in 259 alcoholic probands. *Arch. Gen. Psychiatry*, 23, 104-111.

ANNEX X – LIST OF DELEGATES - REGIONAL WORKSHOP ON STANDARDS OF CARE AND TREATMENT FOR REHABILITATION FACILITIES FOR SUBSTANCE ABUSE, MONTEGO BAY, JAMAICA

LIST OF PARTICIPANTS

| ANTIGUA & BARBUDA | - | ADDRESS |
|------------------------------|---|--|
| Mrs. Beulamay Charles | | Permanent Secretary Ministry of Housing & Social Transformation Dickenson & Popeshead Streets Tel: 562-3637 Fax: 562-5148 Email: socialtransformation@hotmail.com |
| THE BAHAMAS | - | |
| Ms. Rochelle Basden | | Clinical Psychologist Sandilands Rehabilitation Centre, Public Hospitals Authority, Fox Hill, Nassau, Tel: 242-364-9672 Fax: 242-324-3922 Email: robasden@hotmail.com |
| Dr. Nelson Clarke | | Sandilands Rehabilitation Centre The Public Hospitals Authority P.O. Box FH 14383, Fox Hill, New Providence Tel: 242-324-3068 Fax: 242-324-3922 Email: nelsonac@coralwave.com |
| Mr. Terry Miller | | Chief Servant Bahamas Association of Social Health P.O. Box SS 5372 Nassau Bahamas Tel: 242-356-2274 Fax: 242-328-7762 Email: bashbahamas@hotmail.com |

BARBADOS

Mr. Jonathan Yearwood

-
Research and Information Officer
CNR James & Roebuck Streets
Bridgetown
Tel: 246-429-6272
Fax: 246-427-8966
Email: jyearwood@ncsa.org.bb

Ms. Tessa Chaderton-Shaw

Director
National Council on Substance Abuse
CNR James & Roebuck Streets
Bridgetown
Tel: 246-429-6272
Fax: 246-427-8966
Email: tchaderton-shaw@ncsa.org

Ms. Jacqui Lewis

Clinical Director
Verdun House – Substance Abuse Foundation
Verdun House Pool
St John
Tel: 246-433-6577/230-8672
Fax: 246-433-5499
Email: verdunhouse@caribsurf.com and
jlewis_verdun@caribsurf.com

BELIZE

Mr. Esner Vellos

-
Director
NationL Drug Abuse Control Council
Ministry of Health
Amara
25 Amra Ave
Belize City
Tel: 501-227-1121
Cell: 501-602-8846
Fax: 501-227-0520
Email: ndccbze@gmail.com

DOMINICA
Mr. Griffin Benjamin

-

Consultant Psychiatrist
Ministry of Health & Environment
Kennedy Avenue
Roseau
Tel: 767-448-2401/235-7979
Fax: 767-448-6086
Email: cmo@cwdom.dm or
dr-beng@hotmail.com

GRENADA
Mrs. Brenda Scott

-

Coordinator
Alcohol & Other Drug Treatment & Rehabilitation
Programme
Ministry of Health
Ministerial Complex, Botanical Gardens
Tanteen, St Georges
Tel: 473-440-3485
Fax:
Email: bscott58@live.com

Mr. Dave Alexander

Drug Control Officer
Drug Control Secretariat
Ministry of Education
Botanical Gardens
St. Georges
Tel: 473-440-7911
Fax: 473-440-7911
Email: dave.alexander@gov.gd

GUYANA
Dr. Marcia Bassier-Paltoo

-

Director, Adolescent Health
Ministry of Health
Lot 1 Brickdam
Georgetown
Tel: 592-223-7355
Fax: 592-223-55
Email: mpaltoo@yahoo.com

Magnole Saint-Lot (Captain)

Administrator
Salvation Army Drug Rehabilitation Centre
6-7 Water Street
Kingston
Tel: 592-226-1235
Fax:
Email: Maginol_Saint-Lot@CAR.salvationarmy.org
matignol@yahoo.com

Mr. Clarence Young

Project Coordinator
Phoenix Recovery Project
90 Block "CC" Mon Repos
East Coast Demerara
Tel: 592-220-6825
Email: prpsarx@yahoo.com &
cyoung1437@Yahoo.co.

JAMAICA

Mr. Michael Tucker

-
Executive Director
National Council on Drug Abuse
2 – 6 Melmac Avenue
Kingston 5
Tel: 876-926-9002
Fax: 876-960-1820
Email: mtucker@ncda.org.jm

Ms. Gwen Akinlosotu

National Council on Drug Abuse
2 – 4 Melmac Avenue
Kingston 5
Tel: 876-926-9002
Fax: 876-960-1820
Email: gakinlosotu.ncda.org.jm

Ms. Sislyn Malcolm

National Council on Drug Abuse
2 – 6 Melmac Avenue
Kingston 5
Tel: 876-926-9002
Fax: 876-960-1820
Email: smalcolm@ncda.org.jm

St KITTS & NEVIS
Dr. Sharon Halliday

-
Consultant Psychiatrist
Ministry of Health, Community & Social
Development & Gender Affairs
Wellington Rd
Bladen
Basseterre
Tel: 869-465-2551/467-1569
Cell: 869-662-9956
Fax: 869-466-5577/8574
Email: shaldaydm@yahoo.com

Mr. Basil D. Halliday

President & Chief Executive Officer
Diversified Healthcare Solutions, Inc.
P.O. Box 1909
Basseterre
Tel: 869-465-7011/9507 & 919-861-8377 (USA)
Cell: 869-765-9507
Fax: 869-465-7012 & 919-471-5475
Email: bhalliday@diversified-research.com

SAINT LUCIA
Mr. Desmond Philip

-
Director
Turning Point Drug Rehabilitation
A.D.D.R.C.
Chairman
National Council on Substance Abuse
Ministry of Health
The Waterfront
Castries
Tel: 758-458-2076
Fax: 758-453-1041
Email: turningpoint@yahoo.com
& desmondphilip@hotmail.com

Dr. Marcus Day

Director
Caribbean Drug Abuse Research Institute
Box 1419
Castries
SAINT LUCIA

Tel: 758-458-2795 Office
Fax: 758-458-2796
Cell: 758-485-9100
E-mail: daym@candw.lc

ST VINCENT & THE GRENADINES

Dr. Amrie Morris-Patterson

Psychiatrist
Ministry of Health

Tel: 784-526-5756
Fax:
Email: asmpvinci@yahoo.com

SURINAME

Mr. K. Rambali

-
Policy Officer
National Anti-Drug Council,
Executive Office
Ministry of Health
Letita Vriesde Laan
Paramaribo
Tel: 597-424-514
Fax: 597-472-414
Email: ddroffice@sr.net &
rambali_kris@hotmail.com

TRINIDAD & TOBAGO

Dr. Winston Gopaul

-
Specialist Medical Officer
Substance Abuse Prevention & Treatment Centre
Ministry of Health
Tel: 868-645-4630
Fax: 868-662-0289
Email: winstongopaul@hotmail.com

Mr. Paul A . Holder

Ministry of Social Development
NADAPP
62 Abercomby Street
Port of Spain
Tel: 868-625-7055/627-3506
Fax: 868-627-4471
Email: technical.nadapp@gmail.com

Ms. Ester Best

Senior Administrative Officer
Ministry of National Security
52 – 60 Abercomby Street
Port of Spain
Tel: 868-625-1874
Fax: 868-625-3394
Email: ebest@mns.gov.tt

BERMUDA

Ms. Caron Assan

-
Director
Ministry of Culture & Social Rehabilitation
Department for National Drug Control
Suite 304, Melbourne House
11 Parliament Street
Hamilton. HM 11
Tel: 441-292-3049
Fax: 441-295-2066
Email: cassan@gov.bm

Ms. Joanne Dean

Treatment Officer
Ministry of Culture & Social Rehabilitation
Department for National Drug Control
Suite 304, Melbourne House
11 Parliament Street
Hamilton. HM 12
Tel: 441-292-3049
Fax: 441-295-2066
Email: jidean@gov.bm

Dr. Ken- Garfield Douglas

Drug Abuse Epidemiologist
C/o Suite 304 Department for National Drug
Control
11 Parliament St
Hamilton, Bermuda HM12
Tel: 441-505-1038
Fax:
E-mail: kgdouglas@yahoo.com

CAYMAN ISLANDS -

Ms. Joan West-Dacres

Executive Director
National Drug Council
Ministry of Health & Human Services
17 - # 18 Caymanian Village
North Sound Way
P.O. Box 10007, Grand Cayman
Ky1 – 1001 Cayman Islands
Tel: 345-949-9000
Fax: 345-949-6264
Email: JWest-Dacres@ndc.ky

ORGANISATIONS/INSTITUTIONS -
**ORGANISATION OF AMERICAN STATES/
INTER-AMERICAN DRUG ABUSE CONTROL
COMMISSION/ (OAS/CICAD)**

Ms. Anna Chisman

Head, Demand Reduction
ORGANISATION OF AMERICAN STATES/

INTER-AMERICAN DRUG ABUSE CONTROL
COMMISSION/ (OAS/CICAD)
1889 F Street, NW
Washington DC 20006 USA
Tel: 202-458-6221
Fax: 202-458-3658
Email: achisman@oas.org

JOHN HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

Prof. Wallace Mandell

Speaker

John Hopkins Bloomberg School of Public Health
624 North Broadway'
Baltimore, Maryland
21205
USA
Tel: 410-955-3889
Fax: 410-614-8132
Email: wmandell@jhsph.edu

Prof. Emeritus

CONSULTANT

John Hopkins Bloomberg School of Public Health
624 North Broadway'
Baltimore, Maryland
21205
USA
Tel: 410-955-3889
Fax: 410-614-8132
Email:

CARIBBEAN COMMUNITY SECRETARIAT

Ms. Beverly Reynolds

Mr. Arnulfo Kantun

Ms. Dorett Campbell

Ms. Debra Lowe-Thorne

Ms. Janice Tyndall

-

Programme Manager, Sustainable Development

Coordinator, Illicit Drug Project

Senior Project Officer

Administrator, Illicit Drug Project

Senior Clerk, Health Sector Development