

How to improve Opioid Substitution Therapy implementation

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*Experiences from EU countries, part of a joint EAHC-WHO project involving
Bulgaria, Estonia, Germany, Latvia, Lithuania, Poland, Portugal and Romania*

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We would like to thank Dr Emilis Subata, international consultant for WHO Regional Office for Europe, for preparing the first draft of this document. The document is based on inputs by country representatives, as well as representatives from WHO Office for Europe and its partner organizations: the Executive Agency for Health and Consumers, the European Monitoring Centre for Drugs and Drug Addiction, the Council of Europe Pompidou Group and the European Centre for Disease Prevention and Control. We are grateful for their contributions and would like to especially acknowledge the contributions by the European Monitoring Centre for Drugs and Drug Addiction, in particular to chapter 1.

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Foreword

This document is the outcome of the workshop “How to scale-up and implement opioid substitution treatment in the European Union”, which was organized by the WHO Office for Europe during 22-23 May 2012 in Vilnius, Lithuania.

The organization of the workshop and production of the first draft of this document were carried out as part of a joint action with the Executive Agency for Health and Consumers (EAHC) entitled ***Scaling up access to high quality harm reduction treatment and care for injecting drug users in the European Region (Harm Reduction)*** under **Grant Agreement 2008 52 02 Work Package 5 Opioid Substitution Therapy**¹.

The document is based on inputs by country representatives, as well as representatives from WHO Office for Europe, its partner organizations the Executive Agency for Health and Consumers (EAHC) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), and observers from the Council of Europe (CoE) Pompidou Group and the European Centre for Disease Prevention and Control (ECDC).

The first draft of the document was prepared by Dr Emilis Subata, international consultant, and afterwards revised and edited by WHO Regional Office for Europe. We greatly acknowledge the contributions by the European Monitoring Centre for Drugs and Drug Addiction, in particular to chapter 1.

¹ See for more information: <http://www.euro.who.int/en/health-topics/communicable-diseases/hiv-aids/activities/scaling-up-access-to-high-quality-harm-reduction>

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List of abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral therapy
ASI	Addiction Severity Index
CoE	Council of Europe
DOTS	Directly Observed Treatment, Short Course
EAHC	European Agency for Health and Consumers
ECDC	European Centre for Disease Prevention and Control
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
GP	General Practitioner
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use/User
MMT	Methadone Maintenance Treatment
NGO	Nongovernmental organization
NSP	Needle and Syringe Programme
OST	Opioid Substitution Therapy
PWID	People Who Inject Drugs
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

1. Introduction

Rationale, methodology and aim of this document

In 2009 WHO published comprehensive guidelines on psychosocially assisted pharmacological treatment of opioid dependence, to fulfil the information needs of policy-makers, managers, clinicians and health care workers (WHO, 2009a). Also, many countries have introduced national guidelines. The existing recommendations provide solid cornerstones for consideration when implementing and scaling-up OST on national and sub-national levels, as well as ensuring quality of OST programmes. However, these documents focus mainly on *clinical* issues (such as dosage, eligibility criteria, treatment of specific groups etc.) and do not address a different set of questions related to *practical* issues of improving OST implementation and scaling-up. Policy-makers and programme leaders often face practical barriers on *how to* scale-up and implement OST in their country, region or city. And, indeed, in many instances specific solutions regarding overcoming barriers for implementation and scaling-up of OST, as well as improving its quality, are found in national or local conditions. A need was identified for a different type of guidance, dealing with *practical* issues and focusing on ‘*how to*’ questions, which would provide tools to address common challenges to scaling up and implementing quality OST.

In order to discuss the situation of quality, accessibility and coverage of OST in Europe, as well as the need for a practical document, WHO Regional Office for Europe convened a workshop in Vilnius, Lithuania during 22-23 May 2012 on how to scale-up and implement opioid substitution therapy². Representatives from selected EU Member States (Bulgaria, Estonia, Germany, Latvia, Lithuania, Poland, Portugal, and Romania), partner organizations (EMCDDA, Executive Agency for Health and Consumers) and observers (Council of Europe, European Centre for Disease Prevention and Control) participated in the workshop.

The organization of the workshop was carried out as part of a joint action with the Executive Agency for Health and Consumers (EAHC) entitled *Scaling up access to high quality harm reduction treatment and care for injecting drug users in the European Region (Harm Reduction)* under Grant Agreement 2008 52 02 Work Package 5 Opioid Substitution Therapy.

Workshop participants indicated the need for the development of a collection of practical examples from the European Region on how to scale-up and implement OST. It was agreed that the document would include background information from the literature and furthermore, be a collection of practical experiences and actions by health authorities, administrators and OST programme leaders in overcoming obstacles for implementation and scaling-up of OST. The document would incorporate “case studies”, “best practices” and “success stories” from EU countries, particularly the ones participating in the workshop but welcoming experiences from

² See for more information about the workshop annex 2 and: <http://www.euro.who.int/en/health-topics/communicable-diseases/hiv-aids/activities/scaling-up-access-to-high-quality-harm-reduction/key-outputs/meetings-and-events>

additional countries. Sixteen key 'how to' questions were identified as the most relevant for improving OST implementation and scaling-up, focussing on the full range of relevant aspects.

The main aim of this publication is to enable professionals facing challenges in improving implementation and scaling-up of OST, to become familiar with other countries' experiences and to be able to replicate successes in their local contexts and settings.

The document aims to provide tools for addressing the most common challenges in scaling-up and implementing quality OST services. It documents valuable lessons learned from successful guidelines implementation in various countries.

The document is primarily targeted at health policy-makers on national, regional and local levels, administrators of health care institutions and managers of OST sites.

It is structured according to sixteen 'how to' questions, as identified and discussed during the above mentioned workshop. Under each 'how to' question, specific short descriptions of experiences on how challenges were overcome in respective countries are included. These experiences were shared by the workshop participants (see for the full list of participants annex 2) and in addition, one experience from France as found in the literature is included. The document concludes with a set of recommendations on how to improve implementation and scaling-up of OST.

Opioid substitution therapy – an effective intervention for opioid dependence and HIV prevention

Scientific research suggests that opioid dependence is a chronic illness with frequent relapses. Nowadays, opioid dependence is often compared with other chronic diseases, such as hypertension, diabetes and asthma (McLellan AT et al., 2000; WHO, 2004). There are no particular "cures" for chronic diseases. Nevertheless, with appropriate long-term therapy and medical care, together with encouraging behavioural change, it is possible to eliminate or reduce symptoms of the dependence and reach a high quality of life.

In this document opioid substitution therapy (OST) refers to the administration of a prescribed daily dosage of opioid medicines with long-lasting effects to clients³ with opioid dependence, under medical supervision and supported by psychosocial interventions. It is often provided by public institutions or nongovernmental organizations, depending on the country. Psychosocial interventions include counselling, motivational interviewing, cognitive-behavioural therapy, case management, group and family therapy and relapse prevention. They offer support to users as they attempt to manage and overcome their drug problems, and they are the main form of therapy for users of stimulant drugs, such as cocaine and amphetamines. According to a 2011

³ In this document the term 'client' is used to describe a person eligible for opioid substitution therapy. An 'OST client' (or 'client on OST') refers to a client who is receiving opioid substitution therapy.

survey of national experts to the EMCDDA, most European countries report the availability of psychosocial interventions to clients on OST who seek it.

OST is recognized as an effective tool to prevent HIV among people who inject drugs (PWID) and to increase adherence of eligible people living with HIV/AIDS to antiretroviral therapy (ART). It is recognized as a cost-effective strategy, which allows for the achievement of high retention rates of PWID in therapeutic programmes, a significant reduction of illegal opioid use and a reduction of injecting risk behaviour (WHO, 1998; WHO/UNODC/UNAIDS, 2004; WHO, 2005a; WHO 2009a).

Opioid substitution therapy is part of the “essential” core package of services and interventions which are proven to prevent HIV transmission among PWID and from them to their sexual partners and children. These interventions are supported by scientific evidence, and summarized by WHO/UNODC in Evidence for Action technical papers and policy briefs⁴ and in the joint ECDC/EMCDDA guidance (ECDC/EMCDDA, 2011abc)⁵:

- Needle and syringe programmes (NSP)
- Opioid substitution therapy (OST) and other evidence-based drug dependence treatment
- HIV testing and counseling
- Antiretroviral therapy (ART)
- Prevention and treatment of sexually transmitted infections (STIs)
- Condom programmes for PWID and their sexual partners
- Targeted information, education and communication for PWID and their sexual partners
- Vaccination, diagnosis and treatment of viral hepatitis
- Prevention, diagnosis and treatment of tuberculosis (TB)
- Health promotion
- Targeted delivery of services

Methadone and buprenorphine are the main opioid medicines in use in OST and have been proven highly effective in the treatment of opioid dependence as well as in HIV prevention (WHO, 2009a; ECDC/EMCDDA 2011c). Both methadone and buprenorphine have been included in the WHO Model List of Essential Medicines, XIV Edition (WHO, 2005b). The effectiveness of OST with methadone and buprenorphine in reducing illegal opioid use and injecting risk behaviour, increasing the quality of life, improving health, and reducing criminality, has been observed not only in economically developed countries (Amato L et al., 2008; Mattic RP et al., 2008; Gowing L et al., 2008), but also in lower income countries and across different cultures, such as in China, Indonesia, Iran, Thailand, Lithuania, Poland and Ukraine (Lawrinson P et al., 2008; Schaub M et al., 2009).

The WHO Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence recommend that for most clients opioid substitution therapy with methadone or buprenorphine is used in preference to detoxification, that methadone is used in preference to buprenorphine, and that both methadone substitution therapy and detoxification services should be made widely available, including in prisons (WHO, 2009a).

⁴ See: <http://www.who.int/hiv/pub/advocacy/idupolicybriefs/en/>

⁵ See: http://www.emcdda.europa.eu/attacheements.cfm/att_142052_EN_ECDC-EMCDDA%20IDU%20guidance%20-%20web%20version.pdf

As outlined by WHO, UNODC and UNAIDS in the *Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*, an OST coverage of less than 20% of opioid dependent people is considered low, 20-40% medium and above 40% high. The technical guide includes more quality indicators of OST in relation to its impact to HIV prevention, including indicators on the average dose of methadone or buprenorphine and the duration of treatment (WHO/UNODC/UNAIDS, 2009).

OST is the predominant therapy option for opioid users in Europe. All EU countries have adopted a legal basis for substitution therapy, which can be accessed at the website of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)⁶. OST is generally provided in specialist out-patient settings, and more and more in prisons. Office-based general practitioners (often in shared-care arrangements with specialist centres) increasingly play a role and are the main providers of OST in France, Germany, Norway, Luxembourg, Croatia and Belgium (see Fig. 5). OST is available in all EU Member States, as well as Norway. In Turkey, OST in the form of combination buprenorphine-naloxone was introduced in 2010. Overall, it is estimated that there were about 730 000 persons on OST in the EU and Norway in 2011 (EMCDDA, 2013).

The vast majority of OST is still provided in the 15 pre-2004 EU Member States (EU-15 Member States)⁷ (about 95% of total), and numbers in these countries continued to increase between 2003 and 2011 (Fig. 1). Among these countries, the highest increases were observed in Finland, Austria and Greece with a three-fold increase in treatment numbers during this period. In the 12 countries that joined the EU more recently (EU-12 Member States)⁸, treatment numbers remain low.

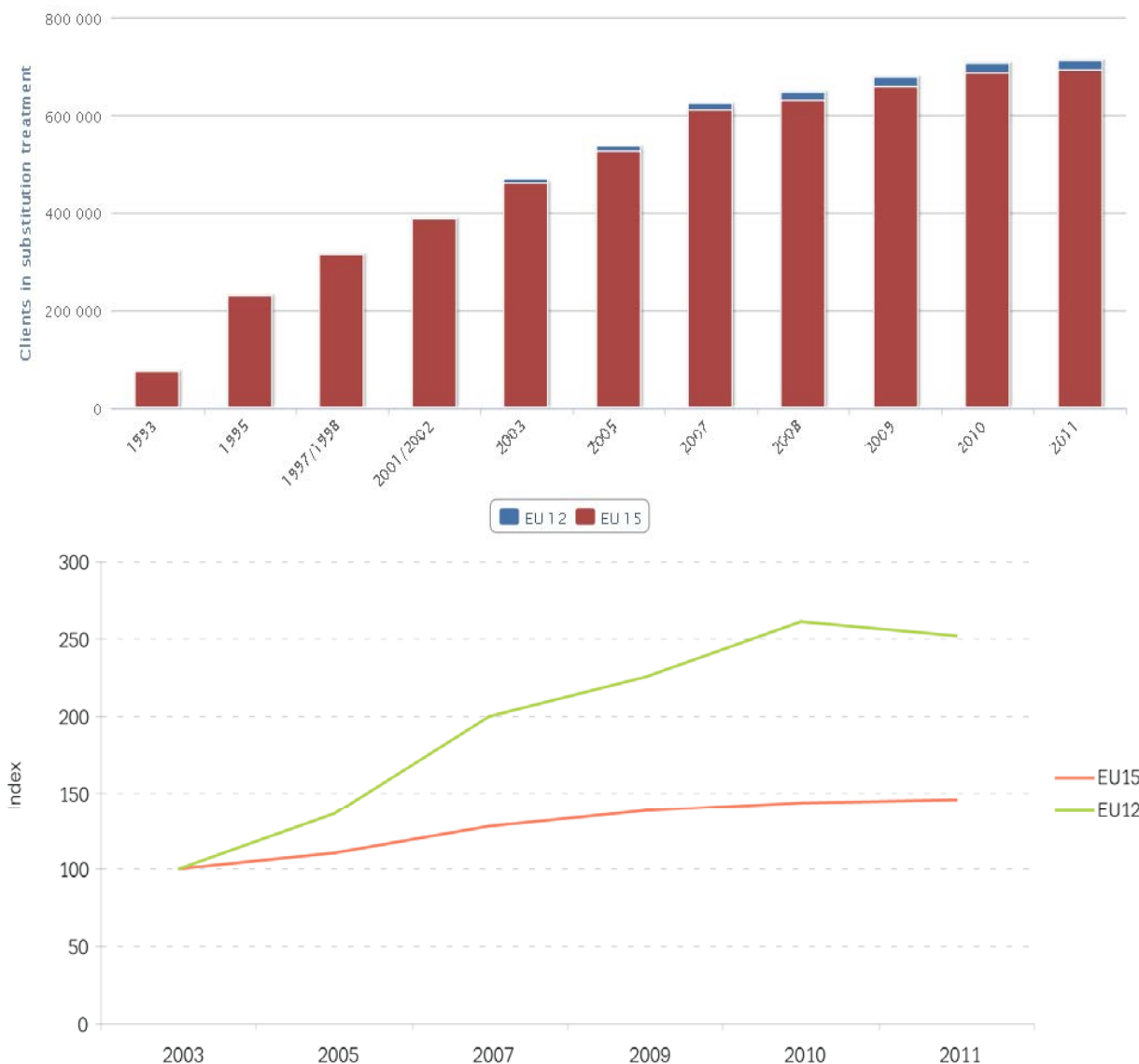
⁶ Accessible at EMCDDA website: Legal frameworks of opioid substitution treatment
<http://www.emcdda.europa.eu/html.cfm/index41823EN.html>

⁷ EU-15 Member States include: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and United Kingdom.

⁸ EU-12 Member States include: Bulgaria, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia.

Fig. 1 and Fig. 2

Trends of clients on opioid substitution therapy in the 15 pre-2004 and the 12 newer EU Member States — estimated numbers (1993-2011) and indexed trends (2003-2011) (EMCDDA, 2013)



Although treatment numbers remain low in the EU-12 Member States, the number of clients on OST more than doubled between 2003 and 2011, from 7 800 to 20 000. Relative to the index year 2003 (Fig. 2), a steep increase can be noted during 2005-2010, but from this date onwards there has been a slight decrease. Proportionally, the expansion of OST in these countries over the eight-year period was highest in Estonia (16-fold from 60 to about 1 000 OST clients, though still reaching only 5% of opioid injectors) and Bulgaria (ten-fold), while there was a four-fold increase in Latvia. The smallest increases were reported in Slovakia, Hungary and Lithuania. Increased provision of OST may be linked to several factors, including response to high levels of injecting drug use and related HIV-transmission, alignments with the EU Drugs Strategy⁹ and the

⁹ EU Drugs Strategy 2005-2012, accessible at: <http://register.consilium.europa.eu/pdf/en/04/st15/st15074.en04.pdf>

funding of pilot projects by international organizations, such as The Global Fund to Fight AIDS, Tuberculosis and Malaria¹⁰ and the United Nations Office on Drugs and Crime (UNODC)¹¹.

Overall, it is estimated that about half of the European Union's problem opioid users have access to OST. The number of OST clients in eastern Europe remains low compared to the rest of Europe (the 12 post-2004 EU Member States represent only 5% of the total number of persons on OST within the EU, while representing 20% of the population and often reporting relatively high levels of opioid use).

A comparison of the number of clients on OST with the estimated number of problem opioid users¹² suggests varying coverage levels throughout Europe (Fig. 3). Of the 17 countries for which reliable estimates of the number of problem opioid users are available, 11 report a number of people on OST corresponding to 40% or more of the target population. Eight of those countries are pre-2004 EU Member States (and Norway), and the remaining countries are Malta, the Czech Republic and Croatia. Coverage reaches 33% in Greece and 20% in Hungary and Cyprus. Of the three countries with coverage levels reported to the EMCDDA which are below 15%, all are EU-12 Member States. Other sources indicate that coverage levels in the EU-15 Member States Poland, Estonia and Romania are also below 15%¹³.

¹⁰ <http://www.theglobalfund.org/en/>

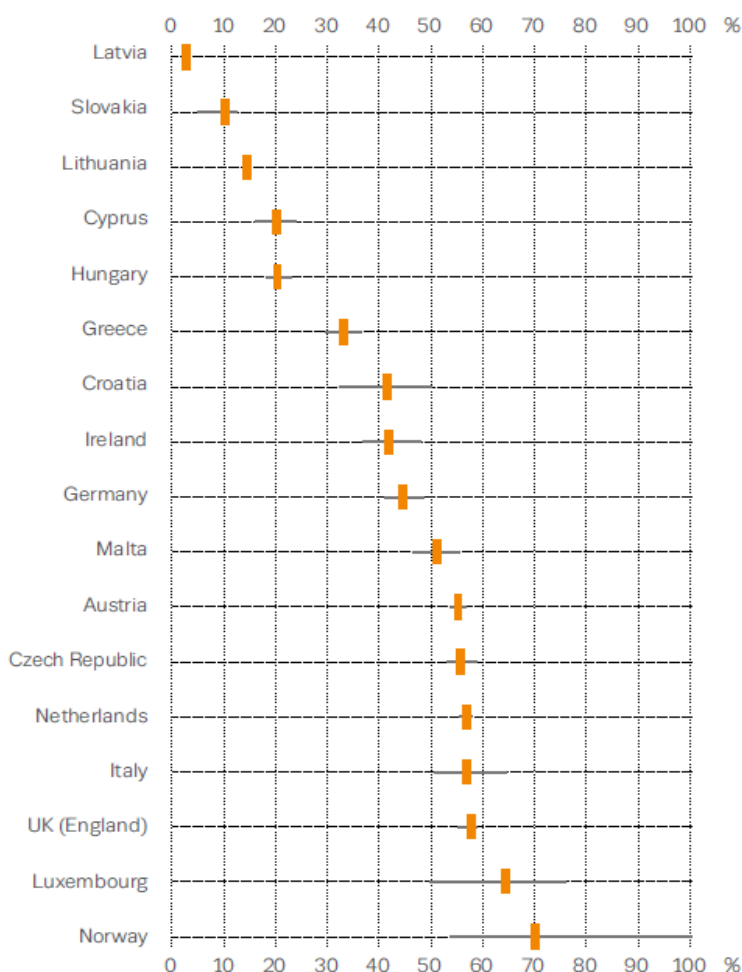
¹¹ <http://www.unodc.org/>

¹² The term problem opioid user is used to describe an opioid user who injects opioids and/or uses opioids during a long period of time/regularly.

¹³ Report of the workshop on how to scale-up and implement opioid substitution therapy in the European Union, see annex 2 or: <http://www.euro.who.int/en/health-topics/communicable-diseases/hiv-aids/activities/scaling-up-access-to-high-quality-harm-reduction/key-outputs/meetings-and-events/report-workshop-on-how-to-scale-up-and-implement-opioid-substitution-treatment-based-on-the-experiences-of-selected-eu-member-states>

Fig. 3

Percentage of problem opioid users in substitution treatment (estimate)



Improved OST access, quality and coverage

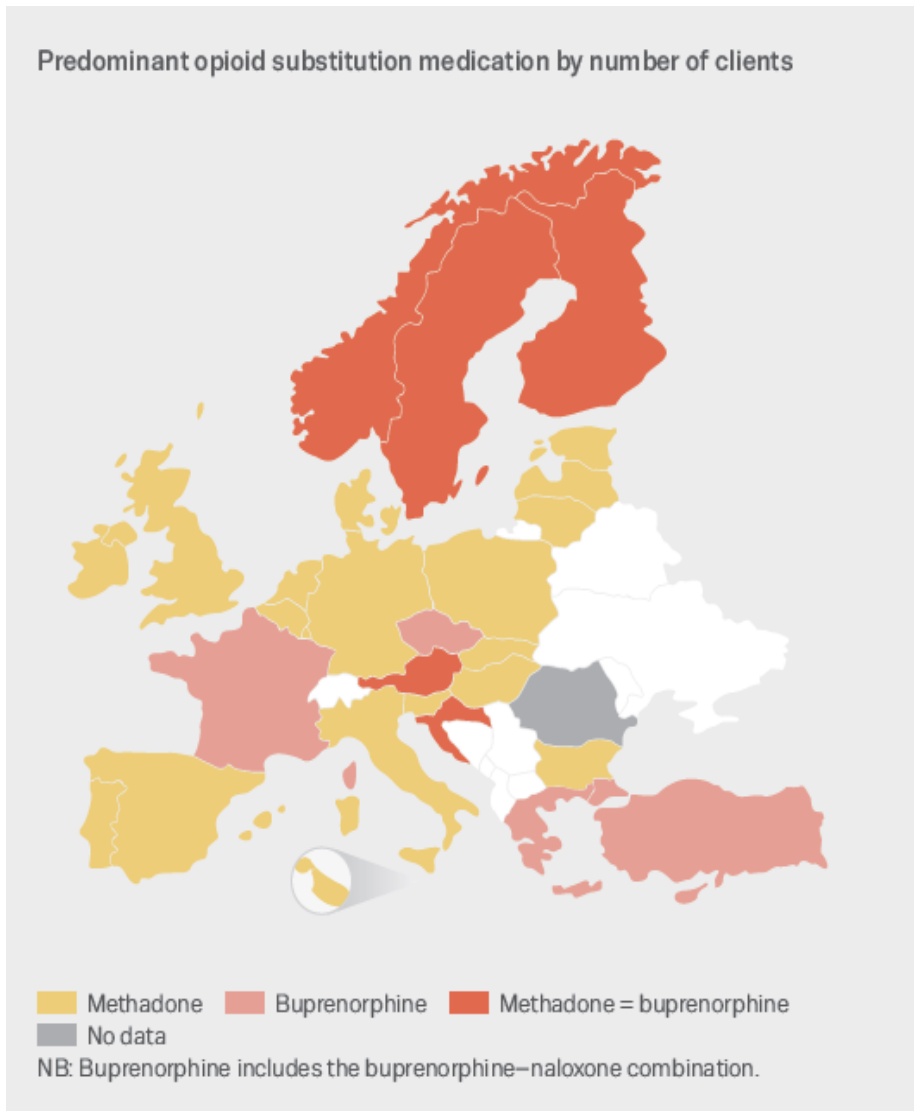
Many countries that joined the EU more recently (the EU-12 Member States) report efforts to improve access, quality and provision of OST. For instance, clinical guidelines for the treatment of opioid dependence with methadone and buprenorphine were issued in Lithuania in 2010. Geographical availability of OST in Latvia is expanding, with new treatment providers outside of the capital Riga. Regulations for the financing of OST under national health insurance have been adopted in the Czech Republic. Lack of funding for OST is however reported as limiting the geographical coverage in Poland and reducing significantly the number of treatment slots available among the main providers of OST in Bulgaria, which are non-publicly funded organizations.

In the EU and Norway, methadone is the most commonly prescribed substitution medication, received by up to 70% of all OST clients (Fig. 4). Buprenorphine is prescribed to up to 25% of European substitution clients, and is the principal substitution drug in the Czech Republic, France, Cyprus, Finland, Turkey and Greece. The combination buprenorphine-naloxone is available in 15 countries. Treatments with slow-release oral morphine, codeine (Germany,

Cyprus) and diacetylmorphine (Belgium, Denmark, Germany, Spain, Netherlands, United Kingdom) represent a small proportion of all treatments (EMCDDA, 2013).

One specific challenge in expanding access to opioid substitution therapy in most EU-12 countries is excessive regulation over who can prescribe OST medications to drug users. Currently, only psychiatrists or medical doctors within defined, specialized treatment centres (e.g. OST clinics) can prescribe OST medications (Fig. 5). Strict legal regulations around OST prescribing may lead to restricted access to essential treatment¹⁴¹⁵.

Fig. 4

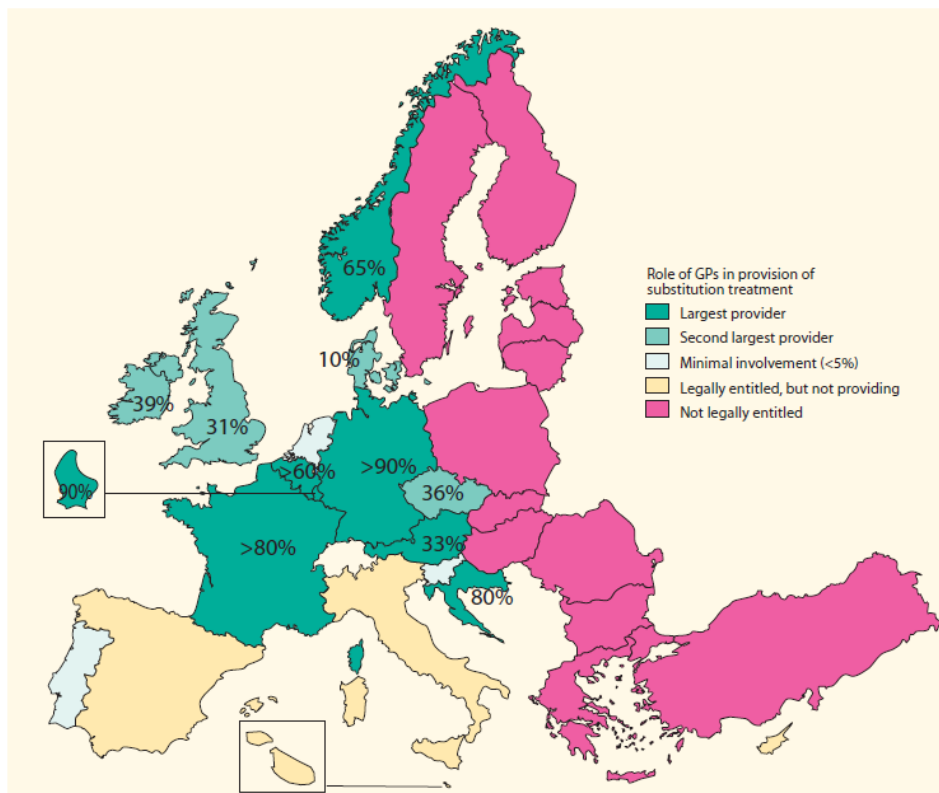


¹⁴ See also: http://ee.euro.who.int/WHO_UNODC_Estonian_mid_term_Evaluation_2011.pdf

¹⁵ See also: <http://www.atome-project.eu/>

Fig. 5

Legal framework and level of OST provision by general practitioners as a percentage of all OST provided in the respective countries (2011 data)



OST in prisons

There have been a growing number of studies and recommendations that opioid substitution therapy should be part of HIV prevention strategies in prisons as an important and highly effective public health intervention (WHO Regional Office for Europe, 2005). A recent systematic review of 21 studies on OST in prisons demonstrates that benefits of prison-based OST are similar to those seen in the community (Hedrich et al., 2012). Moreover, practical guidelines for the introduction of OST in prisons have been developed (WHO Regional Office for Europe, 2007; Kastelic A. et al., 2008; UNODC, 2008; WHO, 2009b; Stöver and Marteau, 2012). An assessment at European level (Hedrich and Farrell, 2012) showed that while 8 countries in Europe provide OST both in prison and community at levels that roughly equal or surpass the EU average of 50%, 14 countries in central, north-east and south-east Europe have no or very low levels of OST provision in prisons (less than 5%), while 8 countries are somewhere in between. While equivalence of care in prisons and the community should be envisaged, large numbers of prisoners still do not have access to OST (Larney S. et al., 2012). Moreover, legal issues may hinder the introduction of OST in prisons. For instance in Latvia, legal provision of OST in prisons is only possible since 1 April 2012.

Current (inter)national guidelines in EU Member States

In 2009, the World Health Organization published the comprehensive “Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence” (WHO, 2009a). The guidelines include recommendations, which were developed on the solid basis of systematic overviews of research data (using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology) and, where such data was unavailable, on expert opinions. The Guidelines provide solid recommendations on 3 levels:

- National and sub-national level for health systems;
- Treatment programme level for programme managers and clinical leaders;
- Client-level for clinicians.

There are some key principles with regard to access to OST, most of which are also reflected in the WHO Guidelines for Psychosocially assisted pharmacological treatment of opioid dependence, as recommendations on OST provision for health systems. To increase access to OST and make it more universal, interventions should be:

- Physically **accessible** – there should be a broad geographical distribution e.g. OST should not only be available in the major cities or unavailable in hard-to-reach locations such as prisons;
- **Affordable** – the costs at the point of service should not be a barrier e.g. clients should not be expected to pay for OST or other ancillary services and OST should also be affordable to disadvantaged populations;
- **Equitable and non-discriminatory** – there should be no exclusion criteria except medical ones e.g. OST should not be limited to those over a certain age or only available to those opioid dependent individuals who are HIV infected or who have “failed” other drug dependence treatments;
- **Non-rationed** – supply of OST should be determined by need and not limited by costs or other considerations; ideally there should be no waiting lists.

In 2010, EMCDDA collected 143 national drug dependence treatment guidelines from 30 countries and developed a Best Practice Portal (EMCDDA, 2011). Out of the 143 guidelines identified, 57 guidelines from 24 countries contained recommendations on OST, 18 of which were published after 2009. Importantly, OST guidelines if compared with guidelines for other treatment modalities have the highest proportion of references to randomized clinical trials and the Cochrane library (especially United Kingdom and Germany). Most guidelines specify the ideal dosage at the beginning of treatment. Also, most agree on the need of direct supervision of dispensing in the initial phases of treatment and specify conditions in which take-away doses can be given. Most agree that OST should be offered to pregnant women, with the preference of methadone, though evidence suggests that buprenorphine may also be beneficial in this particular subgroup. Guidelines agree that psychosocial support should be routinely offered and,

finally, there is a general convergence of national guidelines with WHO Guidelines (EMCDDA, 2011).

However, having well-written and agreed guidelines in place does not automatically imply implementation of quality services at all OST sites, good access to these services and high coverage rates. This is because *only appropriate implementation of guidelines makes a real difference*. Unfortunately, poor implementation of guidelines remains common. This may be due to various reasons, such as barriers from social, organizational and economic points of view, opposing reactions by professionals and/or clients including resistance triggered by changes and innovation.

The reasons for OST being underdeveloped in most EU-12 Member States include:

- Overall low priority for dependence treatment in the context of limited budget for health services;
- Hesitations by health care administrators and/or professionals to be involved with PWID;
- Political/ideological arguments about legitimacy and effectiveness of non-abstinence orientated and harm reduction programmes;
- Low quality of existing OST programmes with therefore limited effectiveness;
- Lack of demand for OST due to stigmatization of clients on OST.

The last point has to do with OST by some users being perceived as only the very last resort, which may be related to negative public opinion about OST. For instance in Latvia and Estonia, there is no waiting list for OST while coverage levels are amongst the lowest in Europe, indicating very limited demand among users.

The treatment of drug dependence in some of the newer EU countries is emerging from the shadow of practice dominated by past Soviet psychiatric discipline of “narcology¹⁶”, rather than evidence-based drug treatment practices. Following the traditional treatment concepts, OST, after being introduced in existent “narcological” infrastructure, was (and in other non-EU post-Soviet countries still is) often implemented as an abstinence-aimed short-term therapy, isolated from other services rather than implemented as a long-term public health intervention integrated with infectious diseases and social services. Inherited characteristics of health care systems in post-Soviet countries included (and in some non-EU post-soviet countries still include) vertical programming, with specialized and distinctly separate services for HIV/AIDS, sexually transmitted infections, other infectious diseases and services for people with drug and alcohol dependencies.

While old attitudes and views with a rigid demarcation of responsibilities are being eroded, psychiatrists (and narcologists) may still feel reluctant to get involved in infectious diseases work.

¹⁶ By 2012 *narcology* has been retained as a speciality separate from psychiatry in Latvia with the licence for specialised medical practice granted after 4 years of post-graduate residential training in narcology. In Lithuania and Estonia, after 1990 substance dependence treatment was assigned to psychiatrists. Narcology is still a separate medical specialty and service in most post-Soviet countries.

Moreover, in some of the EU-12 Member States the tradition is inherited that clinical decisions are based on the opinions and instincts of senior physicians, rather than on evidenced-based medicine (e.g. systematic reviews of relevant scientific research including meta-analysis typified by the Cochrane Collaboration), though this tradition is also subject to change. On the other hand, the tradition and experience of involving general practitioners in opioid dependence and infectious diseases care is not yet available in most EU-12 Member States.

Distinctive approaches to providing OST are described in the box below.

Box 1: Distinctive approaches to OST		
Conservative approach		Recommended approach
Abstinence-orientated (at the most extreme: in the Russian Federation OST is prohibited by law)	↔	Public health intervention – effective strategy for HIV/AIDS (hepatitis B and C, TB etc.) prevention and control
OST of limited duration (long term detoxification), aimed at abstinence (quitting drugs)	↔	OST as long-term treatment, not necessarily aimed at abstinence
Targeted to selected groups motivated to abstinence	↔	Relevant to the majority of opioid dependent people (not just those motivated to abstinence)
Lower dosages	↔	Higher dosages
Restrictive	↔	Inclusive
Isolated – e.g. separated from infectious disease specialists, social services etc.	↔	Good communication and cooperation with other services, e.g. infectious disease specialists, social services etc.
Outcome – drug free clients	↔	Outcome – client retention, improved health and social functioning, reduced substance use and injecting, reduced risk of HIV infection etc.

2. Overview of country experiences categorized under sixteen 'how to' questions

1. How to develop national OST Clinical Guidelines?

National OST clinical guidelines are important in setting the same standards for clinical practice of OST across the country. Without national clinical guidelines the actual implementation of OST can vary considerably, depending on attitudes and ideological considerations of managers of OST sites and their staff. Experiences by Member States have shown that the development of national OST clinical guidelines ideally includes the following steps:

- Initiation of a multidisciplinary specialist working group, e.g. involving Ministry of Health, a professional association, a university clinic etc;
- Use of existing WHO and other European/EU country guidelines as a base, which already include appraisal of available evidence, expert opinions (when evidence is not available) and clients' perspectives¹⁷;
- Approval of the National Clinical Guidelines by National Authorities (e.g. Ministry of Health, National Health Insurance), although this is not a necessary requirement in all Member States.

Country example: Estonia

Developing OST Clinical Guidelines

In Estonia, HIV prevalence is relatively high. Country OST Guidelines were first developed as part of overall drug treatment in 2001 under the leadership of the Estonian Foundation for Drug Prevention in cooperation with the Pompidou Group of the Council of Europe. A revised version was issued by the Estonian Psychiatric Association in 2007. These guidelines included restrictive indications for OST and provided limited clinical guidance. In 2010, the National Institute for Health Development, an institution under the Ministry of Social Affairs which is responsible for the implementation and funding of OST in the country, approached the Estonian Psychiatric Association with the offer to support the development of updated OST guidelines. The Estonian Psychiatric Association did not have sufficient human resources and consequently interest to lead the development of the guidelines on OST (a phenomenon which could be quite common across different countries). Continuous communication between the National Institute for Health Development and the Estonian Psychiatric Association however resulted in a mutual agreement that specialists from the Institute would develop a draft for OST Guidelines, based on WHO guidelines and selected guidelines from different EU countries. The Association will review and adopt the Guidelines and recommend its use among its member psychiatrists.

¹⁷ The EMCDDA Best practice portal contains a compilation of national guidelines for the implementation of practices. The title, the methodological basis and the types of treatment covered by each guideline are provided, along with a download link where available. See: <http://www.emcdda.europa.eu/best-practice/standards/treatment>

2. How to encourage professionals to use international and national guidelines?

Existence of national and international clinical guidelines does not automatically imply that they are used by OST professionals. As discussed before, there could be barriers related to the social, organizational and economic context and there could be resistance to OST from professionals and clients. Another barrier could be the unavailability of literature that documents the evidence-base in national languages and the limited number of clinicians and OST site leaders that are able to access/read international guidelines and research papers in English or other foreign languages.

Based on the experiences collected, several measures can support availability and facilitate implementation of evidence-based guidelines, such as:

- To translate international guidelines into the national language;
- To ensure wide availability of guidelines to practitioners through dissemination of printed hard copies as well as making electronic copies available through the internet;
- To incorporate recommendations and performance indicators from the international and/or national guidelines into health care institutions' internal treatment policies and quality assurance procedures;
- To conduct formal training courses for staff at OST sites to systematically introduce national and international guidelines;
- To, together with professional associations and universities, develop courses on OST and seek accreditation for them by medical universities;
- To include training on clinical guidelines into the postgraduate training of physician residents in psychiatry if applicable;
- To implement a system of continuous on-site training, including intervision sessions (see country examples on the next page), analyses of case studies, etc.

Country examples: Estonia, Latvia and Lithuania**Intervision sessions as a method of on-site training and mutual support for OST specialist teams**

Intervision¹⁸ is a discussion in a group which could consist either of different specialists in an OST team (if multidisciplinary issues are being discussed) or professionals within the same speciality (e.g. when physicians choose to discuss clinical topics). Intervision could be described as an exchange between or mutual consultation of colleagues and is generally used to address general treatment and care issues which need clarification or are perceived as problematic by team staff. Participants in an intervision session are all equal to express their opinions. Here the approach is different from classical “supervision” where the communication is between an experienced and skilled supervisor and a person supervised and eager to learn. In order to reduce the negative influence of hierarchy to the openness of discussion, intervision sessions could have a facilitator, ideally an objective outsider (e.g. a person from another OST site or other department). During intervision sessions the facilitator is not allowed to convey his/her opinion. His/her main task is to structure professional discussion and motivate participants in a small group to openly share the pre-selected organizational/clinical issues or case studies.

Main advantages of intervision are to look for already existing expertise in OST sites and strengthen sound team cooperation. It is interactive, easy to implement and economical.

Discussions during intervision sessions could disclose to which extent real OST implementation is done in line with available guidelines.

The Estonian Institute for Health Development allocated budget to convene intervision sessions at all OST sites of Estonia while inviting “outside” facilitators. The Vilnius Centre for Addictive Disorders (Lithuania) has included intervision sessions at least twice per year as a mandatory part of on-site staff training.

¹⁸ Intervision guidelines were prepared by Franz Trautmann (Trautmann F., 2010) (Trimbos Institute, the Netherlands) in the implementation of the UNODC project “HIV prevention among IDU in community and prison settings in Estonia, Latvia and Lithuania 2006-2010” and are available in English, Estonian, Latvian, Lithuanian and Russian language at UNODC internet site:

<http://www.unodc.org/balticstates/en/publications/pharmacologicaltreatment.html>

3. How to ensure the quality of OST programmes?

A high quality of OST programmes is essential. Low quality OST is not only less effective in outcomes of treatment and HIV prevention, but could also compromise OST in the eyes of local community, policy-makers, administrators, professionals and clients, as it may lead to clients' incompliance with the programme. Country experiences show that there are many ways to increase the quality of OST, including:

- To make international and national guidelines easily available and encouraged to be used by practitioners and institutions in all possible ways;
- To develop internal institutional OST procedures at OST sites, based on the national or international guidelines;
- To implement a multidisciplinary approach and coordination of multidisciplinary staff, e.g. through a case manager;
- To develop a system of referrals to external medical, social and legal services and the collaboration with them (general practitioners, infectious disease specialists, hospitals, social care services, night shelters, labour exchange, NGOs, probation, child protection agencies etc.);
- To implement a system of continuous external and on-site training for professionals, e.g. regular interdisciplinary intervision sessions;
- To maintain an adequate and as much as possible user-friendly environment at the OST sites;
- To ask OST clients regularly (including anonymous client satisfaction surveys) about their opinion of the services and whether their needs are addressed;
- To perform a regular inspection of medical records on how they comply with existing guidelines and legal requirements and to address the possible gaps identified (by external authorities or funding bodies as well as the institution's internal quality control system).

Country example: Lithuania

Case management of OST clients

Case managers were introduced in the Vilnius Centre for Addictive Disorders in 2007. In principle, they are professional social workers with a master's degree in social work, though trained nurses and psychologists could also function as case managers.

The case manager is the primary contact person for an OST client to discuss problems of any kind. For example, if a client needs a consultation with the psychiatrist on an OST site, he/she approaches the case manager and then the case manager arranges the consultation. The case manager has a workload of a maximum of 30 clients.

The case manager is responsible for:

- Collecting and filing all obligatory documents before the initiation of treatment (client's ID, status of medical insurance, etc.);
- Storing and updating medical files;
- Assessing the individual social, legal, etc. needs of the client;
- Agreeing on/developing with a client and other specialist team members a treatment plan including setting specific objectives (e.g. to register at labour exchange, to apply for a night shelter, to show up for HIV, TB, HCV tests, etc.);
- Together with a client reviewing regularly (every 3 months) the implementation of treatment objectives, discussing which were achieved and what were the obstacles for unachieved objectives; updating the next 3-months treatment plan;
- Liaising with other specialists in the OST team and external services (medical, social, legal, etc.) and facilitating, if needed, appointments with external specialists (e.g. by telephone) and, if needed, intermediating with other services or support in representing the interests of the clients;
- Developing social skills of clients (by daily communication with a client and through specially targeted exercises);
- Deciding on when urine/saliva tests for drugs or alcohol breathalyser tests are conducted;
- Recommending physicians on when and for how many days take-home medications (methadone, buprenorphine) should be given (usually as a reward in proportion to positive behaviour change).

The introduction of case managers has limited the tasks of the physician to the assessment of the physical and mental status of clients at the beginning of treatment and at least once per month (if client is stable), as well as to treatment issues (e.g. optimal dose of medications). The physician liaises with the case manager in designing and implementing the overall treatment plan.

Among the benefits of the introduction of the case management approach was the reduction of the demand for psychiatrists and the reduction of their workload. It is important as in many countries it is difficult to identify well-trained psychiatrists to work in dependence treatment clinics. With the introduction of case management, clients receive individualized care and a close observation. Even small positive behavioural changes could be assessed and acknowledged by case managers, and be documented and reinforced.

Country example: Bulgaria**Case management by outreach programs**

In Bulgaria, a system for referral of clients from the outreach programmes of the Information and Consulting Centres to OST has been developed. Outreach programmes are in charge of case management, and pursue the purpose of motivating the client to reduce risk behaviours regarding HIV/AIDS and refer him/her for treatment. Outreach staff members also accompany their clients, if needed, to the respective medical institution and render assistance in the solution of potential social or other problems of the treatment team upon the client's admission for treatment. The majority of people working in these services are trained in screening, providing early intervention and motivational interviewing.

4. How to improve the image of OST among professionals, PWID and the general population?

In many countries, as expressed by countries participating in the workshop in Vilnius in 2012, the image of OST among the general population, professionals and PWID is poor. This may be related to the poor quality of OST programmes and persistence of myths. Myths include that OST is nothing else than a continuation of intoxication with drugs and traps people into a cycle of dependency; opioid medications are toxic; and methadone develops dependence which is “worse” than heroin dependence. In some countries, an abstinence-oriented treatment is traditionally more common and valued. Sometimes abstinence-oriented treatment specialists and client communities do not want to accept OST as a valid treatment option. In order to improve the image of OST, certain steps should be undertaken, including:

- To develop strategies to reduce the grouping of OST clients near OST sites with a big number of clients. This may be done through decentralization, integration of OST into existing health care services, referral of stable clients to primary health care centres and general practitioners and transferring them to mobile OST units;
- To develop widely available fact-sheets on OST, designated to health and social care professionals at large but also to the general population, addressing prevalent myths and misconceptions;
- To develop information leaflets for clients and drug users, addressing persistent myths and misconceptions of OST;
- To encourage a continuous dialogue between OST specialists and client communities and abstinence-oriented drug treatment communities in order to diminish the ideological gap between them;
- To develop strategies for communication with the mass media;
- To encourage formation of self-help groups of OST clients and encourage their role in advocacy efforts.

Country example: Germany**Promotion and qualification of self-help activities**

Self-help groups (including parental self-help groups) should be included to a greater degree in the coordination and planning of activities aimed at reducing the problems which arise in dealing with psychoactive substances. They are an indispensable component of the support offered to persons who are at risk of addiction or already addicted. A landmark in the development of self-help activities has been the growing of self-organization of people who are affected both by drug use and HIV. The opening up of the health sector for self-help and the recognition of the competence of those affected, thanks to the AIDS-Help movement, has led to a new orientation of the somatically focussed medical system in Germany, or at least to first steps in this direction. The self-organization of people affected in the area of drugs via the development of JES-groups (Junkies, Ex-users, Substitution clients) is the most incisive challenge for drug policy and service providers. It requires discussion *with* the people affected and not *about* them. In the meantime, JES groups in nearly 25 cities, with at least some 300 drug users on methadone maintenance therapy actively involved, are working as advocates for their own interests. In their founding statement this philosophy is expressed as follows: "JES is a federation based on solidarity among junkies, ex-junkies and substitute drug users who express themselves with the competence of those directly affected, and demands recognition of their existence by state health and drugs policies. Drug users have just as much right to human dignity as everybody else. They do not have to earn this right by abstinence or by conforming. They have a right to humane, healthy and social living conditions." (Michels I et al., 2007)

Country example: Lithuania

Introduction of mobile clinic to dispense methadone

For a number of years the Vilnius Centre for Addictive Disorders, on average having around 200-300 clients on OST, has faced negative effects due to clients loitering around the premises. The daily attendance of a large number of clients had a potential “market” effect for dealers of benzodiazepines and other psychoactive substances. It was noticed that only 10-15% of the total number of OST clients were involved in loitering around the premises. Sometimes they were seen injecting or consuming alcohol near health care premises. There was a history of strong dissatisfaction about this behaviour from the neighbourhood, police and city authorities.

In order to decentralize most problematic clients and to improve the public image of OST and the Centre, the mobile clinic for dispensing methadone was built and introduced in 2010. The mobile clinic, based in a bus, dispenses methadone at 2 sites, as approved by the city authorities. The determination of locations to dispense methadone has met some resistance from community. Several locations had to be changed before the acceptable sites in the community were found. Since then, most problematic OST clients are transferred to the mobile clinic to take their methadone for 5 days per week under supervision. Due to limited funds the mobile clinic does not operate during weekends. On weekend days, clients come for methadone to the main site for supervised intake to ensure 7 days per week supervised intake and to prevent diversion. In the mobile clinic, clients are not urine screened and it is considered a site with a lower threshold for OST.

New clients are admitted to OST through the main site. They were continuously observed for at least 2 months and if they demonstrate a problematic behaviour they are considered for transfer to the mobile clinic. At the mobile unit a breathalyser is used for determination of alcohol intoxication and appearance of intoxication is not tolerated. Clients have to undergo scheduled routine health examinations (HIV, HCV, syphilis, TB, consultation of psychiatrists) at the main site. If there are positive behaviour changes, a client could be transferred again to the main OST site and eventually he/she could qualify for consideration for take-home medicines.

The mobile unit is staffed with a nurse and two social workers. Psychiatrists occasionally visit the mobile clinic to see their clients. The same mobile clinic provides harm reduction services (needle exchange, rapid HIV testing, counselling) for PWID and commercial sex workers on two other sites in the city (Roma community and railway station).

Introduction of the mobile clinic allowed reducing the grouping of the most problematic clients around the Centre, decreasing a potential “market” for psychoactive substances and improving the image of OST in the eyes of the neighbourhood and city authorities.

5. How to implement new OST sites?

The establishment of a new OST site might for various reasons meet resistance in stakeholders, including politicians, administrators, health care staff, NGOs as well as the neighbourhood. The experience of countries on how to implement new OST sites may therefore be helpful.

Based on the experiences collected, important steps by national or sub-national agencies and institutions to facilitate implementation of a new OST site include:

- To raise awareness of the benefits of OST sites in the wider community;
- To enhance motivation of the OST site's staff and administration, e.g. through provisions meeting security and equipment needs and by providing maximum comfort to deliver services for staff and clients;
- To provide technical assistance in the development of sites' internal protocols and procedures on OST, and regulations on the control of narcotic medications;
- To integrate OST as much as possible into existing services (including private clinics), especially if the OST site is in a small town serving only a few clients;
- To implement a systematic initial training for multidisciplinary staff working at an OST site;
- To implement a system of continuous mentoring and supervision of the new OST site by experienced practitioners/centres through site visits, email and telephone communication;
- To secure a mechanism of funding for continued operation of the OST site.

Country example: Latvia**Improving access to OST – Implementing more OST sites**

By 2008 there was one OST site for methadone treatment operational in Latvia, in the capital Riga, which was established in 1996. Within the framework of the UNODC regional project “HIV prevention and care among PWID in community and prisons settings in Estonia, Latvia and Lithuania 2006-2010”¹⁹, in the course of 2009-2011 Latvian health authorities implemented activities which increased the number of health care facilities providing OST to 10 by 2011.

The UNODC project offered the existing public and private health care psychiatric facilities, funded by the national health insurance systems, small grants of approximately 15-20 000 USD. This grant was used by the health care facility administration to renovate the OST premises, equip them with methadone dispensers and safety doors, safe-boxes and alarm systems to meet security requirements. Small additions to a salary for OST specialists were paid from a grant up to a 1-year period when challenges for staff to implement new OST sites were the greatest.

Staff members were sometimes offered site visits to neighbouring countries’ OST sites. Specialists from OST sites were invited to practical workshops on different topics: clinical aspects of OST, provision of psychosocial assistance and case management in a multidisciplinary team of specialists, basics of motivational interviewing, OST for specific populations (women, including pregnant women) and intervention sessions. Technical support was provided by more experienced clinicians at the Riga Centre of Psychiatry and Addiction Disorders, who supervised other physicians in initiating treatment and deciding on the optimal methadone dose as well as developing internal institutional procedures.

OST services are funded according to approved schemes from the national health insurance system. Therefore, the sustainability of OST sites was ensured after the UNODC project came to an end in 2011.

¹⁹ PowerPoint Presentation on the UNODC project “HIV/AIDS prevention and care among injecting drug users in prison settings in Lithuania, Latvia and Estonia”, available at: http://www.ndphs.org/?mtgs,ph_5_riga

Country example: Romania

Introduction of an OST programme at a private mental health clinic

Until 2008 OST in Romania was funded by two public systems: the Ministry of Health (services at hospitals and outclient clinics) and the National Antidrug Agency at the Ministry of Interior (outclient services). The coordination of funding between these services was suboptimal and no services were available through private or nongovernmental medical institutions. Due to chronic lack of funds in the public system and in the context of limited budget for health services, public OST sites were overcrowded with OST clients. Therefore, the access to OST remained very limited due to long waiting lists.

Too limited public funding and insufficient staffing and training resulted in too poor quality of OST programmes at public health care institutions. There was a constant risk that such OST programmes could be compromised in the eyes of local communities due to overcrowding of clients, poor management and limited effectiveness. In addition, some injecting drug users developed negative attitudes towards OST (*“methadone dependence is worse than heroin”, “methadone is also a drug, more harmful than heroin”*). This situation prompted an idea to integrate an OST programme into a private clinic. In 2008 the first private clinic “PsyMotion” started in Bucharest to offer specialized services for clients with opioid dependence along out-patient services of psychiatry and psychotherapy. After introduction of OST with methadone as the abstinence oriented treatment in 2008, later treatment with methadone was diversified depending on the needs of clients, including detoxification, long-term maintenance with methadone and client stabilization. Buprenorphine is also available for detoxification and maintenance treatment. Each OST client is assigned a case manager. He/she signs an agreement with the client, which is the individualized plan of therapeutic care (treatment goals, priority issues, strengths/weaknesses, objectives and expected deadlines, intervention schedule, responsible staff and treatment grid are addressed). Quality of services is as much as possible assured by integration of services (psychiatry, individual psychotherapy and relapse prevention, crisis intervention, family therapy, general medicine, counselling for HIV and hepatitis testing, laboratory, referral system to other services), evidence-based approaches (motivational Interviewing, national and international treatment guidelines), and adequate medication doses, specialists, professional supervision and intervision, training and education).

The client can contact the case manager with any problem at any time, and connect to other specialists in the OST team as well as external services/specialists. Sufficiently high methadone doses are ensured. Case management, counselling and psychotherapy are core services offered in addition to substitution medications.

The monitoring of OST clients demonstrated a significant reduction of heroin use and injection behaviour, and the improvement of their social status, including employment rates (up to 49% of all OST clients have a job).

Easy access to OST is ensured by a flexible appointment system, extended opening hours, no waiting lists and easy access to treatment starting from the first intake session. For take-home use, methadone is handed out only to relatives who do not use drugs. The maximum period for take-home doses is one month.

6. How to engage the general practitioner in the provision of OST?

There are benefits of provision of OST by general practitioners within the overall scaling-up and implementation of OST. In some countries psychiatrists remain hesitant when it comes to providing care to injecting drug users. Also, psychiatrists may not be trained in the provision of OST in their post-graduate residential training. In other cases the demand for OST is overwhelming, and there is not enough capacity in mental health care services to respond. In many EU countries GPs provide OST for opioid dependent clients who do not have serious co-morbid psychiatric conditions. As recommended in the WHO Psychosocially assisted pharmacological treatment of opioid dependence, OST may be provided at primary health care level by a GP.

OST prescribed by a GP might be considered as less stigmatizing than when offered in specialized addiction or psychiatric services. Treatment by a GP often implies that heroin dependence is treated just like any other chronic disease, such as hypertension or diabetes. Moreover, a GP is in a better position than a psychiatrist to manage frequent concomitant HCV, HIV infections and other physical co-morbidities and recommend/conduct prevention measures and testing for these infections. GPs are also in a good position to care for opioid dependent pregnant women and their newborns.

OST, if provided in primary health care by a GP, can also become accessible for PWID in small cities and remote places, where there is little or no access to mental health care specialists. The OST may be integrated into the existing infrastructure of primary health care centres. Therefore, it could be offered relatively inexpensively. The experience from several countries, including Germany, France, Belgium, the Czech Republic, Norway and Croatia, is valuable to other countries when considering how to scale-up and implement OST through GPs in primary health care.

According to countries' experiences and examples, the involvement of GPs could be increased by the following steps:

- To adjust the national legal framework in order to allow any medical doctor, including GPs, to prescribe OST with methadone or buprenorphine;
- To establish national funding schemes for GPs providing OST;
- To establish training for GPs addressing the assessment of clients with dependency problems and their treatment, including OST;
- To develop a support system, also called 'shared care system', to GPs from specialists in dependence and psychiatry;
- To provide a possibility to GPs to refer more "difficult" clients to OST in specialized and more intensive or in-client services.

Country example: Germany**Provision of OST by GPs**

In Germany in 2011, 2 703 GPs provided OST out of a total of 8 122 who had qualification for dependence treatment. Over the years, the number of GPs providing OST did not change much, while the number of clients increased. In 2011, 28.2% of GPs had less than 3 clients on OST, 52.7% had from 4 to 50 clients on OST, 17.2% had from 50 to 150 clients on OST, and 1.9% had more than 150 clients on OST. OST was also provided by specialized services, though the greatest number of clients receives OST from GPs.

About 80% of clients received methadone or levomethadone and 19% buprenorphine. Only 0.4% of clients were treated with diamorphine and 0.3% with codeine and dihydrocodeine.

In order to get a qualification for dependence treatment (including OST) a GP is required to attend 50 hours of training on diagnosis and management of dependence disorders and to register that qualification. Many GPs, who had a qualification for dependence treatment, were not willing to be engaged in the provision of OST, because of stigmatization and methadone and buprenorphine still being considered as “dirty medicines”.

By legal requirement, each client on OST should also receive mandatory psychosocial assistance. For psychosocial assistance GPs usually refer to psychosocial programmes, which are run by NGOs or municipal services. There is a problem with this requirement, as some clients actually do not need psychosocial assistance. On the other hand, psychosocial assistance is not clearly defined, and thus it could be of unknown quality and effectiveness.

If a client has co-morbid mental conditions or is non-compliant, in big cities a GP may refer him/her to community specialized treatment programmes (Mikels I et al., 2007).

Country example: France**How to scale up OST through general practitioners**

Until the mid-1980s, the primary form of treatment for opioid dependence in France was non-pharmacological, behavioural therapy services provided in special clinics for illegal substance users. Methadone maintenance treatment was only available in specialist methadone clinics to a small number of drug users. General practitioners were actively discouraged from participating in many or even most of these specialty treatment programs. By the mid-1990s, the prevalence of problem heroin users was estimated to approximately 150 000–200 000 persons (i.e. between 2.5 and 3.3 persons per 1 000). Of these persons, it was estimated that 10% were HIV positive and 75% were hepatitis C positive. By 1995, the number of opioid dependent patients in treatment within specialized substance abuse clinics was about 50 000, and the number of patients in methadone treatment clinics had markedly increased to 6 000 per year. Because of the prevalence of opioid dependence and the related overdoses and infections, the French Medication Agency approved buprenorphine for opioid dependence treatment in 1995, and marketing of the product began in February 1996. Buprenorphine differs from methadone in that it is a partial agonist at the mu receptor making overdose unlikely, which facilitates prescribing it by non-specialists medical doctors. Thus, general practitioners were then encouraged to treat opioid-dependent individuals in the office setting using buprenorphine and methadone. Only a few years later, in late 1990s, it was estimated that general practitioners were treating approximately 65 000 patients per year with buprenorphine and another 6 000 patients with methadone. The latest data by EMCDDA show that by 2010, it was estimated that about 111 000 patients were being treated with buprenorphine and 65 000 patients were being treated with methadone. Around 75% of all opioid substitution treatments were prescribed by office-based general practitioners.

Reference:

Auriacombe M, Fatseas M, Dubernet J, Daulouede JP, Tignol J (2004). French Field Experience with Buprenorphine. *The American Journal on Addictions*, 13:S17–S28, 2004

7. How to facilitate access of problem opioid users to OST?

Persons with a drug dependency usually tend to feel ambivalent about their drug use and treatment. For instance, they could acknowledge that drug use has a destructive effect on their life, but on the other hand are hesitant about quitting their use. Even if a client is motivated to enter OST, this motivation often tends to be unstable and changing.

Some OST sites in the countries that joined the EU more recently used to require different kinds of procedures before starting therapy and before the first methadone dose could be dispensed. This usually included the requirement for HIV, HCV and/or TB tests before treatment could be commenced and a physician (internist) examination for contraindications. Such requirements significantly increased the threshold for OST, making it too high for many active (injecting) drug users. A person coming for medical treatment should expect that the health care institution within a reasonable time period manages to improve his/her physical and mental status to a certain degree and/or provide support in a difficult social situation. Waiting lists to enter OST or very high requirements to initiate the therapy may therefore result in delaying therapy or not starting it at all, perpetuating risk behaviour. Therefore, strategies which strengthen drug users' motivation to take practical steps to start OST, providing support and facilitating their entrance to OST, are critical.

Based on the country experiences collected, the following strategies are recommended to be helpful in facilitating improved access:

- For outreach and harm reduction services to provide clients continuously with information about practical steps needed to initiate OST (e.g. to acquire an ID or health insurance) and about the benefits and constraints of OST;
- For outreach or harm reduction programme staff, to accompany hesitant clients to their first consultation if needed and to provide support in meeting the requirements for starting OST;
- To provide methadone on the same day a client approaches the health care service for OST, after legal and obligatory formalities have been completed (identity check, diagnosis of opioid dependence, signing of informed consent, etc.) while other treatment objectives (referral to HIV, HCV tests and more thorough medical examinations) should be addressed when developing an individual treatment plan.

Country example: Portugal

Developing low threshold OST

“GIRUGaia” (GG) is a harm reduction project for people who use drugs, operating in Vila Nova de Gaia²⁰, Portugal, since November 2003. It is institutionally based at *Agência Piaget para o Desenvolvimento (APDES)*²¹ – www.apdes.pt – and co-financed by the Portuguese national Institute for Drugs and Drug Addiction – *Instituto da Droga e da Toxicodependência (IDT)*.

GG assumes the format of an action-research project and its continuous evaluation activity – which systematically involves clients` opinion on what should be changed and improved, for example through the organization of mini focus groups twice a year – allowed the team to understand that a low threshold opioid substitution therapy programme was absolutely necessary to make the intervention more effective.

Based on that information, in 2007 GG created a *Combined Therapy Programme (CTP)* to help heroin users that already failed several previous attempts to overcome their problematic consumption. The main purposes of the programme are to reduce risks and harm related to drug use and to improve the levels of health and social integration of clients. CTP uses the administration of methadone, which by itself facilitates the reduction of consumption, in order to maintain contact and to trace and support a bigger number of people who use drugs in a steady way. The use of methadone, as it stimulates clients` daily adhesion to services, also makes it possible to administer medication for tuberculosis and HIV treatment as well as for psychiatric disturbances to people who were strongly resistant to those treatments before their combination with methadone. Guarantee of the effectiveness of this programme is only possible through the involvement of several partners, such as the local service of infectious diseases, the pulmonary diseases screening service, the addiction treatment centre and the service of collecting and testing of blood. Each of these organizations cooperate with the programme by providing essential services and useful resources for its development, such as: provision of antiretroviral and TB medication, open public pulmonologist and infectious disease consultations, ensuring hours of nursing assistance, blood samples collection, provision of methadone and co-adjuvant medications. This programme extends its local action throughout all urban territories (including the periphery) of the city, offering drug users the possibility to access a proximal service that goes to them, in their everyday life places, and that would be impossible for them to get otherwise (60% of the clients had never gone to a treatment centre when contacted by the team for the first time). Clients are immediately admitted to the programme after a technical evaluation of the case made by GG professionals and without the need of being seen (face-to-face) by a physician. This guarantees the immediate integration and future continuity of contact with people that seek help without forcing them to wait until the physician is present since this professional goes to the field only once every two weeks in the best scenario (which would certainly imply the loss of some clients). In order to make this possible, the physician that voluntarily works in the project allows the nurse to give to the client in his first contact a secure dose of methadone (30 mg) and adjusting it smoothly every day until the medical doctor can evaluate the situation *in loco*. The immediate integration of clients in the methadone programme makes it possible to evaluate the clinical state of clients (mostly hidden drug users in very vulnerable situations) and to offer them the most appropriate treatment.

Example continues on the next page

²⁰ One of the geographically largest and the third most populated county (conselho) in Portugal

²¹ Piaget Agency of Development (English translation)

Methadone is highly effective in maintaining clients in treatment, so its combination with ART and tuberculosis therapy makes the latest more effective too. Probably, without this combination in local settings those two therapies would not be possible to manage within highly vulnerable drug users.

Results of this programme are positive and have shown the importance of this kind of proximity intervention with a multidisciplinary and multi-institutional framework oriented by a pragmatic and humanistic approach. Besides contributing to the decrease of infectious diseases and applying in an effective way the already mentioned therapies, it has shown to improve clients' lives and level of health and social integration in several aspects by:

- Reducing the use of psychoactive substances (29% of clients have stopped using heroin and cocaine, only 20% kept a daily frequency of heroin use, but reported a decrease in at least half of the amount used);
- Lowering the maximum amount of cocaine doses consumed (2, contrasting with the 30 doses mentioned before entering in the programme);
- Contributing to changing the route of the administration of illegal substances (44% injected drugs before entering the programme and 16% of them began smoking instead, 13% decreased the number of injections, preferring to smoke in several occasions);
- Reducing criminal activity (in 2010, 70% have reported, in self-revealed delinquency questionnaires, to have ceased their criminal activity since entering the programme);
- Bringing clients closer to various kinds of services;
- Increasing the number of drug users referred for addiction and for HIV treatment;
- Increasing the number of contacts within hidden populations;
- Promoting a higher quality of life for drug users;
- Promoting individual and public health.

8. How to increase the compliance of OST clients?

OST clients may have criminal histories and may experience imprisonment during their life. They may also have co-morbid mental conditions, such as antisocial personality disorder, schizophrenia, depression, and anxiety disorders. Motivation for treatment and attitudes towards injecting drug use among OST clients is often unstable and fluctuating. Therefore, virtually all OST sites in all countries have problems with clients' compliance. While it will most probably never be possible to reach a 100% compliance of OST clients, various measures could be considered by OST site leaders and staff to potentially increase compliance. Country examples and experiences show that these measures may include:

- To develop approaches which facilitate enrolment into OST;
- To have a vision of OST as a client-friendly service, with clear limits for unacceptable behaviour;
- To be flexible and understanding of the condition of clients when imposing involuntary discharge criteria, such as a positive urine test, and not automatically discharge clients from the programme when discharge criteria are met (as this does not reflect an understanding of the chronic, relapsing nature of a drug dependency);
- To establish a system of recognizing the most urgent needs of clients and developing an individualized multidisciplinary treatment plan addressing those needs, including services outside the institution;
- To develop routine practices, when specific treatment objectives are agreed with the participation of the OST client;
- To promote clear and transparent expectations and behaviour rules from clients on behalf of the OST staff and communicate them to clients;
- To facilitate positive behaviour change, e.g. through increased take-home medication, acknowledgment of small positive behaviour changes or other incentives;
- To establish a system allowing clients to travel inside the country as well as within EU and non-EU countries;
- To explore OST clients' opinion (including anonymous surveys) about the satisfaction with services, opening hours of the OST site, organization of therapy process etc.;
- To encourage formation of clients self-help groups.

Box 2: Travel of OST clients within EU countries

EU countries develop their own national legislation regarding citizens' travel and carrying of prescribed controlled medications according to EU-level guidance. While travelling inside Schengen Treaty countries, OST clients may carry prescribed methadone or buprenorphine in quantities up to their dose for 30 days. In some countries legal acts allow to carry prescribed methadone or buprenorphine to non-EU countries for 15 days.

In all cases a client should carry with him/her all necessary prescriptions and letters from the health care institution as required by law, indicating the name of the client, name of the institution which procured the medications, the average daily dose of methadone or buprenorphine, the form of medication (tablets, solution, tincture) and the total amount of the medicine given with necessary signatures and stamps from a treating physician and/or health care facility. Physicians and clients should be encouraged to get familiar with specific legal regulation in their countries.

It is illegal to carry methadone or buprenorphine to the Russian Federation under any condition and clients should be well informed about the risks of taking methadone or buprenorphine into the country.

9. How to ensure a system of individualized treatment planning and coordination with external services?

The individual assessment of an OST client and setting individual objectives for the client for a specific time period is essential in the provision of high-quality OST. Physicians are trained to perform medical assessments of clients and this includes an assessment of subjective complaints, life histories and past diseases, an objective examination of body systems, and a laboratory and instrumental examination. Social workers and case managers may not be properly trained to comprehensively assess a client's status and situation in different domains (health, employment/support, substance use, social/family and legal status, psychiatric history, etc.). There are instruments (the most known being the Addiction Severity Index – ASI), which permit a *standardized* client assessment, generation of a client's master problem list and development of an individual treatment plan. The repetitive comprehensive and standardised assessment permits a case manager to assess dynamics of a client's status in different domains.

Ideally there should be a therapeutic alliance between the OST multidisciplinary team and the client. The therapeutic alliance would include a mutual agreement on treatment objectives and implementation of an individual treatment plan to reach them.

In maximizing an individual approach, according to country examples policy-makers and OST site leaders ideally should consider how:

- To include an individualized treatment planning system into the internal OST procedures, e.g. to develop forms for a written treatment plan and procedures of reviewing it regularly;
- To develop a system of coordination of multidisciplinary services for the client, e.g. case-management;
- To use standardized instruments, e.g. ASI (Addiction Severity Index), for standard assessment and treatment planning.

Country examples: Latvia and Lithuania**Addiction Severity Index as an instrument for a standardized comprehensive assessment of clients on OST**

Addiction Severity Index (ASI) is a short semi-structured questionnaire, which was designed to collect and assess information about clients' life history related to their dependence. The tool can be used in designing an individual treatment plan. ASI was developed in 1977 by a group of researchers in the Treatment Research Institute in Philadelphia, USA, and led by Tom McLellan. Since then, the questionnaire has been modified many times and translated into many languages²².

ASI includes 7 domains: medical status, employment/support status, drug use, alcohol use, legal status, family/social status and psychiatric status. It takes up to one hour to fill data from the interview with a client into the web-based database. The software allows to compile a standardized client assessment report in MS Word and to print it for medical files. The software also allows to generate a Master Problem list for a client and to develop a standard form of individualised treatment plan to be discussed and agreed on with a client.

Latvian and Lithuanian versions of the questionnaires and a web-based database were developed. Also, OST staff was trained on the tool during the UNODC regional project "Prevention and care of HIV among IDU and prison settings in Estonia, Latvia and Lithuania". At some OST sites, the questionnaires and database are used in everyday clinical practice.

²² The UNODC TREATNET I project has adopted the UNODC version of ASI and also developed a training module for its use in clinical practice, which can be found at: www.unodc.org/treatment/en/training-package.html

10. How to cooperate with law enforcement in implementation of OST?

Law enforcement organizations (police, courts, probation) should be supportive of OST, as significant access of PWID to OST might lead to a reduction in crime rates, demand for heroin and other substances, and overload of courts. For example, a 2013 study by the TRIMBOS institute²³ revealed that the magnitude of avoided (pure) heroin consumption attributable to retention in OST for one month could be in the order of 0.3 metric tons (ranging from 0.1 to 0.9 tons). In this context, problem opioid users not engaged in OST will account for a disproportionate amount of the illicit heroin being consumed in a given market. Significantly curtailing their involvement in it, via engagement with OST, is likely to considerably undermine the market's viability and disrupt functionality by removing or displacing key participants from it.

OST should be available for continuation in police custodies after arrest of OST clients. In some countries, courts refer people who inject drugs to 'quasi-compulsory' treatment instead of imprisonment when it concerns minor criminal offences. In these cases, after an assessment of the client's condition, OST could be offered as one of the options in the spectrum of treatment modalities. Completion of the treatment to the satisfaction of the judge often means closure of the case.

According to countries' examples and experiences, building and strengthening collaboration with law enforcement might include various steps, including:

- To develop an advocacy strategy aimed at the Ministry of Interior in order for OST to be allowed to continue in police custodies;
- To develop a mechanism of continuation of OST in police custodies in cooperation with police and health care services;
- To implement cooperation between OST and police services in encouraging referrals from police custody to OST and other types of treatment and care;
- To implement cooperation with courts and probation services by accepting clients referred to 'quasi-compulsory' treatment instead of imprisonment and offering OST as one of the standard treatment options;

²³<http://www.trimbos.org/~media/Programmas/Internationalisering/Further%20insights%20into%20aspects%20of%20the%20EU%20illicit%20drugs%20market.ashx>

Country example: Lithuania

Cooperation of law enforcement and health care institutions in addressing problems of opioid users in a Roma settlement in Vilnius

A Roma settlement in the outskirts of Vilnius has for a long time been reported to be a semi-open drug dealing and drug injecting scene. The police tried to control the scene for a number of years. A number of drug dealers were arrested. However, drug dealing (mostly heroin) still persisted in spite of all efforts. In order to suppress the drug scene, the police implemented increased and continuous efforts to arrest all drug users that visited the Roma settlement. The number of drug users arrested during one year reached 1 600. For a number of years there were major concerns about how to solve the drug problem at this settlement, but no easy answers were available.

In order to explore the demand for OST in June 2010, Vilnius county police headquarters initiated a 4-month agreement with Vilnius Centre of Addictive Disorders and the Drug Control Department at the Government. According to the agreement, the Vilnius county police provided information on the availability of OST and referred arrested PWID to drug treatment on a voluntary basis. Vilnius Centre for Addictive Disorders promptly assessed clients with written referrals from the police and accepted them into dependence treatment.

In 2010 there was a 4-month waiting list to enter OST at the Vilnius Centre for Addictive Disorders. However, additional funds were allocated by the Government's Drug Control Department to accept clients into OST without any waiting list in the framework of this short term project.

During these 4 months the police referred 123 heroin injectors, of whom 121 appeared at the Vilnius Centre for Addictive Disorders Centre, for treatment. 117 heroin injectors requested to enter OST (methadone), the remaining 4 requested detoxification. All 117 clients received their first methadone dose the same day as they showed up for treatment. They received standard medical and psychosocial OST services, coordinated by a case manager (social worker) at the Centre.

A study, using structured interviews at the beginning of OST and after 2 months, was made to evaluate OST outcomes for clients, who were referred by the police. Results of the study showed that a high number of clients were still on OST after 2 months (80.3%). The treatment resulted in a significant decrease of heroin and other substance use among clients, as well as a reduction of the risk of blood-borne virus transmission, a reduction in criminal behaviour and a reduced number of subsequent arrests at the Roma settlement. The quality of life and health status of clients on treatment improved considerably. The police noted that the overall criminality in the area neighbouring the Roma settlement also reduced by 15% during the time of the cooperation.

Thus, time-limited joint and coordinated actions by police and health authorities proved effective in attracting injecting opioid users into treatment. Comprehensive health care and social services contributed to positive changes in their behaviour, quality of life and health, and to a reduction in criminality. The Vilnius county police headquarters developed a strong positive attitude towards OST as one of the potential components in addressing the persistent drug problem in the city (Subata E et al., 2011).

11. How to integrate OST with HIV, HCV and TB services?

The main objectives of OST include the prevention and management of infectious diseases. However, challenges are seen as OST in European countries is still often provided by the mental health care system where the primary medical specialists are psychiatrists without a tradition to interact with the infectious disease treatment system. With the introduction of OST, there is a need for mental health care centres to establish new models of referral to infectious disease specialists and institutions. On-site testing for HIV and HCV and vaccination for hepatitis B should ideally be available at all OST sites. Based on national regulations and laws, different ways to integrate OST and infectious disease health care services have been documented. Experiences and best practices include:

- To develop HIV, HCV and TB testing and treatment and hepatitis B vaccination policies and procedures on the national level, e.g. legal acts and national guidelines on how to integrate national provisions into procedures in health care institutions;
- To develop sound models of mutual referrals and treatment implementation between OST sites and infectious disease treatment centres, e.g. through clearly defined and agreed referral protocols, and to incorporate them in the individual institution's internal policies and procedures;
- To allocate persons at OST sites, who are responsible for administering visits and consultations, referrals and medical records, and to train them properly;
- To provide OST and HIV, HCV and TB care as integrated services in one location.²⁴

Country example: Estonia

Introduction of integrated treatment

Until 2010, integrated OST/ART was not available in Estonia. As a result, HIV-positive drug users often dropped out of ART. To alleviate the problem the first integrated OST/ART programme for HIV-positive injecting drug users was launched in Tallinn in 2010. Integrated treatment is provided based on the DOTS principle which implies daily contact with medical staff and has significantly improved clients' adherence to ART. Later, the possibility of integrated TB treatment was added. The programme was implemented by the Infectious Diseases Clinic of the West-Tallinn Central Hospital and funded by the National Institute for Health Development from state budget. It was established with support by the UNODC regional project "HIV prevention and care among IDU in community and prisons settings in Estonia, Latvia and Lithuania 2006-2010".

²⁴ See also: 'A Rapid Assessment of the accessibility and integration of HIV, TB and harm reduction services for people who inject drugs in Portugal'. Accessible at: <http://www.euro.who.int/en/what-we-do/health-topics/communicable-diseases/hiv/aids/publications/2012/rapid-assessment-of-the-accessibility-and-integration-of-hiv,-tb-and-harm-reduction-services-for-people-who-inject-drugs-in-portugal-a>

Country example: Lithuania**Organization of testing for HIV, viral hepatitis C and other infectious diseases**

Following the comprehensive assessment of all OST sites in Lithuania, performed by the Medical Audit Inspection at the Ministry of Health in 2011, the Ministry of Health has implemented the Medical Audit Inspection's recommendations and issued a legal act, which mandated the National Clients Fund to financially support HIV, HCV and syphilis tests for all OST clients at least once per year. Clients are referred to regular infectious disease tests from mental health centres, which provide OST. TB consultations by a pulmonologist are recommended if there are indications. They are free of charge as they are also paid by the National Clients Fund.

12. How to make OST available in prisons?

In several EU countries, including Greece, Cyprus, Latvia, Lithuania, Poland and Slovakia, OST is not yet available in prisons. A complete overview of the availability of OST in prisons can be found at the website of EMCDDA²⁵. Continuation of drug use, unsafe injecting and sexual practices, and lack of harm reduction and prevention programmes including needle and syringe programmes (NSPs), make prisons high risk environments for the transmission of HIV, HCV and other communicable diseases.

It is important that OST is continued for all clients upon entry to prison and it should be possible to initiate OST in prisons on the same indications as it is in health care institutions in the community. It is also important that systems are available to ensure continuity of treatment after release from prison and to transfer clients on OST to community health care institutions in order to prevent their relapse into injecting drug use and associated risks (HIV, overdose). Some EU countries were successful in implementing and scaling-up OST in prisons and in developing cooperation with OST sites outside prisons, ensuring continuity of care. Based on countries' experiences and best practices, the implementation of OST in prisons should follow different stages, including:

- To develop and implement advocacy strategies supported by the Ministry of Health in order to positively influence decisions taken by the Ministry of Justice and prison administrations and to ensure equivalence of treatment and care;
- To develop internal procedures of OST in prisons based on existent national and international guidelines and the country's legal basis for substitution treatment;
- To implement introductory training on OST for multidisciplinary staff and prison guards;
- To implement a system of continuous training for multidisciplinary staff, including training on-site (e.g. intervision sessions);
- To establish mentoring and supervision of prisons by more experienced service providers through site visits, telephone and email communication;
- To establish a system so that a space at an OST site is secured for the client in the community, already before his/her release from prison.

²⁵ See: <http://www.emcdda.europa.eu/stats12#display:/stats12/hsrtab9>

Country example: Estonia

Introduction and scaling up of OST in prisons

In many countries, treatment and rehabilitation of diagnosed drug dependent prisoners is done in specially designated prison units. In the Estonian Prison Service these units were located in Tartu, Viru, Harku and Murru prisons, including over 200 places in total. The biggest national treatment and rehabilitation unit with 174 places is located in Tartu Prison. Drug users, who do not need or do not want intensive treatment and/or rehabilitation, receive services on a general basis from the health care and social departments.

Drug dependence treatment in prisons is carried out by the health care department. It is possible to offer both OST and non-opioid treatment. Data about diagnosed drug dependent prisoners is collected by the health care departments. OST is financed from the general budget of the prison health care service.

OST in the Estonian Prison Service started in 2008 by the decision of the Ministry of Justice, which was done in line with the National AIDS Programme. During the first two years the number of clients on treatment was low. In 2008 there were only 2 clients on methadone assisted opioid withdrawal treatment. In 2009 there were 4 clients on methadone assisted opioid withdrawal treatment and 8 clients on OST. In 2010 the number of clients increased significantly to 59 methadone-assisted opioid withdrawal clients and 64 opioid maintenance clients. Throughout 2011 this increase continued and by the end of 2011, 99 prisoners received methadone assisted withdrawal treatment and 118 received OST.

The fast and significant increase in provision of OST over the last years can be partly explained by the fact that from 2010 OST became available in two major detention centres managed by the Ministry of the Interior. The efforts to ensure continuity of OST in institutions governed by 3 different governmental sectors (Ministry of Health, Ministry of Justice and Ministry of Interior) are coordinated by the National Centre for Health Development. Introduction of OST in detention centres filled the last gap in treatment of PWID between the 3 sectors and allows a smooth transfer of clients from one institution to another. Especially the prison in the East-Viru County has a very good cooperation with the detention centre, which is situated next to the prison. The prison medical staff implements OST in both institutions. It also ensures that OST is continued smoothly when a person moves from a detention centre to prison. OST is also provided in the detention centre in the Tallinn area.

Another reason for the expansion of OST was qualified staff motivating prisoners to address their substance use problem. Specialists from health care units, including psychiatrists, were invited to a number of trainings on OST and related topics in Estonia and other Baltic countries, which were provided through the UNODC regional project "HIV prevention and care among IDU and in prison settings in Estonia, Latvia and Lithuania, 2006-2010".

During recent years, the prison service has put a lot of efforts in developing and improving the drug treatment and rehabilitation services in prisons. In every prison there are currently staff members experienced in working with drug users. In the coming years the prison service expects further increases in the number of clients on OST in prisons.

Country example: Germany**OST in the penitentiary system**

In accordance with the WHO "Guidelines of HIV and AIDS in Prisons" (WHO, 1993), which recommend that "prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison", OST is available in prisons in Germany. However, the implementation is the individual responsibility of each of the 16 federal states (Bundesländer) and even varies from prison to prison. There are several important distinctions when compared to the services outside the prison system. Prisoners as clients have no right to choose their doctors; it is not possible to dissociate the clients from the specific intramural prisoner 'drug scene', and too often there is a lack of positive attitudes among staff towards OST. Only 6 out of the 16 federal states provide OST in prisons. It is estimated that no more than 700 inmates participate in substitution treatment whereas at least 1/3 of the 10 000 intravenous drug users in prisons on an average day would be eligible for substitution treatment. Admission criteria vary between the federal states and long-term maintenance treatment is often not an option. OST is generally an integral component of a broader drug service concept to reach and stabilise abstinence, to improve access to further treatment after release and to improve relapse prevention. Psychosocial care is provided by social workers from outside the prison, but due to lack of financial resources often falls on prison staff. Sometimes self-help groups (AIDS self-help groups or drug user groups) from outside the prison are allowed to support prisoners on treatment. Prison systems are found to be slow in responding to epidemics of viral infectious diseases and injecting drug use. OST is well-known to be an effective response in minimizing the risks and harms of opioid dependent prisoners by reducing heroin use, drug injecting and needle sharing, and prison-based drug trade, and therefore the provision of OST should be broadened (Michels I et al., 2007).

13. How to monitor access, quality and outcomes of OST at national level?

In order to sustain and achieve adequate funding for OST in the country/region, it is essential to gather and provide regularly information on clients' accessibility to OST as well as OST coverage within PWID. Quality and outcome indicators should be reported on, including the average waiting time for clients to access OST. OST national monitoring systems may therefore be implemented.

According to country experiences, the process of developing a monitoring system is therefore recommended to include the following aspects:

- To incorporate international and European indicators into national monitoring and evaluation systems;
- To incorporate EMCDDA treatment demand indicators into national monitoring and evaluation systems;
- To monitor outcome indicators of OST;
- To monitor continuously the extent and progress of the impact of OST on HIV prevention on the national and local level.

Country example: Bulgaria

Monitoring OST at the national level

In Bulgaria, OST programme managers prepare quarterly reports to the National Centre of Addictions on the activities of the programmes and the trends in their development, as well as an annual report with an assessment of the efficiency of the programme including conclusions according to a template prepared by the National Centre.

Planned indicators and procedures for evaluation of the efficiency of the OST programmes are an integral part of the protocol of each programme.

14. How to avoid risks to staff, other clients and the OST site?

Some clients on OST have a criminal history and may have spent time in prison settings. There may be clients with co-morbid mental disorders. Clients sometimes show up at an OST site with alcohol or stimulant intoxication and may be aggressive towards other clients or staff.

According to experiences from countries, some measures should be considered at the national and programme levels to ensure maximum safety for staff, other clients and the OST site, including:

- To encourage responsible behaviour of clients regarding safeguarding opioid medications from their children and intoxicated driving;
- To enforce the code/internal regulations of client behaviour which would not allow any aggressive behaviour towards staff and other clients or damaging of the property;
- To use alcohol breathalysers and drug screens in the context of motivating the behaviour change of clients;
- To assess the risk of opioid medication diversion on an individualized basis and follow patterns of practice, which minimizes the risk of diversion;
- In case of present dependence from other substances (alcohol, benzodiazepines, stimulants), to offer an OST client in-client withdrawal and dependence treatment for their other dependence while continuing OST;
- To hire security guards to be present during working hours, to establish alarm buttons, video surveillance and other technical means to minimize safety risks.

Country example: Latvia

Minimizing risks for staff and other clients

New OST sites in Latvia, established during 2009-2011 under the UNODC regional project “HIV prevention and care among IDU in community and prisons settings in Estonia, Latvia and Lithuania 2006-2010” were equipped with safety doors, safe-boxes and alarm systems to ensure the security of medical supplies, as required by national legal acts. Alarm buttons were installed at methadone dispensing offices in case of aggressive behaviour by clients. The latter were hardly used, but increased the nurses’ subjective feeling of safety. Nurses were instructed about coping mechanisms in case of any serious aggressive behaviour or open robbery. Old and new OST sites in Latvia chose to implement a friendly and open nurse and client face-to-face office setting, where a nurse administered methadone and buprenorphine over the desk and supervised the consumption of medication.

OST staff in new sites believed that a friendly setting in methadone dispensing offices promotes more open communication between staff and clients, increases cooperation and ultimately reduces risks of destructive and aggressive behaviour.

Country example: Lithuania**Minimizing risks for staff and other clients**

For some OST clients, alcohol consumption is a serious problem on top of their drug dependency. Some clients, while being on OST for a longer period of time, increase their alcohol consumption, which can progress to a level of dependence.

Keeping in mind that at least 50-80% of OST clients are infected with hepatitis C, alcohol consumption is a serious additional risk factor for the development of liver cirrhosis. Physicians and social workers are encouraged to discuss this topic in their consultations with clients, including a discussion on abnormal liver enzymes, when values are available. In case of alcohol dependency and binge drinking, in-client detoxification from alcohol is offered while OST is being continued. To some OST clients, detoxification from alcohol has to be offered repeatedly, with subsequent treatment in psychosocial programmes, self-help groups or with medications (disulphiram).

After assessing the great negative impact of alcohol use towards client's behaviour and non-compliance, the OST staff reached consensus to implement a strict OST policy, related to administration of methadone to alcohol-intoxicated clients. This policy implied that if a client presents for methadone intake with signs of intoxication, methadone is not dispensed automatically. The case manager refers a client for determination of the alcohol concentration with a breathalyser. If alcohol is found in the client's breath, a nurse suspends administration of methadone and asks the client to return a few hours later with zero alcohol concentration.

The enforcement of this requirement has met strong resistance in some clients. Nevertheless, the implementation of this treatment policy led to overall positive behavioural changes among clients. Most of them learned to come to the OST site without previous consumption of alcohol early in the morning or interference with binge drinking late in the night. During the implementation of this policy some clients had to be hospitalized due to severe alcohol withdrawal symptoms and underwent detoxification.

15. How to meet the legal requirements on the control of opioid medications and reduce the diversion of opioid medications?

Methadone and buprenorphine are controlled medications. Diverted medications might be injected and traded on the illegal market, even more so when there is limited access to OST. Measures should be enforced to prevent diversion of controlled medications at the national and programme level, though these measures should be balanced with the flexibility of dispensing medications and with the individualized management of clients on OST.

According to countries' experiences, the following measures should be implemented in order to reach the reduction of diversion of medications:

- To develop a national framework, which aims at reducing diversion of controlled medications, however ensures flexibility and attractiveness of OST to clients;
- To develop and implement internal institutional procedures on acquiring, turnover, dispensing and reporting of controlled medications;
- To appoint staff members, responsible for the control of opioid medications in the institution;
- To implement a system of supervised administration of methadone and buprenorphine in the initial phases of treatment;
- To provide medications for home use on an individual basis after assessment of the risk of diversion.

16. How to fund provision of OST?

Ways of funding OST could be complicated and funding may come from different sources. Medical insurances often fund only the medical component of treatment, while psychosocial assistance is not (sufficiently) financially reimbursed. At the same time, OST clients, especially those who have injected drugs for many years, could need intensive social support and social reintegration efforts. If the OST is expected to be accessible and effective, funding of easy-to-access, low threshold, free of charge OST, as well as a well-coordinated approach, is key. A multidisciplinary approach is often preferred, however needs to be seen in light of available resources, where immediate scaling-up numbers of clients on treatment should be priority in the short term to implementing a more expensive multidisciplinary approach.

Funding of HIV, HCV and TB treatment, as well as treatment of most other physical and mental disorders is usually structured around the mainstream patient, which is not a person who injects drugs. In most countries, a requirement is that an OST client has a health care insurance. However, in some EU-12 Member States many PWID do not have a health insurance. Often PWID are not officially employed, not officially registered at the labour exchange office or homeless. Naturally, counselling and support from a social or outreach worker to regain personal ID documents (if they were lost) and to register at labour exchange, is vital in ensuring that the client is eligible for comprehensive health care services.

Based on the country experiences collected, the following strategies of funding are found to be useful in ensuring funding for OST implementation and scaling-up:

- For public health insurance systems to reimburse OST, meeting the pre-set quality criteria, depending on the number of clients treated and services provided;
- For public health insurance systems to include case management and/or essential psychosocial services in the package of services eligible for reimbursement;
- For municipalities to develop legal frameworks and mechanisms to fund OST for clients, who have no public health insurance and are not eligible for OST funding from the public health insurance system;
- For municipalities to fund psychosocial services and case management if needed, for clients who receive OST from GPs at primary health care level. Also, for municipalities to fund additional psychosocial services for clients who need intensive and continuous social support and case management.

Country example: Germany**Funding OST**

After several pilot programmes showed the effectiveness of methadone maintenance treatment, the German Social Health Insurers approved this treatment modality and in 1991 introduced methadone treatment guidelines for financing this kind of treatment. In Germany, treatment and prescription (medication) costs are generally paid by public health insurance schemes which provide legally mandated coverage for almost 90 percent of the population (in special cases, e.g. the homelessness, doctors' fees are met by social welfare services). There is also the freedom to choose one's general practitioner or hospital.

Until 2004, SHI funded clients and most clients supported by social welfare had to suffer from illnesses in addition to the drug addiction itself to be eligible for substitution treatment. Since 2004, it is sufficient to be diagnosed as being addicted to heroin. In general, drug users will be accepted for treatment when there is a documented history of compulsive opioid use for at least two years (according to SHI) and when they are at least 18 years old.

Despite the fact that the SHI guidelines are effective nationwide, there are variations among the federal states with respect to the organization and delivery of substitution treatment and accompanying psychosocial care. Depending on the number of substitution treatment providers in a given area, doctors can be authorized to treat up to 20 clients funded by SHI. There is however no such limitation specified in the Regulations on the Prescription of Narcotics. Thus, doctors approved to treat 20 SHI clients may care, for example, for another 20 clients funded by social welfare or an unlimited number of clients who pay for treatment and medication themselves (Mikels I et al., 2007).

3. Conclusion and Recommendations

OST has been proven highly effective in the treatment of opioid dependence as well as in HIV prevention. In general, OST is well implemented in most EU countries. In comparison, the number of OST clients in central and east Europe remains low. Most countries in central and east Europe report, although modest, improved access, quality and provision of OST over the last years.

This document presents several country examples related to practical issues around implementing and scaling-up OST. Based on the existing literature and country experiences, the following recommendations can be made:

- The key principles with regard to access to OST, as reflected in the WHO Guidelines for Psychosocially assisted pharmacological treatment of opioid dependence (WHO, 2009a), should be followed to ensure low threshold access to OST (see Annex 1).
- Legal frameworks should be modified/ amended in order to expand the range of providers allowed to prescribe OST, such as primary health care providers. General practitioners' involvement should thus be facilitated by the national legal framework, funding schemes and training opportunities. The involvement of primary health care providers is to date the most cost efficient way of scaling up OST.
- Funding for OST implementation and scaling-up should be ensured and health insurance systems should be appropriate and available for all clients in need for OST. OST should be free of charge or of minimal cost to clients.
- Continuity of OST for persons entering and leaving the criminal justice system should be guaranteed by close collaboration between the involved ministerial agencies.
- Provision of OST should be linked to, and as much as possible integrated into, other services, such as HIV, HCV and TB testing and treatment services, and compliance to OST should be facilitated and stimulated.
- A national framework should be developed, aiming to reduce diversion of controlled medications, while ensuring flexibility and attractiveness of OST to clients.
- Measures to raise awareness of the benefits of OST and to improve the public image of OST, such as publishing comprehensive factsheets and information leaflets, should be encouraged. National guidelines should be available, easily accessible and in line with existing international guidelines.
- The quality of OST should be guaranteed by development of internal institutional procedures.
- International and European indicators should be incorporated into national monitoring and evaluation systems.

4. References

Amato L, Minozzi S, Davoli M, Vecchi S, Ferri MMF, Mayet S. (2008a). Psychosocial and pharmacological treatments versus pharmacological treatments for opioid detoxification. *Cochrane Database of Systematic Reviews* 2008, Issue 4. Art. No.: CD005031. DOI: 10.1002/14651858.CD005031.pub3.

Auriacombe M, Fatseas M, Dubernet J, Daulouede JP, Tignol J (2004). French Field Experience with Buprenorphine. *The American Journal on Addictions*, 13:S17–S28, 2004

ECDC/EMCDDA (2011a). *Prevention and control of infectious diseases among people who inject drugs*. Stockholm: ECDC.

ECDC/EMCDDA (2011b). *Evidence for the effectiveness of interventions to prevent infections among people who inject drugs. Part 1: Needle and syringe programmes and other interventions for preventing hepatitis C, HIV and injecting risk behaviour*. ECDC and EMCDDA Technical Report. Stockholm: ECDC.

ECDC/EMCDDA (2011c). *Evidence for the effectiveness of interventions to prevent infections among people who inject drugs. Part 2: Drug treatment for preventing hepatitis C, HIV and injecting risk behaviour*. ECDC and EMCDDA Technical Report. Stockholm: ECDC.

EMCDDA (2011). *Guidelines for the Treatment of Drug Dependence. A European Perspective*. Selected issue. European Monitoring Centre for Drugs and Drug Addiction, 2011. http://www.emcdda.europa.eu/attachements.cfm/att_144638_EN_SI_treatment-guidelines-p3.pdf

EMCDDA (2013). *European Drug Report 2013: Trends and developments*. European Monitoring Centre for Drugs and Drug Addiction, 2013. <http://www.emcdda.europa.eu/publications/edr/trends-developments/2013>

Gowing L, Farrell M, Bornemann R, Sullivan LE, Ali R. (2008). Substitution treatment of injecting opioid users for prevention of HIV infection. *Cochrane Database of Systematic Reviews* 2008, Issue 2. Art. No.: CD004145. DOI: 10.1002/14651858.CD004145.pub3.

Hedrich D., Farrell M. (2012) Opioid maintenance in European prisons: is the treatment gap closing? *Addiction*. 2012 Mar;107(3):461-3.

Hedrich D., Alves P. Farrell M. et al. (2012). The effectiveness of opioid maintenance treatment in prison settings: a systematic review. *Addiction*, 107, 501-517.

Kastelic A., Pont J., Stover H., (2008). *Opioid Substitution Treatment in Custodial Settings*. Bis-Verlag der Carl von Osietzky Universitat Oldenburg.

Lawrinson P., Ali R., Buavirat A., et al. (2008). Key findings from WHO collaborative study on substitution therapy for opioid dependence and HIV/AIDS. *Addiction*, 103, 1484-1492.

Larney S, et al. (2012). Effect of prison-based opioid substitution treatment and post-release retention in treatment on risk of re-incarceration. *Addiction*. 2012;107(2):372–380

McLellan A.T., et al. (2000). Drug Addiction, a chronic medical illness: Implications for treatment, insurance and outcome evaluation. *Journal of American medical association* 284:13.

Michels I., Stöver H., Gerlach R. (2007). Substitution treatment for opioid addicts in Germany. *Harm Reduction Journal* 4:5. <http://www.harmreductionjournal.com/content/4/1/5>

Schaub M., Subata E., Chtengelov V. et al. (2009). Feasibility of Buprenorphine Maintenance Therapy Programs in the Ukraine. *European Addiction Research*, 2009,15: 157-162

Stöver H., Marteau D. (2012). Scaling-Up of Opioid Substitution Treatment in Adult Prison Settings – Scientific Evidence and Practical Experiences. *International Journal of Prisoner Health*, 7(2/3): 45 – 52.

Subata E., Malinauskaite A., Astrauskiene A. (2011). Cooperation of law enforcement and health care institutions and its effectiveness in addressing problems of opioid users. *Public Health* 2(53), pages 45-52. [http://www.hi.lt/images/Sv_2\(53\)_Subata.pdf](http://www.hi.lt/images/Sv_2(53)_Subata.pdf)

Trautmann F. (2010). *Intervision Guidelines*. UNODC regional project “HIV prevention among IDU and prisons in Estonia, Latvia and Lithuania 2006-2010” (English, Estonian, Latvian, Lithuanian and Russian).
<http://www.unodc.org/balticstates/en/publications/pharmacologicaltreatment.html>

UNODC (2008). *Drug Dependence Treatment: Interventions for drug users in prisons*. Accessed at March 28, 2011 at http://www.unodc.org/docs/treatment/111_PRISON.pdf

WHO (1993). WHO guidelines on HIV infection and AIDS in prisons. World Health Organization, Joint United Nations Programme on HIV/AIDS, Geneva. http://data.unaids.org/publications/IRC-pub01/jc277-who-guidel-prisons_en.pdf

WHO (1998). Principles for preventing HIV infection among drug users. WHO Regional Office for Europe, Copenhagen. http://whqlibdoc.who.int/euro/1998-99/EUR_ICP_LVNG_02_06_01.pdf

WHO (2004). *The Practices and context of Pharmacotherapy of opioid dependence in eastern Europecentral and eastern Europe*. World Health Organization, Geneva.
www.who.int/substance_abuse/publications/treatment/en/index.html

WHO (2005a). *Effectiveness of Drug Dependence Treatment in Preventing HIV among Injecting Drug Users*. Evidence for Action Technical Papers. World Health Organization, Geneva.
www.who.int/hiv/pub/idu/idu/en/index.html

WHO (2005b). XIV Edition of the Model List of Essential Medicines, WHO, Geneva. Accessed on March 28, 2011: www.who.int/medicines/en/

WHO Regional Office for Europe (2005). Status Paper on Prisons, Drugs and Harm Reduction. World Health Organization Regional Office for Europe, Copenhagen.
www.euro.who.int/document/e85877.pdf

WHO Regional Office for Europe (2007). *Health in prisons. A WHO guide to the essentials in prison health*. WHO Regional Office for Europe, Copenhagen
(<http://www.euro.who.int/document/e90174.pdf> (English) or
<http://www.euro.who.int/Document/E90174R.pdf> (Russian)).

WHO (2009a). Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. WHO, Geneva.
http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf

WHO (2009b). *Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings*. WHO, Geneva.
http://www.wpro.who.int/publications/PUB_9789290614302.htm

WHO/UNODC/UNAIDS (2004). *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*. Position paper, WHO. Geneva.
www.who.int/substance_abuse/publications/treatment/en/index.html

WHO/UNODC/UNAIDS (2009). *Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*. WHO, Geneva.
http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2010/idu_target_setting_guide_en.pdf

5. List of annexes

1. The key principles with regard to access to OST, as reflected in the WHO Guidelines for Psychosocially assisted pharmacological treatment of opioid dependence (WHO, 2009a)
2. Workshop on how to scale-up and implement opioid substitution therapy
 - a. *List of Participants*
 - b. *Workshop report*

Annex 1 The key principles with regard to access to OST, as reflected in the WHO Guidelines for Psychosocially assisted pharmacological treatment of opioid dependence (WHO, 2009a)

- Treatment should be accessible to disadvantaged populations.
- Pharmacological treatment of opioid dependence should be widely accessible; this might include treatment delivery in primary care settings. Patients with co-morbidities can be treated in primary health-care settings if there is access to specialist consultation when necessary.
- At the time of commencement of a treatment service, there should be a realistic prospect of that service being financially viable.
- Essential pharmacological treatment options should consist of opioid agonist maintenance treatment and services for the management of opioid withdrawal. At a minimum, this would include either methadone or buprenorphine for opioid agonist maintenance and outpatient withdrawal management.
- Psychosocial support should be available to all opioid dependent patients, in association with pharmacological treatments of opioid dependence. At a minimum, this should include assessment of psychosocial needs, supportive counselling and links to existing family and community services.

Annex 2. Workshop on how to scale-up and implement opioid substitution therapy

- a. List of Participants
- b. Workshop report



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