Report on the Assessment of Drug Dependence Treatment Quality Standards for Drug Dependence Treatment Programs in the former Yugoslav Republic of Macedonia

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Prepared by: Doc. Dr. Liljana Ignjatova

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and most of all, my gratitude goes to my patients, from whom I have learned and am still learning a lot.

I dedicate this paper to my patients, people with drug use disorders who deserve nothing less than ***ethical and scientifically based standards of treatment and care*** *that are available and similar to the standards applied to the treatment of other chronic diseases.*

Doc. Dr. Liljana Ignjatova (Dr. Kiteva)

President of the Inter-ministerial State Commission for Fight against Illicit Drug Production, Trafficking and Abuse

Contents

Glossary of Terms

ESA	Employment Service Agency of the Republic of Macedonia
GLOK32	UNODC-WHO Programme on Drug Dependence Treatment and Care
GF	Global Fund
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
TEMC	Toxicology and Emergency Medicine Clinic
MH	Ministry of Health
ICD	International Classification of Diseases
MJ	Ministry of Justice
MLSP	Ministry of Labor and Social Policy
ICSW	Intermunicipal Center for Social Work
NAS	Neonatal abstinence syndrome
NGO	Non-governmental Organisation
NPS	New psychoactive substances
NCPTDA	National Center for Prevention and Treatment of Drug Addiction
OST	Opioid Substitution Treatment
PG	Pompidou Group
PHI	Private Health Institution
SIA	Sector / Secretariat of Interior Affairs
AIDS	Acquired Immunodeficiency Syndrome
WHO	World Health Organization
TREATNET	Resource Center of the International Drug Addiction Treatment and Rehabilitation Network
HERA	Health Education and Research Association
HOPS	Healthy Options Project Skopje
DES	Directorate for Execution of Sanctions
HIV	Human immunodeficiency virus
UNODC	United Nations Office on Drugs and Crime
UNAIDS	Joint United Nations Programme on HIV/AIDS
CPTDA	Center for Prevention and Treatment of Drug Addiction

Executive Summary

The goal of this Study is to assess the quality of treatment and care for people with drug use disorders in the former Yugoslav Republic of Macedonia by applying the methodology for assessing the quality standards developed by the UNODC Office in Nigeria "National Minimum Standards for Drug Dependence Treatment in Nigeria", which are closely related to the recently released "International Standards for the Treatment of Drug Use Disorders" (UNODC,WHO, 2016). The aim of the Study is to identify which services are available for the treatment and care of people with drug use disorders in the former Yugoslav Republic of Macedonia, what strengths and weaknesses such treatment has, what works and what does not, in order to formulate future strategies and recommendations for improving the quality of drug dependence treatment that will guide the decision-makers and stakeholders.

In order to obtain as objective insight as possible in the country's situation related to the treatment and care of people with drug use disorders, by either filling out the Questionnaire or performing interviews and group discussions, information was obtained from the Ministry of Justice, Directorate for Enforcement of Sanctions; Ministry of Labor and Social Policy; NCPTDA; CPTDAs; PHIs; Day Center for Rehabilitation of Drug Users in Ohrid, Inter-municipal Center for Social Work; HOPS NGO; Therapeutic Community "Shroud"; Toxicology and Emergency Medicine Clinic; and service users.

The results were analyzed and structured using the seven basic principles of International Standards for the Treatment and Care of Addictions.

Regarding the principle 1 – "Treatment must be available, accessible, attractive and appropriate to the needs":

In the country, essential services for the treatment of people with drug use disorders are offered in specialized centers, private clinics in Skopje and partially, in the Toxicology and Emergency Medicine Clinic. Primary health care doctors are not involved in the treatment of people with drug use disorders. In some cities of the country, despite the need, specialized centers have not been opened (Kichevo, Prilep, Struga, etc.). Staff and training of some staff is insufficient. Opiate dependence treatment with buprenorphine is centralized only in the capital and is not available in prisons. Treatment programs for people with drug use disorders have a number of barriers (financial, geographical, working hours). Money for hospital treatment through buprenorphine induction is irrationally spent at the Toxicology and Emergency Medicine Clinic, instead of performing such induction in outpatient and day hospital conditions at the centers in the country. Some citizens do not have the right to treatment because they lack the necessary identity documents.

Regarding the principle 2 – "Ensuring ethical standards in treatment services":

Studies on stigma and discrimination against risk groups, which also include injecting drug users, show that these individuals face stigma and discrimination mainly when using services within the health sector. In the country, people with drug use disorders do not have equal right to access buprenorphine when it comes to opiate addiction treatment. They do not decide which center in the capital or

in the country they will be treated at. The availability of psychiatric and somatic comorbidity treatment is limited by various barriers. Living conditions and adequate treatment and care of people with drug use disorders who are deprived of liberty are unsatisfactory. Patients do not receive written information about their rights and obligations set out in Methadone Treatment Protocols and NGOs' Work Protocols. The staff providing services to people with drug use disorders is not sufficiently trained on the subject of human rights. Studies involving people with drug use disorders are sometimes carried out without ensuring their written consent and without an Ethics Committee consideration.

Regarding the principle 3 – "Promoting treatment of drug use disorders by effective coordination between the criminal justice system and health and social services":

Amendments to the Law on Execution of Sanctions, by which responsibility for inmates' health care has been moved from the Ministry of Justice to the Ministry of Health, have not yet been fully implemented. Alternative measures for treatment instead of punishment are not implemented in practice. Measures of forced custody and treatment of persons with drug use disorders are implemented in public health institutions where evidence-based opiate dependence treatment medications are not available. Prisons do not have all treatment programs for people with drug use disorders found in the community, such as voluntary counseling and testing for hepatitis C and HIV, treatment of hepatitis C, psycho-social treatment, buprenorphine treatment etc. Individuals treated with opioid agonists do not receive therapy for home when using a weekend/holiday leave from prison, if they are not accompanied by a family member who will pick up the therapy, so treatment is discontinued. Preparations of people with drug use disorders before release from prison are insufficient; there is no training on overdose prevention; it can happen that people get out of prison without the documents they need to continue their treatment; there is no training on acquiring work skills; there are no measures related to housing, rehabilitation and reintegration into the community. Training for criminal justice system staff in the area of drug use disorders is scarce or completely lacking. Measures for protection of medical records data of inmates with drug use disorders are not sufficient.

Regarding the principle 4 – "Treatment must be based on scientific evidence and respond to specific needs of individuals with drug use disorders":

Human and financial resource allocation in the treatment of drug use disorders is not guided by the evidence of effectiveness and cost-effectiveness of treatment interventions for these disorders. Not all services have drugs available for the treatment of drug use disorders and opioid overdose according to evidence-based medicine, nor medications for psychiatric comorbidities treatment. Not all services offer psycho-education and psycho-social treatment and family therapy. There are barriers to availibility of somatic and surgical treatments. Programs for psycho-education and reproductive health services are not available in all services. Skills training events for persons with drug use disorders are insufficient. Primary health care family doctors are not included in the treatment of people with drug use disorders. Multi-professional teams and their adequate qualification for the treatment of drug use disorders are lacking in the services of the country. Health workers' education and training in identification, diagnosis and evidence-based treatment of drug use disorders through schools and universities' curricula are insufficient. Continuous education for health professionals and associates is carried out through the GFATM Project which will end

this year. Evaluation of treatment programs is not made by patients in most services, and where it is made, program evaluation results do not always influence treatment norms and procedures.

Regarding the principle 5 – "Responding to the needs of special subgroups and conditions":

The country has no specific services for women, pregnant women, adolescents, ethnic minorities and marginalized groups such as the homeless. There are no Protocols for the treatment of women and pregnant women, adolescents, ethnic minorities and the homeless. Measures for social empowerment of marginalized groups are insufficient, as well as the outreach activities to expand the treatment coverage of ethnic minorities and marginalized groups with drug use disorders.

Regarding the principle 6 – "Ensuring good clinical governance of treatment services and programs for drug use disorders":

Policies for drug use disorder treatment are based on the principles of universal health care and developed through an active involvement of key stakeholders, including the target population and NGOs. Written treatment policies and protocols according to which services are provided are available. Protocols on buprenorphine treatment, and treatment of children and women are lacking. Part of the staff is not qualified for the work, and supervision and support are not sufficient to prevent the burnout syndrome among employees. Centers are not attractive workplaces to young people. Some employees of the Centers are not sensitized to the work with this population and are reluctant to work. There is a steady source of funding for the treatment programs for people with drug use disorders, but not for their evaluation, supervision, monitoring, and continuous education, and the programs implemented through NGOs. There is a network between institutions and organizations, but it is insufficient to provide a comprehensive treatment to people with drug use disorders. There is a system of records in public institutions. Treatment programs are not adapted to the changes (NPSs, behavioral addiction, stimulants) and do not keep up with time.

Regarding the principle 7 – "Integrated treatment policies, services, procedures, approaches and linkages must be constantly monitored and evaluated":

Treatment policies are formulated by relevant government bodies and commissions with the active involvement of stakeholders, the target group and NGOs. Links between prevention, treatment and drug use consequence prevention are not sufficient and operational. Treatment planning is based on the extent of the problem, but sufficient care is not taken of the characteristics of the population. Coordination between CPTDAs is realized through the NCPTDA. Regarding the cooperation between different agencies and ministries, a State Inter-ministerial Commission for Fight against Illicit Drug Production, Trafficking and Abuse was established. Minimum standards of treatment in terms of space and staff are not observed, nor in terms of the number of patients per one psychiatrist. There are mechanisms in place for clinical governance, monitoring and evaluation of patients only in centers where there is staff. There is information on the number, type and distribution of services available in the centers, Toxicology and Emergency Medicine Clinic, and ICSW Day Care Centers, for planning and program development purposes.

1. Introduction

This Report is a result of the work of the Consultant in conducting the assessment of drug dependence treatment quality standards in the country, within "UNODC-WHO Programme on Drug Dependence Treatment and Care" (GLOK32).

This Report is based on the available documentation, literature and previous research regrading the evaluation of Drug Addiction Treatment Programs in the former Yugoslav Republic of Macedonia, as well as interviews, group discussions and online communication with employees in the services for treatment and care of addictions, service users and UNODC representatives.

1.1. Background

It is estimated that a total of 247 million people, or 1 in 20 people aged 15 to 64 used illicit drugs in 2014, which corresponds to a global prevalence of 5.2%. The magnitude of the drug problem in the world becomes more evident if one takes into account that more than 1 in 10 drug users, i.e. about 29.5 million people, or 0.6% of the population aged 15 to 64 suffer from drug dependence disorders. Almost half, i.e. 12 million people with drug use disorders inject drugs. It is estimated that 1.6 million or 14% of injecting drug users live with HIV, and 6 million have hepatitis C. Annually, the number of deaths related to drugs was estimated at 207,400 in 2014, or 43.5 deaths per 1 million population aged 15–64, although this is unacceptable and can be prevented. This places a heavy burden on health care systems in terms of prevention, treatment and care of drug use disorders and their health consequences. Only one out of every six problematic drug users worldwide has access to treatment, due to a lack of service provision.[1] In terms of women, although one in three people using drugs is a woman, one in five people is a woman in treatment programs.

The former Yugoslav Republic of Macedonia is one of the countries that are part of the so-called "Balkan Route", which has been a major transit area for trafficking of heroin from West Asia to Europe in the last 30 years. Over the last two decades, various changes have been noticed in trade channels and ways of trade down the traditional "Balkan Route". With the emergence of new states and a number of borders, some states and border crossings, which are risky drug trafficking areas, have reinforced their measures to deal with such trafficking, which in turn motivates traffickers to expand their routes. To date, the Balkan Route has been the southern corridor for trafficking of heroin from Afghanistan, for about 83% of the world's heroin, to major markets either in Western Europe or Russia.

In order to assist its Member States in Southeast Europe and the Balkans, UNODC, in cooperation with WHO, is implementing a UNODC-WHO Programme on Drug Dependence Treatment and Care (GLOK32), and in close cooperation with the UNODC Regional Programme for Southeast Europe. The aim is to promote and support

1 https://www.unodc.org/doc/wdr2016/WORLD_DRUG_REPORT_2016_web.pdf

worldwide, and especially in low– and middle-income countries, ethical and evidence-based policies, strategies and interventions in order to increase access to evidence-based drug addiction treatment services and reduce health and social consequences caused by drug use and addiction.

TREATNET standards of drug addiction treatment (2012) are developed on the basis of UNODC-WHO principles of drug dependence treatment and care, and the fact that drug addiction is a multi-factorial health disorder that requires a bio-psycho-social approach to treatment and care, reflect the comprehensive package of treatment and care interventions that can be useful guidelines at service provision or planning/policy levels. Also, UNODC Office in Nigeria used the UNODC/WHO publication Principles of Drug Dependence Treatment and Care and WHO Quality Rights Standards and produced a common and comprehensive document "National Minimum Standards for Drug Dependence Treatment in Nigeria", which is closely related to the recently published "International Standards for the Treatment of Drug Use Disorders" of 2016[2].

The development of drug dependence treatment and care in accordance with internationally and nationally recognized and evidence-based quality standards has the potential to contribute to the improvement of services for treatment and care of people affected by drug use disorders e, their families and communities.

In accordance with the national requirements for drug addiction treatment and care, UNODC aims to support the Inter-ministerial State Commission for Fight against Illegal Drug Production, Trafficking and Abuse of the Government of the former Yugoslav Republic of Macedonia in its efforts to collect data for evaluating the quality of drug addiction treatment and care services in the country.

1.2 Overview of the Situation Related to Drug Dependence Treatment in Macedonia

An overview of the situation regarding the drug dependence treatment in Macedonia was made by analyzing the existing documentation and recent research of developments related to treatment in the former Yugoslav Republic of Macedonia, published by the WHO, EMCDDA, Institute of Public Health of the Republic of Macedonia and other authors and co-authors cited in this document.

Drug use surveys among the general population in the country have not been conducted so far, so there are no data on drug use among the general population. In 2010, research was done by the Institute of Public Health to estimate the number of IDUs in the Republic of Macedonia and an estimate of 10,200 drug injecting persons in the country was obtained[3].

2 UNODC, WHO (2016) International Standards for the Treatment of Drug Use Disorders. http://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_59/ECN72016_CRP4_V1601463.pdf

3 Mikik et al. Report from the bio behavioural survey and assessment of population size of injecting drug users in Macedonia, 2010. Skopje: Institute of Public Heath of the Republic of Macedonia.

According to the National Focal Point, the number of problematic drug users, mainly opiate injecting users in the country is around 8,000, corresponding to a rate of 1.5 per 1,000 population aged 15–64[4].

Drug abuse and addiction treatment services are mainly designed for the treatment of opiate dependence in outpatient conditions, and the beginnings of opioid agonist (methadone) treatment date back in 1979/80 as part of the Psychiatric Hospital Skopje. Since 2005 until today, within the Building a Coordinated Response to HIV/AIDS Prevention Program (supported by the Global Fund), the Ministry of Health has opened additional 11 Centers for Prevention and Treatment of Drug Abuse and Dependence (CPTDAs), of which 9 in other cities in the country, one in Skopje and one in Skopje "Idrizovo" Prison, where the methadone treatment existed even before. These Centers were supported by the Ministry of Health, Ministry of Labor and Social Policy, Inter-municipal Social Work Centers, the local community and non-governmental organizations.

Treatment is generally available within the public health sector, while the funding of programs is implemented through the Health Insurance Fund and the Ministry of Health. In the capital Skopje, there are 4 private psychiatric clinics that treat drug users. The Toxicology and Emergency Medicine Clinic started its treatment, mainly buprenorphine maintenance treatment, from 2009. Opioid agonist treatment is available in all prisons in the country through the opioid agonist treatment services in two correctional/detention facilities in Skopje and Bitola or through the services in the city where the prison is located. Long-term treatment to maintain abstinence from drugs is implemented in the Therapeutic Community "Shroud" in Strumica. Persons with dual diagnosis requiring inpatient treatment are hospitalized in both the male and female wards for violent patients at the Psychiatric Hospital Skopje or in the psychiatric wards within special, general and clinical hospitals in other cities across the country.

The coverage of problematic drug users in drug abuse and addiction treatment programs is about 18.5%, if we take into account the fact that about 1,600 patients in the country are treated with methadone in public, private and detention facilities, and about 250 patients are treated with buprenorphine, while the estimated number of injecting drug users is 10,200. This number of treated patients does not include clients that buy the drug buprenorphine privately upon a prescription of a psychiatrist in the country or an internist from the Toxicology and Emergency Medicine Clinic, because their number is unknown. About one half of treated patients come from Skopje.

According to the Final Report – Overview of HIV Program in Macedonia, prepared in October 2015 by Dorthe Raben, Stine Finne Jakobsen from the WHO Collaborating Centre on HIV and Viral Hepatitis, Anders Sönnerborg from the Karolinska Institute in Stockholm and Emilis Subata from the WHO Collaborating Centre for Harm Reduction, the OST (opioid substitution therapy) coverage is 23%[5], i.e. the coverage is medium (20–40% of the estimated number of injecting drug users)[6], taking the estimated

4 EMCDDA. Country Overview: The former Yugoslav Republic of Macedonia, 2013. http://www.emcdda.europa.eu/publications/country-overviews/mk, accessed 30 October 2015

5 Dorthe Raben, Stine Finne Jakobsen, Anders Sönnerborg, Emilis Subata. HIV program review in Macedonia. Final Report. Evaluation Report. October 2015

6 WHO, UNODC, UNAIDS. WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2012 revision, Geneva.

number of injecting heroin users at around 8,000. Older EMCDDA reports point out that Macedonia has the highest OST coverage in comparison with neighboring countries in the region[7].

The number of patients treated in the period from 1 January 2016 to 30 June 2016 at the centers for prevention and treatment of drug addiction in the Republic of Macedonia, including people who use opiates in Skopje Idrizovo Prison, as well as prisons in Shtip, Tetovo, Strumica, Gevgelija, Ohrid, Struga and Kumanovo, are shown in Table 1[8]. Drug users serving their sentences in Idrizovo Prison are treated at the Center for Prevention and Treatment of Drug Addiction (CPTDA) within the prison, while persons imprisoned or detained in the prisons of Shtip, Tetovo, Strumica, Gevgelija, Ohrid, Struga and Kumanovo are treated at the Centers for Prevention and Treatment of Drug Addiction in psychiatric wards of general or clinical hospitals in the cities where these prisons are located. Persons detained or imprisoned in the Skopje Prison and Bitola Prison are not included in this number. In these two prisons, the number of people with drug use disorders treated is low, at around 30.

Table 1.
Distribution of patients treated at CPTDAs in the first half of 2016, by cities and by gender

Center	Male	Female	Total
Skopje	464	69	533
Kumanovo	101	15	116
Tetovo	85	12	97
Shtip	67	2	69
Ohrid	148	15	163
Kavadarci	51	4	55
Gevgelija	35	6	41
Strumica	33	5	38
Bitola	83	15	98
Veles	40	4	44
Idrizovo Prison	268	13	281
Total	1375	160	1535

The number of people with drug use disorders admitted to treatment and those who dropped out of treatment in the first half of 2016 is shown in Table 2[9].

7 Hedrich D, Jekabsone I, Pirona A, Salminen M, Wiessing L (EMCDDA). Prevention of infectious diseases among people who inject drugs in some Western Balkan countries. A report based on the Reitox Academy organised on 29–30 October 2013 in Sarajevo, Bosnia and Herzegovina. 2014.

8 Source: Report of Skopje Psychiatric Hospital to the Global Fund regarding the key outcomes of services for IDUs: Harm Reduction/Substitution Treatment Programs

9 Source: Report of Skopje Psychiatric Hospital to the Global Fund regarding the key outcomes of services for IDUs: Harm Reduction/Substitutional Treatment Programs

Table 2. Number of patients admitted to treatment and dropped out of treatment in the first half of 2016

Center	Number of admitted patients			Number of dropped-out patients		
	m	f	total	m	f	total
Skopje	60	10	70	66	6	72
Kumanovo	17	0	17	6	0	6
Tetovo	11	0	11	4	1	5
Shtip	6	0	6	7	2	9
Ohrid	69	5	74	54	3	57
Kavadarci	37	2	39	30	4	34
Gevgelija	6	1	7	6	1	7
Strumica	64	6	70	3	0	3
Bitola	17	3	20	15	3	18
Veles	11	2	13	9	1	10
Idrizovo Prison	271	17	288	296	21	317
Total	569	46	615	496	42	538

The distribution of patients who dropped out of treatment and the reasons thereof are shown in Table 3[10].

Table 3. Distribution of dropped-out patients, by reasons for treatment discontinuation

Center	Discontinued treatment			Completed detxification			Transferred to another institution			Total
	m	f	total	m	f	total	m	f	total	Total
Skopje	22	3	25	1	1	2	43	2	45	72
Kumanovo	4	0	4	0	0	0	2	0	2	6
Tetovo	3	1	4	0	0	0	1	0	1	5
Shtip	4	1	5	0	0	0	3	1	4	9
Ohrid	22	1	23	10	0	10	22	2	24	57
Kavadarci	12	2	14	6	0	6	12	2	14	34
Gevgelija	4	1	5	1	0	1	1	0	1	7
Strumica	1	0	1	1	0	1	1	0	1	3

10 Source: Report of Skopje Psychiatric Hospital to the Global Fund regarding the key outcomes of services for IDUs: Harm Reduction/Substitutional Treatment Programs

Center	Discontinued treatment			Completed detxification			Transferred to another institution			Total
	m	f	total	m	f	total	m	f	total	Total
Bitola	10	3	13	0	0	0	5	0	5	18
Veles	6	1	7	1	0	1	2	0	2	10
Idrizovo Prison	143	6	149	10	2	12	143	13	156	317
Total	231	19	250	30	3	33	235	20	255	538

1.2.1. Criteria for treatment

The criteria for treatment with opioid agonist from 2005 to 2012 were:

- The patient must be older than 18,
- The patient must have a **history of opioid abuse of at least 1 year**,
- The patient must have **previous unsuccessful detoxification attempts** in health institutions,
- Voluntary consent to methadone treatment,
- Treatment Agreement signed with the Treatment Center.

Since 2012, the Protocol for Opioid Dependence Treatment has listed the following treatment criteria:

- The patient must be older than 18,
- **Dg. F11.2 (ICD–10),**
- Voluntary consent to methadone treatment,
- Treatment Agreement signed with the Treatment Center.

Patients younger than 18 can be treated with methadone if additional criteria are met:

- If the patient is HIV positive,
- If there is a Consent and Treatment Agreement signed by both the patient and parent.

1.2.2. Treatment duration

There is no limitation regarding the length of treatment in addiction treatment services. The only obstacle in the length of treatment may be the financial exhaustion of patients who pay for their treatment in PHIs or at the Toxicology and Emergency Medicine Clinic if not included in the group of patients who do not pay for their medication.

1.2.3. Home therapy for stable patients

According to the Protocol of Methadone Administration for Treatment of Opiate Addiction, it is possible for stable patients to obtain home therapy for 7 days and when traveling abroad or during holidays, they can obtain 14 daily therapies. Often, the criterion – patient stability is not respected due to other social and health problems that compromise the treatment (e.g. somatic comorbid condition that makes it difficult to travel to the Center, financial problems, etc.). In treatment with buprenorphine at the Toxicology and Emergency Medicine Clinic, patients from other cities in the country receive therapy for 2 weeks.

1.2.4. Limiting the dosage

According to the Protocol of Methadone Administration for Treatment of Opiate Addiction, for most people addicted to opioids, the optimal maintenance dosage is 80–120 mg/day (± 20 mg/day). Maintenance doses higher than 120 milligrams may be necessary in some patients. In making a decision on daily doses higher than 120 milligrams, a shift is made to a daily regimen for at least 6 months. The average daily dose of methadone is different in different centers, and it varies from 5 to 11 ml in Skopje. The average daily dose of methadone in Skopje prisons is lower than in community centers and amounts to 5.3 ml, which is due to the fact that patients decrease their dosages during their prison sentence. This is not the case with the average dose in Bitola Center and Bitola Prison, where the average dose is the same and amounts to 5.7 ml[11].

1.2.5. Waiting list

Since 2012 to date, there has been no barrier by introducing Waiting Lists. In the period before, there was a ban on admission of patients for methadone treatment in NCPTDA in Skopje, while the buprenorphine treatment at the Toxicology and Emergency Medicine Clinic was allowed (for some patients who co-paid for the services, while other patients bought the medication themselves), as well as treatment at PHIs.

1.2.6. Availability of opiate addiction treatment drugs

There are two medications registered and available in the country, which according to evidence-based medicine are applied in opiate dependence, and they are methadone and buprenorphine. Methadone treatment in the country has a long history and the first patients were involved in such treatment in 1979/80 at Skopje Psychiatric Hospital, which even today, is the main drug addiction treatment facility. Buprenorphine has been registered and available in the country since 2009, and

11 Ignjatova L., Mucollari G., Mehic-Basara N., Tomcuk A., Kovacevic M., Gjocaj M. Treatment systems overview South Eastern Europe. Council of Europe, 2011

in 2010, the Ministry of Health provided free medication for 100 patients treated exclusively at the Toxicology and Emergency Medicine Clinic (TEMC) within the Clinical Center in Skopje, where patients made co-payments for the services. Since 2013, the Ministry of Health has been covering the costs for buprenorphine, for 200 patients. Since 2015, the drug has been available at the National Center for Prevention and Treatment of Drug Addiction (NCPTDA), where most patients diagnosed with opiate dependence syndrome are treated in three outpatient clinics.

1.3 Assessment Goals

The goal of this Study is to assess the quality of treatment and care for people with drug use disorders in the former Yugoslav Republic of Macedonia by applying the methodology for assessing the quality standards developed by the UNODC Office in Nigeria "National Minimum Standards for Drug Dependence Treatment in Nigeria", which are closely related to the recently released "International Standards for the Treatment of Drug Use Disorders" (UNODC,WHO, 2016). The aim of the Study is to identify which services are available for the treatment and care of people with drug use disorders in the former Yugoslav Republic of Macedonia, what strengths and weaknesses such treatment has, what works and what does not, in order to formulate future strategies and recommendations for improving the quality of drug dependence treatment that will guide the decision-makers and stakeholders.

2. Initial Phase

In the initial phase of this Project, all the preparations and communications were made with a UNODC representative and stakeholders. The instrument (Assessment Form) was adapted with minor adjustments made in questions 1.3.1 and 1.3.2, where the word "indigenous" was removed and in 3.5.1, where the word "agonist" was replaced by "antagonist", and then it was sent to the four private health organizations in Skopje, employees in all 12 CPTDAs, employees of Day Centers for the Rehabilitation of Drug Users in Ohrid, a representative from the Ministry of Health (MH), Ministry of Labor and Social Policy (MLSP) and the Ministry of Justice (MJ) – Directorate for Execution of Sanctions (DES), a representative of Idrizovo Prison, a representative of the Toxicology and Emergency Medicine Clinic, civil society representatives and beneficiaries of drug addiction treatment services, to be completed and returned to the Consultant.

A meeting in a continuous education seminar from 1 to 3 September 2016 in the Struga Drim Hotel (supported by the Global Fund) was agreed with 33 representatives of various profiles (psychiatrists, doctors, psychologists, social workers and nurses) from CPTDAs in the country and Ohrid Day Center for Rehabilitation of Drug Users, where UNODC/WHO Principles of Drug Dependence Treatment were to be presented and the treatment of people with drug use disorders was to be discussed in three focus groups (1 – psychiatrists and doctors, 2 – psychologists and social workers, 3 – nurses) with the aim to obtain data. A meeting was arranged for 7 October in Skopje with some of the participants of the first workshop and other aforementioned representatives, in order to obtain treatment data from other participants and jointly finalize the Report.

3. Methodological Approach

3.1 Research Methodology

The assessment of the current situation in the former Yugoslav Republic of Macedonia related to the quality of treatment and care for people with drug use disorders is the first step towards improving the quality of treatment and care for these people and the establishment of evidence-based, comprehensive and effective treatment. According to the tasks arising from the Consultant's Terms of Reference, the quality of services offered to people with drug use disorders should be assessed, as well as the type of services available, strengths and weaknesses of current treatment in the country, in order to formulate future strategies and recommendations for improving the quality of drug use disorders' treatment, which will serve as guidelines for decision-makers and stakeholders. To achieve this goal, the most adequate methodological approach is a mixed methodology for collecting both quantitative and qualitative data. Quantitative data will provide a clear picture of the situation and treatment facilities in the country, while qualitative information will serve the purpose of understanding the phenomenon. To collect qualitative data, structured interviews, focus groups, observation, and analysis of existing data and research were used. The data collected were analyzed and structured using the seven basic principles of International Standards for the Treatment and Care of Addictions[12], including:

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

Principle 2: Ensure ethical standards in treatment services

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

Principle 4: Treatment should be based on scientific evidence and respond to the specific needs of people with drug use disorders

Principle 5: Target the needs of specific subgroups and conditions

Principle 6: Ensure good clinical management of services and programs for drug use disorder treatment

Principle 7: Integrated policies on treatment, services, procedures, access and links must be continuously monitored and evaluated.

This methodological approach allowed us to identify the strengths and weaknesses of current treatment and care of people with drug use disorders and possible ways to improve the quality standards of treatment and care for these people.

12 UNODC, WHO (2016) International Standards for the Treatment of Drug Use Disorders. http://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_59/ECN72016_CRP4_V1601463.pdf

3.2 Data Collection Tool

The main data collection tool for this Study was an Assessment Data Collection Form (documents) completed by analyzing the documents and an Assessment Data Collection Form (interview) filled with the findings of individual interviews. These Forms were developed by the UNODC Office in Nigeria within the document "National Minimum Standards for Drug Dependence Treatment in Nigeria", which contains the UNODC/WHO Principles of Drug Dependence Treatment as follows:

1. Availability and accessibility of drug dependence treatment
2. Screening, assessment, diagnosis and treatment planning
3. Evidence-informed drug dependence treatment
4. Drug dependence treatment, human rights and patient dignity
5. Targeting special subgroups and conditions
6. Addiction tretament and the criminal justice system
7. Community involvement, participation and patient orientation
8. Clinical governance of drug dependence treatment services
9. Treatment systems: policy development, strategic planning and coordination of services

These nine treatment quality criteria are included in the Assessment Forms used for this research. For each criterion there are several questions to be answered under the following criteria:

A = Adequately met

I = Inadequately met

N = Not met

N/A = Not applicable

A/R = Available upon referral

For each unmet or inadequately met criterion, a comment is made on the issue and a proposal is given on how the situation can be improved.

The Form that is completed by analyzing the documents contains a section stating the name and type of the facility, name and position of the author, the document's name, date and type, and date and place. The Form that is filled with the findings of individual interviews contains a section indicating the type of the facility, name and position of the interviewer, initials and date of birth of the respondent, the respondent type, and date and place of the interview.

The Assessment Form, which is a part of the document "National Minimum Standards for Drug Dependence Treatment in Nigeria" was adapted with minor changes only in questions 1.3.1 and 1.3.2, where the word "indigenous" was removed to make it adequate for application in the Macedonian social and cultural context.

3.3 Material

In order to obtain as objective insight as possible in the country's situation related to the treatment and care of people with drug use disorders, this Survey included representatives from the:

- Ministry of Health
- Ministry of Labor and Social Policy
- Ministry of Justice – Directorate for Execution of Sanctions
- National Center for Prevention and Treatment of Drug Addiction
- 12 Centers for Prevention and Treatment of Drug Addiction, including the Idrizovo Prison Center
- Day Center for Rehabilitation of Drug Users in Ohrid
- 4 private health organizations treating people with drug addictions
- Toxicology and Emergency Medicine Clinic
- Non-governmental organizations
- Therapeutic Community "Shroud"
- Service users

By either filling out the Questionnaire or performing interviews and group discussions, information was obtained from the Ministry of Justice, Directorate for Enforcement of Sanctions; Ministry of Labor and Social Policy; NCPTDA; CPTDAs; PHIs; Day Center for Rehabilitation of Drug Users in Ohrid, Inter-municipal Center for Social Work; HOPS NGO; Therapeutic Community Shroud; Toxicology and Emergency Medicine Clinic; and service users.

4. Field Work

The aim of the field work was to collect relevant data in order to assess the situation with the treatment and care of people with drug use disorders. This phase included representatives of all institutions and organizations, as well as representatives from the target group described in the "Material" Section, who had already received the questionnaires via email and got acquainted with their content, and some of them filled the questionnaires in and returned them to the Consultant. All parties involved were instructed that the items on which they had no information and did not apply to their sector should be left unanswered.

A meeting was convened with CPTDAs' representatives from 1 to 3 September 2016, where group discussions were performed to complement the information obtained electronically. Individual meetings were held with other representatives (Toxicology and Emergency Medicine Clinic, NGOs, the target group) and a joint meeting was organized on 7 October 2016 financially supported by UNODC.

Information obtained through completing the Questionnaire and submitted electronically was collected from all CPTDAs except the Idrizovo Prison Center; from 3 private health facilities; the Day Center for the Rehabilitation of Drug Users in Ohrid, HOPS NGO and the Therapeutic Community Shroud, and it was supplemented with data from discussions in 3 focus groups involving employees from Drug Dependance Treatment and Care Programs. One focus group included CPTDA managers, psychiatrists and physicians, the second focus group included psychologists and social workers from CPTDAs and the Day Center for Rehabilitation of Drug Users in Ohrid, while the third focus group included CPTDA nurses. An interview was conducted with a HOPS NGO representative, Toxicology and Emergency Medicine Clinic's representatives and target group representatives.

At the final meeting on 7 October, the draft version of the Report was presented, which was supplemented with participants' comments. The meeting was attended by representatives from the Ministry of Justice, Directorate for Enforcement of Sanctions; Ministry of Labor and Social Policy; NCPTDA; CPTDAs (Skopje, Tetovo, Bitola, Ohrid and Shtip); PHI Heliomedika; Day Center for Rehabilitation of Drug Users in Ohrid; Therapeutic Community Shroud and NGO HOPS.

The Draft Report as amended was sent to the UNODC Office in Belgrade for possible comments that were incorporated in the Final Report.

5. Results and Conclusions

The overview of the situation related to the treatment and care of drug use disorders in Macedonia was made by analyzing the existing documents (Guidelines with a Protocol for Opioid Dependence Treatment with Methadone, Clinical Pathway for Methadone Treatment, Clinical Pathway for Treatment with Buprenorphine, Treatment Agreement, Treatment Consent, narrative and numerical reports of Psychiatric Hospital Skopje to the Global Fund, reports on supervisions, NCPTDA Annual Reports, Guide on Treatment and Care of Drug-using Children, 2015–2019 National Penal System Development Strategy, Law on Execution of Sanctions, 2014–2020 National Drug Strategy[13], 2015–2020 Local Drug Strategy of the City of Skopje), previous research on the situation related to treatment in the former Yugoslav Republic of Macedonia, published by the WHO Office in Skopje, the EMCDDA, PG – Council of Europe, Public Health Institute of the Republic of Macedonia and other authors and co-authors who are cited in this document, interviews with employees in the services for treatment and care of drug use disorders, group discussions, interviews with the target group and questionnaires received online and observations. This analysis is done for the first time in the country, taking into account relevant criteria, i.e. 2016 Treatment Standards for the Treatment of Drug Use Disorders prepared by UNODC and WHO, which are produced to support Member States in the development of treatment services that offer effective and ethical treatment[14]. Principles by which the analysis was done in this Report are consistent with the principles developed by UNODC and WHO, which are as follows:

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

Principle 2: Ensure ethical standards in treatment services

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

Principle 4: Treatment should be based on scientific evidence and respond to the specific needs of people with drug use disorders

Principle 5: Target the needs of specific subgroups and conditions

Principle 6: Ensure good clinical management of services and programs for drug use disorder treatment

Principle 7: Integrated policies on treatment, services, procedures, access and links must be continuously monitored and evaluated.

13 http://www.cph.mk/ftp/Strategii/Nacionalna%20strategija%20za%20droga%20%20mkd%20strategija%202014-2020.pdf

14 UNODC, WHO (2016) International Standards for the Treatment of Drug Use Disorders. http://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_59/ECN72016_CRP4_V1601463.pdf

5.1 (Principle) Treatment must be available, accessible, attractive and appropriate to the needs

5.1.1. (Standard) *Essential treatment services for drug use disorders should be available through organization of treatment interventions at different levels of health systems: from primary health care to tertiary health services with specialized treatment programs for drug use disorders.*

Treatment of people with drug use disorders is implemented in specialized institutions – Centers for Prevention and Treatment of Drug Abuse and Addiction. Primary health care is not involved in treating this category, nor is tertiary health care. Family doctors of people with drug use disorders refer them for treatment in specialized centers. The only public health institution that participates in the treatment of this category of patients, which is not a specialized center, is the Toxicology and Emergency Medicine Clinic in Skopje (tertiary health care), where drug overdose and other emergency conditions are treated, but this clinic also offers opioid agonist treatment (exclusively with buprenorphine), mainly for maintenance and rarely detoxification purposes.

5.1.2. (Standard) *Essential treatment services are in place that include brief interventions, diagnostic assessment, outpatient counselling, outpatient psychosocial and evidence-based pharmacological treatment of drug use disorders, outreach services and services for management of drug-induced acute clinical conditions such as overdose, withdrawal syndromes and drug-induced psychoses.*

Essential treatment services in the public health sector are offered only at the specialized centers for treatment and care of people with drug use disorders. In the capital Skopje, essential treatment services are also offered in four private clinics. Even at the level of specialized centers, there are no standardized working conditions, i.e. no minimum requirements/standards are met. Some of the centers have insufficient staffing or insufficiently trained staff, so they cannot respond to the needs of people with drug use disorders in terms of essential services. Staff members working in some of the centers are resident doctors in another area of medicine and they lack sufficient training to treat people with drug use disorders. In some centers, staff turnover is frequent. Some centers lack infirmaries and work just like day hospitals and refer patients to ambulance of psychiatric wards in hospitals that are remote from the centers.

5.1.3. (Standard) *Essential treatment services for drug use disorders should be within reach of public transport and accessible to people living in urban and rural areas.*

According to **geographical** availability, methadone treatment is available in 12 centers for prevention and treatment of drug and other psychoactive substance addiction (CPTDAs) in 10 cities in the country and in three prisons located in two cities of the country. Buprenorphine treatment is available only in the capital (Skopje), and until the end of 2015, it was solely available at the Toxicology and Emergency Medicine Clinic, while since then, also at the National Center for Prevention and Treatment of Drug Addiction (NCPTDA) in the former Yugoslav Republic of Macedonia. Patients from other cities can buy the drug in pharmacies on their account, if it is prescribed by a doctor. In the capital Skopje, there are 4 private health institutions (PHIs), i.e. psychiatric clinics that treat people dependent to opiates with methadone and buprenorphine. Patients from the capital Skopje should use two buses to reach

NCPTDA, where there are no barriers to admission, although other services such as the CPTDA at the 8 September City General Hospital and private services are closer, but they have barriers to admission. Private services charge for the treatment, while the Center at the 8 September City General Hospital treats only citizens living in the municipality where the hospital is located. In spite of the fact that this is a city hospital and treats all Skopje citizens from all other diseases, people with drug use disorders from municipalities other than the municipality where the hospital is located are not entitled to treatment in this hospital. On the other hand, the municipality where this city hospital is located has the lowest unemployment rate and the number of low-threshold patients there is the smallest, so this geographical barrier helps to avoid low-threshold patients.

5.1.4. (Standard) *Low threshold and outreach services, as part of a continuum of care, are needed to reach the 'hidden' populations most affected by drug use, often non-motivated to treatment or relapsing after a treatment program.*

Low-threshold programs for treatment of people with dependence are not appealing to institutions, so all newly established programs in Skopje by using various barriers (financial, geographical region of origin, etc.) avoid low-threshold patients who are treated at NCPTDA. Thus, some patients have to commute longer, to change two buses to get to the NCPTDA, although some other services in the city are geographically more accessible to them[15]. Non-governmental organizations through their outreach workers and other activities reach this hidden population and refer and accompany its members to the NCPTDA in Skopje.

5.1.5. (Standard) *Within a continuum of care, people with drug use disorders should have access to treatment services through multiple entry points.*

People with drug use disorders voluntarily enter and leave treatment and there are no restrictions on the number of admissions.

5.1.6. (Standard) *Essential treatment services for drug use and drug-induced disorders should be available during a sufficiently wide range of opening hours to ensure access to services for individuals with employment or family responsibilities.*

As regards **a sufficiently wide range of opening hours,** NCPTDA and CPTDAs work only in one shift, which makes access for the group of employed patients more difficult, as well as for all those who need medical care in the afternoon and evening[16, 17]. Afternoon services are available at PHIs and TEMC using staff on duty, but there is a financial barrier there, so those services are unavailable to most people with drug use disorders, especially to low-threshold patients. CPTDAs do not work during the weekend and emergency units of hospitals where centers belong do not accept patients with drug use disorders on weekends. In some specialized centers, the availability of treatment services for persons with drug use disorders is even more restrictive; so, for example, one center has a doctor/psychiatrist only one day a week

15 Ignjatova L. Breaking barriers for treatment of heroin addiction with the aim to improve availability, accessibility, coverage and quality of treatment. Bolesti zavisnosti trendovi i izazovi, Beograd 2015:15–20

16 Ignjatova, L. et al. Client and staff satisfaction survey that add an important perspective to the evaluation of the methadone treatment centers. 5-th Adriatic drug addiction treatment conference and 7-th SEEA Symposium on addictive behaviors. Ohrid, R. Macedonia, 28 September – 2 October 2010. Ovisnosti Vol XI, Sup 1:17.

17 Ignjatova L. Breaking barriers for treatment of heroin addiction with the aim to improve availability, accessibility, coverage and quality of treatment. Bolesti zavisnosti trendovi i izazovi, Beograd 2015: 15–20

and patients can be admitted only on that day, except for exceptional cases. In another center, admissions take place from Monday to Thursday, but not on Friday, because the next two days are non-working for the center, so there is no opportunity to observe the patient the following day.

5.1.7. (Standard) *Essential treatment services should be affordable to clients from different socio– economic groups and levels of income with minimized risk of financial hardship for those requiring the services.*

In terms of **affordability**, the treatment at CPTDAs is free, except for the 10% co-payment by patients in the first month of treatment, when such treatment is covered by the Health Insurance Fund (Health Insurance Fund covers 90% of the treatment, while clients participate with 10%). After the first month, all expenses for treatment of patients are taken over and covered by the Ministry of Health. Most centers do not charge patients their co-payments of 10%. At the TEMC, about 243 patients are treated with buprenorphine; they receive the medication free of charge, but make co-payments for the other services, although NGOs and clients report that within a certain period at the beginning of their treatment, they had to buy the drug themselves as a prerequisite to get free medications afterwards. At TEMC, the Buprenorphine, partial agonist opioid, is most often introduced in an inpatient setting, which contributes to higher treatment costs, both for the state and patients, due to the co-payment they have to pay. At the four PHIs, treatment costs are covered by patients[18].

Transportation is an additional financial burden for individuals with drug use disorders and a barrier to access to treatment. There are no treatment centers in all cities of the former Yugoslav Republic of Macedonia, and transportation costs are very high and present an obstacle to access to treatment. Some patients have to travel even 50 kilometers to reach their regional center, and Ohrid ICSW manages to provide bus tickets only for a very small portion of them and for people at higher social risks. Provision of longer-distance tickets is too expensive, so Ohrid ICSW manages to provide only 4 bus tickets a month, which compromises treatment in certain situations because it prevents daily or more frequent monitoring and treatment of persons with unstable health conditions and those requiring more intensive treatment.

Homeless people with drug use disorders accommodated at the “Chichino Selo” Shelter are not entitled to cash benefits or lose such right if they had it before, because they are accommodated and provided with food, not taking into account the fact that they need funds for transportation to their treatment centers.

In Macedonia, there are people with drug use disorders who lack personal documents, because their citizenship is not regulated or because they have no documents at all, so they cannot get health insurance. Persons who were on methadone treatment leave prison with no identity cards and other documents, and some of them lack citizenship, so they cannot get the necessary health insurance documents. People without health insurance have no access to treatment, unless they are able to pay.

5.1.8. (Standard) *Treatment services should be gender-sensitive and tailored to the needs of women including specific child-care needs and needs in pregnancy.*

Treatment services are not **gender-sensitive**, nor are tailored to women’s needs (see Chapter Targeting the needs of specific subgroups and conditions).

18 Ignjatova L. Breaking barriers for treatment of heroin addiction with the aim to improve availability, accessibility, coverage and quality of treatment. Bolesti zavisnosti trendovi i izazovi, Beograd 2015:15–20

5.1.9. (Standard) *Treatment services should provide access to social support, general medical care and referrals to specialized health services for the management of complex co-morbid health conditions.*

Social support for patients is offered by social workers employed in some of the services in the country, but there is no budget for the implementation of specific programs that would strengthen the community of drug users[19][20]. Social workers are employed in NCPTDA, most CPTDAs, two PHIs, while other services in the country refer people with drug use disorders to social workers in civil society organizations or ICSW. Lack of social support for this category of patients contributes to the abuse of therapy in order to provide housing, food, transportation and meet other basic needs. In a few cases, social workers from the centers, with particular efforts and using ICSW's programs, managed to provide social assistance as care from a third person, permanent financial assistance, family pension; in one case in Ohrid, even a home for a person with drug use disorder, furniture for the home, inclusion in a public kitchen etc. Non-governmental organizations (NGOs) and day centers for the rehabilitation of drug users of the Ministry of Labor and Social Policy (MLSP) are serious CPTDAs' partners in the implementation of psycho-social support for patients.

Most patients who come to CPTDAs for treatment are intravenous drug users; nevertheless, CPTDAs have rarely had a patient who was HIV-positive. By the end of 2014, only 12 IDUs were diagnosed with HIV[21]. Among the new cases of HIV-positive people by 2014, there was only one drug injecting person. The prevalence of hepatitis C among this population is high at 70.1%.[22] Thanks to the funding from the Global Fund for fight against AIDS, malaria and tuberculosis, the country has developed programs for the prevention and treatment of somatic comorbidities – blood-borne infections. Treatment of **somatic comorbidities** is carried out by referrals to other healthcare institutions, which is a barrier for clients. People with substance use disorders with hepatitis C from other cities lack available and affordable diagnostic and treatment assessment services. For this purpose, they travel to Skopje, and for some of them, travel and examination co-payment costs present a barrier. Hospitalization in another hospital is difficult.

The country is lacking the specific programs, especially the services for the outpatient and inpatient clients to address the psychiatric comorbidities. Psychiatric hospital wards are challenging for clients to access, most probably as a result of the resistance of psychiatrists to work with the patients with drug use disorders.The Psychiatric Clinic (tertiary health care) and the Psychiatry Ward at the City General Hospital 8th September do not treat patients with psychiatric comorbidity if they receive opioid agonist therapy. Typically, clients with psychiatric comorbidity who are treated with the opioid agonists are referred to the Psychiatric Hospital Skopje, where

19 Ignjatova, L. et al. Client and staff satisfaction survey that add an important perspective to the evaluation of the methadone treatment centers. 5-th Adriatic drug addiction treatment conference and 7-th SEEA Symposium on addictive behaviors. Ohrid, R. Macedonia, 28 September – 2 October 2010. Ovisnosti Vol XI, Sup 1:17.

20 Ignjatova L. Breaking barriers for treatment of heroin addiction with the aim to improve availability, accessibility, coverage and quality of treatment. Bolesti zavisnosti trendovi i izazovi, Beograd 2015: 15–20

21 Institute of Public Health of the Republic of Macedonia. Facts about HIV/AIDS in the Republic of Macedonia in the period 1987–2014 (11/28/2014). (http://www.iph.mk/en/facts-about-hiv-aids-in-the-republic-of-macedonia-for-2014/, accessed 30 October 2015)

22 Mikik et al. Report from the bio behavioural survey and assessment of population size of injecting drug users in Macedonia, 2010. Skopje: Institute of Public Health of the Republic of Macedonia.

hospitalization is performed in a supervised ward for the violent patients, which is posing a barrier for patients and their families, thus the number of hospitalizations is very small.

Outpatient/day hospital treatment of psychiatric comorbidity is found in Skopje CPTDA. In other cities of the country, patients with dual diagnosis are referred for examination to psychiatric ward infirmaries, where they are prescribed medications for their comorbid psychiatric disorder. These examinations are not performed in other cities' CPTDAs, because they usually lack psychiatrists and psychiatric disorder drugs, which prevents people with dual diagnosis to take the necessary treatment and respond well thereto.

5.1.10. (Standard) *Treatment services for drug use disorders should be oriented towards the needs of served populations with due respect to cultural norms and involvement of service users in service design, development and evaluation.*

Service users are involved in the evaluation of treatment services at NCPTDA, but not in the other centers and institutions. Patients are getting increasingly involved in various committees and groups for drafting important documents on drugs.

5.1.11. (Standard) *Information on availability and accessibility of essential treatment services for drug use disorders should be easily accessible through multiple sources of information including internet, printed materials and open access information services.*

Regarding most of the services, **there is no publicly accessible information on the availability and accessibility of essential services**, but non-governmental organizations, some private and public health services have websites, some services have printed materials, i.e. flyers containing information about their services. Occasionally, campaigns and TV broadcasts are used to share information on available services. Service users report that no information is available about treatment services.

Conclusions and recommendations regarding the principle "Treatment must be available, accessible, attractive and appropriate to the needs"

Conclusions giving rise to recommendations:

In the country, essential services for the treatment of people with drug use disorders are offered in specialized centers, private clinics in Skopje and partially, in the Toxicology and Emergency Medicine Clinic. Primary health care doctors are not involved in the treatment of people with drug use disorders. In some cities of the country, despite the need, specialized centers have not been opened (Kichevo, Prilep, Struga, etc.). Staff and training of some staff is insufficient. Opioid dependence treatment with buprenorphine is centralized only in the capital and is not available in prisons. Treatment programs for people with drug use disorders have a number of barriers (financial, geographical, working hours). Money for hospital treatment through buprenorphine induction is irrationally spent at the Toxicology and Emergency Medicine Clinic, instead of performing such induction in outpatient and day hospital conditions at the centers in the country. Some citizens do not have the right to treatment because they lack the necessary identity documents.

Recommendations:

- Involve primary health care in the treatment and care of people with drug use disorders

- Meet standardized working requirements in terms of staff and training of staff in all specialized centers in the country
- Decentralize treatment with buprenorphine and make it available in all centers and prisons in the country
- Remove barriers to treatment (financial, geographical, working hours)
  - Free treatment for people with drug use disorders
  - Cover transportation costs for people with drug use disorders
  - Flexible working hours and involvement of all facilities to ensure service availability (emergency services, shift work)
  - Accept low-threshold patients in available treatment facilities
- Rationally spend the money for treatment of people with drug use disorders (day hospital and outpatient inclusion of buprenorphine for opioid dependence treatment, except in exceptional cases where there are hospital treatment indications)
- Open up centers in more cities in the country, as appropriate (according to the number of people with drug use disorders, distance from existing regional centers etc.)
- Provide identity documents to people with drug use disorders in order to exercise their right to treatment
- Set up gender-specific programs for women
- Ensure treatment for somatic and psychiatric comorbidities without any barriers
- Involve patients in the planning, development and evaluation of services.

5.2. (Principle) Ensuring ethical standards in treatment services

5.2.1 (Standard) *Treatment services for drug use disorders should respect in all cases human rights and dignity of service users, and humiliating or degrading interventions should never be used.*

Public poll results in terms of the rights and stigma associated with risk groups and HIV/AIDS in Skopje, Prilep and Veles imply that there is a high level of **stigma and discrimination** faced daily by these risk groups, including drug injecting persons. The high level of stigma and discrimination is confirmed by the experience of risk groups, as well as information by NGOs. According to them, risk groups are faced with stigma and discrimination mainly when using services within the health care sector. Most of the NCPTDA employees are sensitive and do not create problems of stigma and discrimination, which of course is not the case outside the institution, particularly in the health sector[23].

23 WHO Office, Skopje. Report on the public opinion survey regarding the rights and stigma associated with risk groups and HIV/AIDS in Skopje, Prilep and Veles. August 2016, Skopje

In treatment centers in Skopje, people with drug use disorders are not able to choose at which center they will be treated. Neither in other cities in the country, people with drug use disorders can choose at which center they will be treated, because everyone should be treated in their regional center. However, some patients that should be treated at the Gevgelija Center choose the Center in Strumica, which they think is more flexible.

In most centers, buprenorphine is not available, or only one drug for evidence-based opiate addiction treatment is available (methadone), so service users do not have a choice of medications.

Skopje people with drug use disorders having a psychiatric comorbidity cannot be treated at the psychiatric ward of 8 September CGH and the Psychiatric Clinic. Such people can be treated in the Ward for Violent Patients at the Psychiatric Hospital Skopje, but not in other wards.

People with drug use disorders having a somatic comorbidity are requested by health workers to have additional examinations and tests, to pay for additional protective equipment of staff etc.

Buprenorphine is not available for treatment in prisons. Neither is hepatitis C treatment available to persons deprived of liberty.

The 2015–2019 National Penitentiary System Development Strategy recognizes as weaknesses the following: lack of funds affecting the conditions for persons deprived of their liberty in prisons and detention centers; the presence of cases of abuse and corrupt practices by prison and detention staff; cases of violent behavior of inmates in correctional institutions; poor resettlement of offenders; mistreatment of vulnerable inmates; lack of educational process for inmates; underdeveloped cooperation with other external institutions such as the courts and the Ministry of Education and Science.

In their treatment, patients have the right to engage family members, NGOs or others persons recognized and accepted by the staff.

There are Treatment Protocols in place at the centers and NGOs, which stipulate the rights and obligations of service users; however, service users do not receive information on their rights in writing.

At the Day Center for Rehabilitation and Reintegration of Drug Users and Their Family Members, which operates within Ohrid ICSW, drug users have a choice between treatment options available. There, drug users receive clear and comprehensive written (Treatment Agreement, List of Services, Consent to Service Use, Consent to respect the House Rules) and verbal information on their right to service.

5.2.2. (Standard) *Informed consent should be obtained from a patient before initiating treatment and guarantee the option to withdraw from treatment at any time.*

In all public and private health institutions that treat people with drug use disorders, patients sign a written voluntary consent, exept those who have been imposed a security measure of compulsory custody and treatment in a psychiatric institution. Also, in the Therapeutic Community “Shroud”, clients sign a written voluntary consent.

Service users from Ohid CPTDA decide voluntarily and on their own whether to join the treatment program of the Day Center for Rehabilitation and Reintegration of Drug Users and Their Family Members, which operates within Ohrid ICSW.

5.2.3. (Standard) *Patient data should be strictly confidential, and registration of patients entering treatment outside the health records should not be allowed in all cases. Confidentiality of patient data should be ensured and protected by legislative measures and supported by appropriate staff training and service rules and regulations.*

Data on patients in all public and private health organizations are confidential. NGOs protect their data with codes. Training events on personal data protection have been conducted for employees in public health organizations and civil society organizations. Patients' records are kept locked, and each request for access to documents by an expert or the court shall be recorded in a special register. Some service users report that their employers have the information that they are on drug use disorder treatment, but do not know whew from they received that information or they just assume.

Medical charts of persons in treatment due to drug use disorders in Skopje Idrizovo Prison are sometimes taken to the infirmary doctor from the storage place by an inmate who does some work for the prison.

5.2.4. (Standard) *Staff of treatment services should be properly trained in the provision of treatment in full compliance with ethical standards and human rights principles and norms, and show respectful, non-stigmatizing and non-discriminatory attitudes towards service users.*

Most of the NCPTDA's employees are sensitized and do not create problems of stigma and discrimination, which of course is not the case outside the institution, particularly in the health sector [24].

The staff is not trained on human right principles and norms.

5.2.5 (Standard) *Services and procedures are in place which require staff to adequately inform patients of treatment processes and procedures, including the right to withdraw from treatment at any time.*

According to the Clinical Guidelines for Methadone Application in Opioid Addiction Treatment, the multi-professional treatment team shall give the person with drug use disorders when joining the Methadone Program, information about the purposes of treatment, the drug (therapeutic and side effects of the drug, dosage and dose-reduction procedure, manner of preparation, dispensing and dosing, the right and conditions under which taking the therapy home is allowed, safe storage of the drug at home); about his/her rights (health treatment without discrimination, respect for his/her personality and confidentiality of information on his/her health, the right to be advised and informed of the diagnosis, the therapeutic plan, course of treatment, the daily dose and treatment difficulties, the right to be informed of treatment effects and **the right to refuse treatment, dosage, diagnostic or therapeutic procedure**); about his/her obligations (regular visit to the institution, regular and active participation in treatment programs, active cooperation with the treatment team, respecting the House Rules and non-violent and non-aggressive behavior); about the consequences if failing to meet his/her obligations (loss of the right to take his/her therapy home, exclusion from the program and referral to another facility only in case of self-aggressive and hetero-aggressive behavior).

24 WHO Office, Skopje. Report on the public opinion survey regarding the rights and stigma associated with risk groups and HIV/AIDS in Skopje, Prilep and Veles. August 2016, Skopje

5.2.6. (Standard) *Any research in treatment services involving human subjects should be subject to review of ethical committees, and participation of service users in the research should be strictly voluntary with informed written consent ensured in all cases.*

Only some of the Studies conducted in treatment services have provided written consent of patients, other Studies have been conducted with oral consent, i.e. service users have been involved in research voluntarily.

Conclusions and recommendations regarding the principle "Ensuring ethical standards in treatment services"

Conclusions giving rise to recommendations:

Studies on stigma and discrimination against risk groups, which also include injecting drug users, show that these individuals face stigma and discrimination mainly when using services within the health sector. In the country, people with drug use disorders do not have equal right to choose buprenorphine when it comes to opiate addiction treatment. They do not decide which center in the capital or in the country they will be treated at. The availability of psychiatric and somatic comorbidity treatment is limited by various barriers. Living conditions and adequate treatment and care of people with drug use disorders who are deprived of liberty are unsatisfactory. Patients do not receive written information about their rights and obligations set out in Methadone Treatment Protocols and NGOs' Work Protocols. The staff providing services to people with drug use disorders is not sufficiently trained on the subject of human rights. Studies involving people with drug use disorders are sometimes carried out without ensuring their written consent and without an Ethics Committee consideration.

Recommendations:

- Educate health care workers in order to reduce stigma and discrimination against people with drug use disorders
- Equal availability of the medication buprenorphine for all people with drug use disorders in the country, including persons deprived of their liberty
- Equal availability of somatic and psychiatric comorbidity treatment services for people with drug use disorders, as well as for all other patients in the country
- Improve living conditions and provide adequate treatment and care of people with drug use disorders who are deprived of their liberty, and ensure equal treatment and care of people with drug use disorders in the community
- Provide written information about service users' rights listed in Methadone Treatment Protocols and NGOs' Work Protocols
- Train health professionals working permanently or temporarily with people with drug use disorders on the topic of human rights
- Review by an Ethics Committee and provide written consent from people with drug use disorders when they are included in research.

5.3. (Principle) Promoting treatment of drug use disorders by effective coordination between the criminal justice system and health and social services

5.3.1. (Standard) *Treatment for drug use disorders should be provided predominantly in health and social care systems, and effective coordination mechanisms with criminal justice system should be in place and operational to facilitate access to treatment and social services.*

By the amendments to the Law on Execution of Sanctions, the responsibility for health care of inmates has moved from the MJ to the MH. Health care of inmates and detainees has been transferred to public health facilities providing primary health care in the area where the correctional facility is located[25]. Full implementation of this change in the law is still lacking.

5.3.2. (Standard) *Treatment of drug use disorders should be available to offenders with drug use disorders and, where appropriate, be a partial or complete alternative to imprisonment or other penal sanctions.*

People with drug use disorders who are offenders are treated in both Skopje prisons, and in Bitola Prison, or receive treatment at CPTDAs in the cities where their prison is located. The number of people referred to drug addiction treatment instead of punishment remains low. In NCPTDA, of a total of 453 patients treated in July 2016, only one patient had a security measure, and not a single patient had an alternative treatment measure instead of imprisonment. Other CPTDAs report the same situation. 2015–2019 National Penal System Development Strategy recognizes the failure to implement alternative measures into practice as a weakness[26].

On the other hand, people with drug use disorders, who have been imposed a security measure of compulsory custody and treatment in a psychiatric institution, are referred to the public health psychiatric institution "Demir Hisar", and opiate agonist treatment is not available in this institution.

5.3.3. (Standard) *Treatment of drug use disorders as an alternative to incarceration or in criminal justice settings should be supported by appropriate legal frameworks.*

There is a legal framework for alternative measures in place, but the implementation of alternative measures in practice is a challenge.

5.3.4. (Standard) *Criminal justice settings should provide opportunities for individuals with drug use disorders to treatment and health care that are guaranteed in health and social care systems in a community.*

Some of the programs available in the community are lacking in prisons, such as testing and counseling for HIV and hepatitis C, treatment with buprenorphine, detoxification and psycho-social treatment. Hepatitis C treatment is also lacking.

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25 Official Gazette of the RM no. 170/13 of 6 December 2013 http://www.pravda.gov.mk/documents/zakonsankcii170.13.pdf

26 2015–2019 National Penal System Development Strategy http://www.pravda.gov. mk / documents/Nacionalna_strategijaENG.pdf

5.3.5. (Standard) *Treatment interventions for drug use disorders should not be imposed on individuals with drug use disorders in criminal justice system against their will.*

Drug use disorder treatment in prisons is voluntary, and persons deprived of liberty enter and leave treatment voluntarily.

5.3.6. (Standard) *Essential prevention and treatment services should be accessible to individuals with drug use disorders in criminal justice settings, including prevention of transmission of blood-borne infections, pharmacological and psycho-social treatment of drug use disorders and comorbid health conditions, rehabilitation services and linking with community health and social services in preparation for release.*

Prisons have no buprenorphine, while Idrizovo Prison continues the treatment with buprenorphine only if it was started at the Toxicology and Emergency Medicine Clinic. When leaving for the weekend or having some days off on another basis (vacation), people with drug use disorders and treated with opioid agonists do not receive therapy for home if there is no family member accompanying them (the so-called "Receiver"), who will get the therapy for home. Prisons lack Harm Reduction Programs. Hepatitis C treatment is not available in prisons. Preparations for release are insufficient and psycho-social interventions including education and vocational training for reintegration after release from prison are not provided, nor any training to prevent overdose. Some people with drug use disorders get out of prison unprepared and without personal documents. Measures for rehabilitation and reintegration into the community are insufficient for prison returnees with drug use disorders, as for other people with such disorders. The number of re-offenders in prisons is very large.

5.3.7. (Standard) *Appropriate training programs for criminal justice system staff, including law enforcement and penitentiary system officers and court professionals should be in place to ensure recognition of medical and psychosocial needs associated with drug use disorders and support treatment and rehabilitation efforts.*

Training of penitentiary system staff in the area of drug use disorders is implemented with financial support from the Global Fund, through periodic continuous education seminars. However, it is not enough and most of the employees and people with drug use disorders in prisons feel that education is necessary for all employees and persons deprived of their liberty. These training events do not include court professionals.

5.3.8. (Standard) *Treatment of drug use disorders in criminal justice system should follow the same evidence-based guidelines and ethical and professional standards as in the community.*

Drug (opioid) use disorder treatment is implemented according to the Clinical Guidelines with a Protocol on Opiate Dependence Treatment with Methadone. There is no buprenorphine and psycho-social treatment in prisons. Occasional psycho-education is conducted with support by the Global Fund Project. Medical records of persons with drug use disorders are accessible to inmates who work at the prison infirmary.

5.3.9. (Standard) *Continuity of treatment for drug use disorders should be ensured in all cases by effective coordination of health and social services in communities and criminal justice settings.*

There is a longstanding practice of good cooperation between CPTDAs and prisons, as well as with the Directorate for Execution of Sanctions at the Ministry of Justice, resulting in continuous treatment of persons addicted to drugs entering or leaving prison.

There are cases that often address NGOs, because after release from prison, these persons do not have any documents such as identity card, birth certificate, health insurance etc. and they are not able to resume treatment after release from prison. There are cases where people cannot take out the necessary documents after release from prison, and therefore, they cannot continue with their treatment.

Centers' Social Services help people coming out of prison to exercise their rights to post-penal financial assistance, refer them and intervene in terms of their social protection rights at the Centers for Social Work, and assist them in obtaining personal and health documentation. The Day Rehabilitation Center in Ohrid, in addition to the above activities, refers these persons to vocational training in the ESA and the public kitchen where they can get hot meals.

Conclusions and recommendations regarding the principle "Promoting treatment of drug use disorders by effective coordination between the criminal justice system and health and social services"

Conclusions giving rise to recommendations:

Amendments to the Law on Execution of Sanctions, by which responsibility for inmates' health care has been moved from the Ministry of Justice to the Ministry of Health, have not yet been fully implemented. Alternative measures for treatment instead of punishment are not implemented in practice. Measures of forced custody and treatment of persons with drug use disorders are implemented in public health institutions where evidence-based opiate dependence treatment medications are not available. Prisons do not have all treatment programs for people with drug use disorders found in the community, such as voluntary counseling and testing for hepatitis C and HIV, treatment of hepatitis C, psycho-social treatment, buprenorphine treatment etc. Individuals treated with opioid agonists do not receive therapy for home when using a weekend/holiday leave from prison, if they are not accompanied by a family member who will pick up the therapy, so treatment is discontinued. Preparations of people with drug use disorders before release from prison are insufficient; there is no training on overdose prevention; it can happen that people get out of prison without the documents they need to continue their treatment; there is no training on acquiring work skills; there are no measures related to housing, rehabilitation and reintegration into the community. Training for criminal justice system staff in the area of drug use disorders is scarce or completely lacking. Measures for protection of medical records data of inmates with drug use disorders are not sufficient.

Recommendations:

- Implement amendments to the Law on Execution of Sanctions
- Implement alternative treatment measures instead of punishment in practice, in adequate cases
- Ensure availability of evidence-based treatment in all institutions where judicial custody and treatment measures are enforced
- Provide programs available for the treatment of drug use disorders and their consequences in prison/detention facilities, by including preventive programs/measures that exist in the community
- Provide continuous opioid agonist treatment in multi-day leaves from prison

- Prepare people with drug use disorders before being released from prison (training on overdose prevention, measures for rehabilitation and reintegration into the community, training for acquiring job skills, measures for providing employment, housing, obtaining documents needed for continuous treatment)
- Training for criminal justice system employees in the area of drug use disorders
- Measures to protect medical records data of persons deprived of liberty.

5.4. (Principle) Treatment must be based on scientific evidence and respond to specific needs of individuals with drug use disorders

5.4.1. (Standard) *Resource allocation in treatment of drug use disorders should be guided by existing evidence of effectiveness and cost-effectiveness of prevention and treatment interventions for drug use disorders.*

Human and financial resource allocation in the treatment of drug use disorders is not guided by the evidence of effectiveness and cost-effectiveness of prevention and treatment interventions for these disorders. Human resources in drug use disorder treatment specialist services are insufficient. Financial resources are spent on hospital treatment even when it is not needed (induction of buprenorphine). Alternative treatment measures instead of a penalty are not applied in practice, which contributes to the detention of people with drug use disorders and their treatment in prisons/detention centers, which is much more expensive. Barriers to access to drug use disorder treatments are created, thus reducing the treatment coverage and increasing the risk of other health and social consequences.

5.4.2. (Standard) *A range of evidence-based treatment interventions of different intensity is in place at different levels of health and social systems with appropriate integration of pharmacological and psycho-social interventions.*

Some specialized centers in the country lack antidote naloxone for the management of overdose, and sometimes there is no doctor who can carry out the intervention. Overdosed people are sent to the Toxicology and Emergency Medicine Clinic in Skopje or to hospitals in other cities.

Services for detoxification of drug users are available in outpatient settings, but not in inpatient ones, except in some psychiatric wards and TEMC, where no psycho-social support is offered during detoxification, and hospital treatment co-payment is required, so inpatient treatment is not provided to all those who need it.

Buprenorphine is not available at the centers of other cities in the country, and some of the centers lack medications for treatment of psychiatric disorders. Patients are referred to ambulance of the psychiatric ward to be prescribed drugs for treatment of their psychiatric disorders, in order to purchase them through pharmacies. Drugs that are opioid antagonists (Naltrexone hydrochloride) are not registered in the country, but they are procured through an emergency import and are rarely applied in treatment.

From the information obtained from clients, the action and side effects of drugs are not always explained to them.

When admitted, patients are physically examined, and regarding the treatment of blood-borne infections and other somatic conditions, patients are referred to appropriate clinics or other healthcare facilities. Vaccines are not available in treatment services.

When surgical and medical procedures are necessary, patients are referred to appropriate institutions, but sometimes their admission is refused or they are requested additional tests such as hepatitis status and if positive, patients are not operated or they are requested to buy equipment for additional protection of medical personnel. Some of the services offer health education and individual counseling on reproductive health and family planning, and through NGOs free gynecological services are also offered.

Some of the services offer family counseling, and the NGO HOPS, supported by the City of Skopje, supports drug users' children by providing them with the opportunity to attend workshops organized by a pedagogue and psychologist at the Center for Reintegration and Rehabilitation of Drug Users and their Families in Skopje.

There are two Day Centers for Reintegration and Rehabilitation of Drug Users and their Family Members, which are in close contact with CPTDA and located in Ohrid and Kavadarci. The Kumanovo Day Center for Rehabilitation and Reintegration of Drug Users and their Family Members has not been in operation in recent years. In Ohrid, both centers (the medical and social one) are at the same location and in the same space, so patients receive services from both centers in one place, which has proved to be good practice. The Day Center for Rehabilitation and Reintegration of Drug Users and their Family Members in Ohrid has an outpatient program for resocialization and reintegration of people with drug use disorders through the MLSP. The team of this Center regularly informs clients on employment opportunities and refers them to the ESA and training in computers and foreign languages organized by ESA and local government.

The Therapeutic Community "Shroud", which works closely with Strumica CPTDA, offers a psycho-social program for treatment, resocialization and reintegration of people having problems with addictions to drugs, alcohol and gamble, and their family members, with financial compensation by users. Strumica Municipality provides free treatment for 4 persons with drug use disorders in the municipality. In addition to professionals, treatment involves operators coming from the target group, who have completed the withdrawal treatment. In the reintegration phase, employment of already recovered clients is provided in the Therapeutic Community, through the social enterprise developed by the Community.

Drug users have the opportunity to attend skills training supported by the Global Fund through NGOs.

There is collaboration between services, as well as cooperation with NGOs, as needed.

5.4.3. (Standard) *Health professionals at primary health care are trained in identification and management of the most prevalent disorders due to drug use.*

Although not included in the treatment, family doctors are involved in continuing education on dependence. Continuous education is implemented for family doctors

from Skopje regarding drug use disorders and for family doctors from the country regarding dependence caused by prescribed drugs.

Drug addiction treatment is not sufficiently integrated in medical faculties' curricula.

5.4.4. (Standard) *In treatment of drug use disorders health professionals at primary health care should be supported by specialized services for substance use disorders at advanced levels of health care, particularly for treatment of severe drug use disorders and patients with co-morbidities.*

Drug use disorder treatment in the country is implemented in specialized centers that are designed primarily for the treatment of opiate dependence. Diagnosis and comprehensive assessment is made at the centers on the part of multidisciplinary teams (psychiatrist, psychologist, social worker and nurse), but only if there are any such teams. All addiction treatment services lack multi-professional staff. Family doctors are not involved in the treatment of drug use disorders; they only refer persons with drug use disorders to the specialized centers.

5.4.5. (Standard) *Organization of specialized services for drug use disorders should be based on multidisciplinary teams adequately trained in the delivery of evidence-based interventions with competencies in addiction medicine, psychiatry, clinical psychology and social work.*

Treatment services are lacking multi-professional teams and qualifications of some staff members are insufficient[27].

Staffing in NCPTDA and CPTDAs is insufficient and different centers lack different staff: mostly psychiatrists, but also doctors, social workers, psychologists and nurses. There is not one center where staffing is sufficient, which affects treatment efficiency. PHIs lack social workers and/or psychologists. TEMC does not have staff specialized in psychiatry, so they outsource their psychiatrist services, while social workers and psychologists are lacking. Part of the staff providing drug use disorder services lacks the competence in Addiction Medicine, Psychiatry, Clinical Psychology.

5.4.6. (Standard) *The duration of treatment is determined by individual needs and there are no pre-set limits of treatment or there are no limits that can't be modified according to the patient needs.*

There is no limitation regarding the length of treatment in addiction treatment services. The only obstacle in the length of treatment may be the financial exhaustion of patients who pay for their treatment in PHIs or at the Toxicology and Emergency Medicine Clinic if not included in the group of patients who do not pay for the medication.

5.4.7. (Standard) *Training of health professionals in the identification, diagnosis and evidence-based treatment of drug use disorders should be in place at different levels of education and training of health professionals including university curricula and programs of continuing education.*

Health workers' training in identification, diagnosis and evidence-based treatment of drug use disorders through schools and universities' curricula needs more improvement. Schools and universities' curricula contain a small part in this

27 Ignjatova L, Spasovska Trajanovska A. Surviving at workplace at the centers for prevention and treatment of drug addiction. Global Addiction and SEEA net Joint Conference 1–3 June 2015, Belgrade, Serbia

area. Psychiatry residency contains only a one-month turnus on drug use disorders, and only 1 exercise and 2 classes of lectures are dedicated to this topic. Continuous education is taking place through the GFATM Project which will end this year; however, the number of trained staff is small, and training events often lack psychiatrists. Education sessions cover topics of prevention, pharmacological and psycho-social treatment. Thirty family doctors from Skopje have been involved in continuous education on drug use disorders in the last 2 years of the Global Fund Project.

5.4.8. (Standard) *Treatment guidelines, procedures and norms are regularly updated in accordance with accumulated evidence of effectiveness of treatment interventions, knowledge about the needs of patients and service users and results of evaluation research.*

The criteria for opioid agonist treatment according to which from 2005 to 2012, the patient had to have a history of opioid abuse of at least 1 year and previous failed detoxification in health institutions, were replaced by the criterion – dependence diagnosis set (F11.2 according to ICD).

In most services, evaluation of treatment programs is not made by patients and results of NCPTDA's program evaluation by patients do not always influence treatment standards and procedures. Regular evaluation by users is performed every 6 months at the Day Center for Rehabilitation of People with Drug Use Disorders and Their Families in Ohrid, and based on evaluation results, services are revised.

5.4.9. (Standard) *Treatment services and interventions for drug use disorders should be adapted for relevance to the socio-cultural environment in which they are applied.*

Services are relevant to the socio-cultural environment, but specific services for treatment of specific subgroups are lacking (see section: Target the needs of specific subgroups and conditions).

Conclusions and recommendations regarding the principle "Treatment must be based on scientific evidence and respond to specific needs of individuals with drug use disorders"

Conclusions giving rise to recommendations:

Human and financial resource allocation in the treatment of drug use disorders is not guided by the evidence of effectiveness and cost-effectiveness of prevention and treatment interventions for these disorders. Not all services have medications available for the treatment of drug use disorders and opioid overdose according to evidence-based medicine, nor medications for psychiatric comorbidities treatment. Not all services offer psycho-education and psycho-social treatment and family therapy. There are barriers to availibility of somatic and surgical treatments. Programs for psycho-education and reproductive health services are not available in all services. Skills training events for persons with drug use disorders are insufficient. Primary health care family doctors are not included in the treatment of people with drug use disorders. Multi-professional teams and their adequate qualification for the treatment of drug use disorders are lacking in the services of the country. Health workers' education and training in identification, diagnosis and evidence-based treatment of drug use disorders through schools and universities' curricula are insufficient. Continuous education for health professionals and associates is carried out through the GFATM Project which will end this year. Evaluation of treatment programs is not

made by patients in most services, and where it is made, program evaluation results do not always influence treatment norms and procedures.

Recommendations:

- Separation of the National Center for prevention and treatment of drug addiction as an autonomous institution
- Rational investment of human and financial resources in drug use disorder treatment programs
- Apply in practice alternative treatment measures instead of penalty for people with drug use disorders, in adequate cases
- Outpatient treatment of people with drug use disorders, whenever there is an indication thereof
- Reduce barriers to treatment and greater treatment coverage of persons with drug use disorders, in order to reduce costs of other social and somatic comorbid conditions
- Ensure multi-professional teams in treatment services and their proper professional training
- Provide medications according to evidence-based medicine for the treatment of drug use disorders and overdose in all drug use disorder treatment services
- Provide medications for the treatment of comorbid psychiatric conditions in all drug use disorder treatment services
- Provide psycho-education and psycho-social treatment services, including family therapy for patients in all drug use disorder treatment services
- Provide vaccines for voluntary vaccination in services for the treatment of drug use disorders
- Provide unfettered somatic and surgical treatment without any barriers to people with drug use disorders
- Educate health professionals in order to reduce stigma and discrimination against people with drug use disorders
- Provide evidence based training to national proffesionals on comprenhensive drug dependence treatment
- Wide availability of free reproductive health programs for people with drug use disorders
- Provide skills-acquiring training in order to decrease unemployment in this population
- Include primary health care professionals in the treatment of people with drug use disorders, supported by specialized centers' teams
- Incorporate doctors' training on drug use disorders into medical schools and faculties' curricula with an adequate share
- Provide addictology specialization within the Psychiatry Department and draft a Curriculum for the same

- Provide sustainable continuous education in drug use disorders for health professionals and associates
- Evaluate treatment programs for people with drug use disorders by users and incorporate evaluation results in treatment programs.

5.5. (Principle) Responding to the needs of special subgroups and conditions

5.5.1. (Standard) *The needs of special subgroups and conditions are reflected in service provision and treatment protocols, including the needs of women, adolescents, pregnant women, ethnic minorities and marginalized groups such as the homeless.*

Specific services for women, adolescents, pregnant women, ethnic minorities and marginalized groups such as the homeless, are lacking.

The Methadone Treatment Protocol contains a small section on the treatment of pregnant women. There is a Protocol on Treatment of Neonatal Abstinence Syndrome (NAS). Professionals have developed a Protocol on the Treatment of Substance-using Children, but it has not been put into use yet. HOPS NGO published a Guide on Treatment and Care of Young People Who Use Drugs in 2014[28].

5.5.2. (Standard) *Special services and treatment programs should be in place for adolescents with substance use disorders to address specific treatment needs associated with this age and to prevent contacts with patients in more advanced stages of drug use disorders, and separate settings for treatment of adolescents should be considered whenever possible.*

Treatment of **minors** is still a serious challenge for the country; there are no specific programs for youth in health care institutions. The Statute of the Psychiatric Hospital Skopje, where the National Center for Prevention and Treatment of Drug Addiction is located, envisages treatment for adults, while the Psychiatric Clinic which has a Child and Adolescent Ward, does not treat addictions. Yet, this Ward treats young patients with comorbidity of drug/psychotropic substance use and other comorbid psychiatric disorders[29].

Treatment with buprenorphine is available for persons over 16 at the Toxicology Clinic, but there are other barriers: there is no multi-professional team; psycho-social support is not offered during treatment; there is no protocol for the treatment of drug-using minors (though a document was drafted); a psychiatrist's assessment is required to start the therapy with buprenorphine, but it is not specified which institution makes the assessment for treatment at the Toxicology Clinic; the treatment at the Clinic is not free, i.e. there is co-payment for hospital treatment and buprenorphine induction; buprenorphine is paid for a while until free treatment is provided.

In Bitola, there are many young people who abuse glue and tramadol, but there is no program for this. In the Bitola specialized center, according to the Protocol on Methadone Treatment, minors (16–18 years of age) are treated with methadone with the consent of their parent/guardian.

28 Dekov, Vlatko and Ignjatova, Ljiljana. Guide on Treatment and Care of Drug-using Children. Skopje: Association HOPS – Healthy Options Project Skopje, 2014: 10–11

29 Dekov, Vlatko and Ignjatova, Ljiljana. Guide on Treatment and Care of Drug-using Children. Skopje: Association HOPS – Healthy Options Project Skopje, 2014: 10–11

At the Day Center for Rehabilitation and Reintegration of Drug Users and Their Family Members in Ohrid, informative and counseling work is performed, as well as psycho-education of minors and their parents (short treatment of 1 to 2 weeks).

Supported by the City of Skopje, the NGO HERA – Health Education and Research Association, in 2012 opened a Counseling Center for the prevention of drug and other psychoactive substance use among high school students from Skopje, which offers confidential and free services. In 2015, within 10 months, the Counseling Center had 242 visits by 207 clients. Young people going to counseling most commonly use substances such as marijuana, alcohol and sedatives, much less narcotic analgesics and opiates, and some of them do not use substances[30].

Supported by the City of Skopje, the NGO HOPS opened a Center for Rehabilitation and Reintegration of Drug Users and Their Families in Skopje. This Center also provides support to drug users' children, who have the opportunity to attend workshops organized by a pedagogue and psychologist.

According to legislation, Drug Use Harm Reduction Programs are not available to persons under 18 years of age.

5.5.3. (Standard) *Treatment services and programs for drug use disorders need to be tailored to the needs of women and pregnant women in all aspects of their design and delivery, including location, staffing, programme development, child friendliness and content.*

There are no **gender-specific drug addiction treatment programs** in the country; women are treated in mixed gender programs that do not suit their needs. The number of female patients in programs is very small, up to 15% of the total number of patients in the capital Skopje, while in other cities, this proportion is lower. Female patients experience existing programs as unsafe for them and inadequate to their needs[31][32,33].

Pregnant women have always had priority for treatment and there have never been waiting lists for them.

5.5.4. (Standard) *Treatment services are tailored to the needs of people with drug use disorders from minority groups, and cultural mediators and interpreters are available whenever necessary in order to minimize cultural and language barriers.*

Treatment services are not tailored to the needs of minority group people with drug use disorders. Research shows inadequate treatment of women, Roma, children/youth.[34]

The number of Roma community patients in the NCPTDA in Skopje has been growing in recent years. The number of Roma population in Bitola Center is relatively large compared to the total number of Roma in the city. The number of Roma in the

30 Ignjatova L. Counseling on prevention of drug and other psychoactive substance use among students of secondary schools in Skopje, Drugs – Policies and Practices, 2016; 4 (6): 20–23

31 Ignjatova L, Raleva M. Gender difference in the treatment outcome of patients served in the mixed-gender program. Bratisl Lek Listy, 2009;110 (5):285–289

32 Ignjatova L., Kaselic A., Segrec N., and Vangelski S.K. Towards gender specific tailored programmes Heroin Addiction and Related Clinical Problems 2016;18(3s1): 38

33 Ignjatova L., Kovacevic M., Kastelic A., Segrec N. "Differences and similarities in treatment needs of the female drug users in region" Simpozijum "U susret promenama", Beograd, 16–17 June 2016

34 Dimitrievski Vanja. (2011) Promotion of the right of access to social and healthcare services for Roma using drugs

Treatment Center and Day Center for Rehabilitation and Reintegration of Drug Users and Their Family Members in Ohrid is growing, but other patients who stigmatize Roma negatively react to this.

However, the number of Roma in treatment programs remains low and further efforts are needed to attract the Roma population, among which a number of myths about treatment is spreading, especially about the methadone treatment, leading to resistance to treatment in this population.

In 2016, with the support from the City of Skopje, the NGO HERA opened a Counseling Center for the Prevention of Drug and Other Psychoactive Substance Use in Shuto Orizari – a municipality with predominant Roma population.

5.5.5. (Standard) *A package of social assistance and support in order to achieve means of sustainable livelihoods needs to be integrated into treatment programs for people with drug use disorders living in the street, unemployed, homeless and rejected by their families.*

Homeless people from Skopje are accommodated at the Shelter "Chichino Selo" where they have housing and food. Social services from the CPTDAs help people with drug use disorders who are at social risk to exercise their social rights.

NGO social workers cover the cost of obtaining documents, co-payment at the health institution etc. to people with financial difficulties. NGOs provide food and hygiene parcels for persons at high social risk and help them to fulfill their social rights.

5.5.6. (Standard) *Outreach services should be in place to establish contact with people who may not seek treatment because of stigma and marginalization.*

A number of NGOs have specific harm reduction programs for the **Roma population** and drug-injecting **sex workers** in several cities in the country (Skopje, Ohrid, Strumica, Gevgelija, Tetovo, Gostivar and Bitola). Most of these programs offer medical and social services, psychiatric and legal assistance, court representation in case of human rights violation[35]. Social workers from NGOs often accompany persons from these groups for admission to treatment, and cover the cost of healthcare co-payment to those who have financial difficulties.

Conclusions and recommendations regarding the principle "Responding to the needs of special subgroups and conditions"

Conclusions giving rise to recommendations:

The country has no specific services for women, pregnant women, adolescents, ethnic minorities and marginalized groups such as the homeless. There are no Protocols for the treatment of women and pregnant women, adolescents, ethnic minorities and the homeless. Measures for social empowerment of marginalized groups are insufficient, as well as the outreach activities to expand the treatment coverage of ethnic minorities and marginalized groups with drug use disorders.

Recommendations:

- Develop specific programs and protocols for treatment of women/pregnant women
- Develop specific programs and put in use the Protocol for Treatment of Substance-using children and adolescents

35 Ignjatova L., Mucollari G., Mehic-Basara N., Tomcuk A., Kovacevic M., Gjocaj M . Treatment systems overview South Eastern Europe. Council of Europe, 2011

- Strengthen social capacities of marginalized groups
- Provide outreach activities through cultural mediators and interpreters to attract ethnic minorities and marginalized groups in programs for the treatment and care of people with drug use disorders.

5.6. (Principle) Ensuring good clinical governance of treatment services and programs for drug use disorders

5.6.1. (Standard) *Treatment policies for drug use disorders are based on the principles of universal health coverage, best available evidence and developed with the active involvement of key stakeholders including the target populations, community members (families), non-governmental organizations, religious organizations.*

Policies on drug use disorder treatment are based on the principles of universal health care and developed by active involvement of key stakeholders, including the target population and NGOs.

5.6.2. (Standard) *Written service policy and treatment protocols are available, known to all staff and guide delivery of treatment services and interventions.*

Written policies are available as follows: 2014–2020 National Drug Strategy[36] and 2015–2020 Local Drug Strategy of the City of Skopje, as well as Protocols on NAS Treatment, Guide on Treatment and Care of Young People Using Drugs[37], 2012 Guidelines and Protocol on Opiate Dependence Methadone Treatment containing information on pharmacological treatment and psychological and social interventions. This document contains specific proposals for assessment and examinations; criteria for inclusion in methadone programs; therapeutic plan and purpose; and other practical issues, including doses and schemes on how to administer substitution therapy. Staff at the Day Center for Rehabilitation and Reintegration of Drug Users and Their Family Members in Ohrid work under the Methodological Work Guidelines developed by the MLSP, Code of Work with Clients and the Law on Social Protection.

5.6.3. (Standard) *Staff working at specialized services for drug use disorders should be adequately qualified, and receive ongoing evidence-based training, certification, support and supervision. Supervision and other forms of support are needed for the prevention of burnout among staff members.*

Part of the staff working in specialized drug use disorder services is not sufficiently qualified despite the continuous evidence-based training, which most often is not attended by psychiatrists who are insufficient, nor by staff whose turnover is high at the centers. The number of trained staff is small and lacks psychiatrists. Psychiatric Hospital Skopje, i.e. the NCPTDA supervises all centers in the country, and monitors their treatment, which is made possible through the support and funding by the Global Fund. Supervision and support from superiors is insufficient and the burnout syndrome is present among a large portion of centers' staff, contributing to making the centers unattractive workplaces to young and new employees.

36 http://www.cph.mk/ftp/Strategii/Nacionalna%20strategija%20za%20droga%20%20mkd%20strategija%202014-2020.pdf

37 Dekov, Vlatko and Ignjatova, Ljiljana. Guide on Treatment and Care of Drug-using Children. Skopje: Association HOPS – Healthy Options Project Skopje, 2014: 10–11

5.6.4. (Standard) *Policies and procedures for staff selection, recruitment, employment and performance monitoring are clearly specified and known to all.*

There are no clear policies and procedures for staff selection, recruitment, employment and performance monitoring. Specialized centers employ staff members who are not sensitized to the population they work with, as well as staff that is reluctant to work with such population.[38]

5.6.5. (Standard) *A sustainable source of funding is available at adequate levels and proper financial management and accountability mechanisms are in place. Whenever possible, costs for staff education and for evaluation should be included in the relevant budget.*

Programs at specialized services for treatment and care of people with drug use disorders and the Toxicology and Emergency Medicine Clinic are funded by the Program for Treatment of Persons with Drug and Alcohol Dependence. Continuous education costs are covered by the Global Fund Project, which will end this year.

5.6.6. (Standard) *Services for the treatment of drug use disorders should network and link with relevant general and specialized health and social services in order to provide a continuum of comprehensive care to their patients.*

All CPTDAs are networked and report regularly to NCPTDA every 6 months. Coordination between Centers is the task of the Psychiatric Hospital Skopje, i.e. NCPTDA, and it was established with the support of the GF. Supervision, monitoring and evaluation of Centers' work also takes place through NCPTDA and the GF. NCPTDA and CPTDAs regularly report to the Ministry of Health once a month, NCPTDA regularly reports to the GF Unit at the MH every 6 months using both narrative and numerical reports. NCPTDA and some CPTDAs also submit an Annual Report to the hospitals where they belong.

The relationship between certain institutions is assisted by the Global Fund Project and cooperation among them is better than with other institutions. NCPTDA has a long-term and good cooperation with the Infectious Diseases Clinic, Institute of Tuberculosis, MJ DES, and through social workers with Social Work Centers and MLSP. In Ohrid, both centers (the medical and social one) are at the same location in the same space, so patients can receive services from both centers in one place, which has proved to be good practice. Networks between CPTDAs, ICSW, local government, MLSP, MH, Psychiatric Hospital Demir Hisar, Psychiatric Hospital Skopje, City General Hospital 8 September, Toxicology and Emergency Medicine Clinic, Health Insurance Fund, PHIs, SIA (for obtaining documents) and NGOs have been established, but in most cases comprehensive treatment is not provided to clients.

5.6.7. (Standard) *Adequate record systems are in place to ensure accountability and continuity of treatment and care.*

There are record systems in place at all specialized CPTDAs, Toxicology and Emergency Medicine Clinic, and ICSW Rehabilitation Centers.

5.6.8. (Standard) *Service programmes, rules and procedures are periodically revised on the basis of continuous feed-back, monitoring and evaluation processes, as well as the constantly updated data on the drug use trends in populations.*

38 Ignjatova L, Spasovska Trajanovska A. Surviving at workplace at the centers for prevention and treatment of drug addiction. Global Addiction and SEEA net Joint Conference, 1–3 June 2015, Belgrade, Serbia

Programs for drug use disorder treatment are designed for the treatment of opioid addiction and are not prepared to respond to changes in relation to trends in the use of other drugs and behavioral dependence in the population. They are not adapted to the changes (new psychoactive substances (NPSs), behavioral dependency) and have not kept up with the times.

Conclusions and recommendations regarding the principle "Ensuring good clinical governance of treatment services and programs for drug use disorders"

Conclusions giving rise to recommendations:

Policies for drug use disorder treatment are based on the principles of universal health care and developed through an active involvement of key stakeholders, including the target population and NGOs. Written treatment policies and protocols according to which services are provided are available. Protocols on buprenorphine treatment, and treatment of children and women are lacking. Part of the staff is not qualified for the work, and supervision and support are not sufficient to prevent the burnout syndrome among employees. Centers are not attractive workplaces to young people. Some employees of the Centers are not sensitized to the work with this population and are reluctant to work. There is a steady source of funding for the treatment programs for people with drug use disorders, but not for their evaluation, supervision, monitoring, and continuous education, and the programs implemented through NGOs. There is a network between institutions and organizations, but it is insufficient to provide a comprehensive treatment to people with drug use disorders. There is a system of records in public institutions. Treatment programs are not adapted to the changes (NPSs, behavioral addiction, stimulants) and do not keep up with time.

Recommendations:

- Develop protocols for buprenorphine treatment and for the treatment of children and women
- Attract staff to work in specialized centers for treatment of people with drug use disorders
- Ensure a measure to screen and provide support for staff at risk of burnout
- Provide a permanent source of funding for the evaluation, supervision and monitoring of specialized treatment centers, and also for staff's continuous education and programs implemented through NGOs
- Ensure effective institutions' networking in order to provide comprehensive treatment for people with drug use disorders
- Adjust existing programs to the changes related to drugs and create new programs for the treatment of people who use synthetic drugs (NPSs), programs for the treatment of behavioral addiction, and programs for the treatment of individuals using stimulants, cannabis etc.

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

5.7.1. (Standard) *Treatment policies for drug use disorders need to be formulated by relevant governmental authorities on the principles of universal health coverage, best available evidence and with active involvement of key stakeholders including the target populations, community members (families), non-governmental organizations, religious organizations.*

Treatment policies are formulated by relevant government bodies and commissions with the active involvement of stakeholders, target groups and NGOs.

5.7.2. (Standard) *Links between drug use prevention, drug dependence treatment, and prevention of health and social consequences of drug use are established and operational.*

Specialized centers offer services for prevention and treatment of ddrug use disorders, as well as prevention of health and social consequences of drug use. Drug prevention is also offered by other organizations and institutions, as well as prevention of health and social consequences of drug use. Linkages between prevention, treatment and drug use consequence prevention are not sufficient and operational.

5.7.3. (Standard) *Treatment planning is based on estimates and descriptions of the nature and extent of the drug problem, as well as of the characteristics of the population in need.*

Treatment planning is based on the extent of the problem, but sufficient care is not taken of the characteristics of the population (children, women, Roma) .

5.7.4. (Standard) *Roles of national, regional and local agencies in different sectors responsible for the delivery of treatment for drug use disorders and rehabilitation are defined and mechanisms for effective coordination established.*

Coordination between centers is the task of the Psychiatric Hospital Skopje, i.e. NCPTDA, and it is supported by the Global Fund. Regarding the cooperation between different agencies and ministries, a State Inter-ministerial Commission for Fight against Illicit Drug Production, Trafficking and Abuse was established.

5.7.5. (Standard) *Quality standards for drug treatment services are established and compliance is required for accreditation.*

Minimum standards of treatment in terms of space and staff, as well as in terms of the number of patients per one psychiatrist are not observed. In some of the centers, there is not enough space, light, ventilation, toilet facilities etc. In terms of personnel, standards in most CPTDAs are not met.

5.7.6. (Standard) *Mechanisms for clinical governance, monitoring and evaluation are in place including clinical accountability, continuous monitoring of patient health and well-being, and intermittent external evaluation.*

There are mechanisms for clinical governance, monitoring and evaluation of patients in centers that have staff.

5.7.7. (Standard) *Information on the number, type, and distribution of services available and used within the treatment system for planning and development purposes.*

There is information on the number, type and distribution of services available in specialized centers, reported monthly to the MH and every 6 months to the Global Fund Project Unit in the Ministry of Health. Information on the number, type and distribution of services available at the Toxicology and Emergency Medicine Clinic is also submitted to the MH. ICSW Day Centers report to the MLSP for planning and program development purposes.

Conclusions and recommendations regarding the principle "Integrated treatment policies, services, procedures, approaches and linkages must be constantly monitored and evaluated"

Conclusions giving rise to recommendations:

Treatment policies are formulated by relevant government bodies and commissions with the active involvement of stakeholders, the target group and NGOs. Links between prevention, treatment and drug use consequence prevention are not sufficient and operational. Treatment planning is based on the extent of the problem, but sufficient care is not taken of the characteristics of the population. Coordination between CPTDAs is realized through the NCPTDA. Regarding the cooperation between different agencies and ministries, a State Inter-ministerial Commission for Fight against Illicit Drug Production, Trafficking and Abuse was established. Minimum standards of treatment in terms of space and staff are not observed, nor in terms of the number of patients per one psychiatrist. There are mechanisms in place for clinical governance, monitoring and evaluation of patients only in centers where there is staff. There is information on the number, type and distribution of services available in the centers, Toxicology and Emergency Medicine Clinic, and ICSW Day Care Centers, for planning and program development purposes.

Recommendations:

- Establish operational links between prevention, treatment and prevention of drug use consequences
- Plan treatment based on the problem type and extent, and the characteristics of the population concerned
- Establish nacional minimum quality standards
- Observe standards in terms of CPTDAs' space and personnel capacities.

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7. Annexes

Annex 1.

2. UNODC / WHO Principles of Drug Dependence Treatment

1: AVAILABILITY AND ACCESSIBILITY OF DRUG DEPENDENCE TREATMENT

Description and Justification

Drug dependence and its associated social and health problems can be treated effectively in the majority of cases if people have access to a continuum affordable treatment and rehabilitation services in a timely manner. To this end, all barriers to treatment access need to be minimised.

Components

Many factors contribute to treatment accessibility, including: location, distribution and linkages; timeliness and flexibility of opening hours; legal framework (requirements to register people with substance use disorders in official records, if associated with the risk of sanctions, may discourage patients from attending treatment programmes, thus reducing accessibility); availability of low threshold services; affordability; cultural relevance and user friendliness; responsiveness to multiple needs and diversification of settings; criminal justice system responses (law enforcement officials, courts and prisons may closely collaborate with the health system to encourage drug dependent individuals to enter treatment); and services tailored to gender-specific treatment needs.

2: SCREENING, ASSESSMENT, DIAGNOSIS AND TREATMENT PLANNING

Description and Justification

Patients afflicted with drug use disorders often have multiple treatment needs across a range of personal, social and economic areas that cannot be addressed if their addictive symptoms are treated in isolation. As for any other health problem, diagnostic and comprehensive assessment processes must be the basis for developing a personalised and effective approach to treatment and engaging the patient into treatment.

Components

These include**: screening,** which is a useful assessment procedure to identify individuals with hazardous or harmful drug use, or drug dependence, as well as associated risk behaviours; **assessment and diagnosis,** which are core requirements for treatment initiation; a **comprehensive assessment,** which takes into account the stage and severity of the disease, somatic and mental health status, individual temperament and personality traits, vocational and employment status, family and

social integration, and legal situation; and the **treatment plan**, developed with the patient, which establishes goals based on the patient's needs and outlines interventions to meet those goals.

3: EVIDENCE-INFORMED DRUG DEPENDENCE TREATMENT

Description and Justification

Evidence-based good practices and accumulated scientific knowledge on the nature of drug dependence should guide interventions and investments in drug dependence treatment. The high quality of standards required for approval of pharmacological or psychosocial interventions in all the other medical disciplines should be applied to the field of drug dependence.

Components

These include: a range of **evidence-based pharmacological and psychosocial interventions** relevant to different stages of addiction and treatment; **sufficient duration** (in treating complex chronic diseases and preventing relapse, long-lasting treatment programmes have been found to be the most effective); the **integration** of psychosocial and pharmacological treatment methods; **multidisciplinary teams** including medical doctors, psychiatrists, psychologists, social workers, counsellors and nurses; **brief interventions**, which can benefit individuals with experimental and occasional substance use and are an effective and economical prevention option; **outreach and low-threshold interventions** that can reach patients not motivated to engage in structured forms of treatment; the wide distribution and availability of **basic services** including detoxification, psychosocially assisted opioid agonist pharmacotherapy of opioid dependence, counselling, rehabilitation strategies and social support; **medically supervised withdrawal** for patients who are highly dependent on substances; **maintenance medications**; **psychological and social interventions**; **self-help support groups,** which complement formal treatment options; **socio-cultural relevance**; **knowledge transfer and ongoing clinical research;** and **training of treatment professionals** from early on in their careers.

4: DRUG DEPENDENCE TREATMENT, HUMAN RIGHTS, AND PATIENT DIGNITY

Description and Justification

Drug dependence treatment services should comply with human rights principles and affirm the inherent dignity of all individuals. Treatment should be based on an individual's right to the highest attainable standard of health and well-being and should not discriminate against individuals for any reason.

Components

People with drug dependence **should not be subject to discrimination** because of their past or present drug use. The same standards of **ethical treatment** should apply to the treatment of drug dependence as they do to any other health condition. These include the patient's right to autonomy and self-determination, and the treating staff's obligation to beneficence and non-maleficence. **Access to treatment and care services**, including measures to reduce the health and social consequences of drug use, needs to be ensured at all the stages of addiction. As any other medical procedure, general conditions of drug dependence treatment, whether psychosocial

or pharmacological, **should not be forced** on patients. Only in **exceptional crisis situations** of high risk to the individual or to others, compulsory treatment should be mandated for specific conditions and periods of time as specified by the law. When the use and possession of drugs results in state-imposed **penal sanctions**, and the offer of treatment as an alternative to imprisonment or other penal sanction is made, the patient is entitled to reject treatment and choose the penal sanction instead. **Discrimination** should not occur based on any grounds, be it gender, ethnic background, religion, political belief, or health, economic, legal or social condition. The **human rights of people** with drug dependence should never be restricted on the grounds of treatment and rehabilitation. Inhumane or degrading practices and punishment should never be elements of treatment of drug dependence.

5: TARGETING SPECIAL SUBGROUPS AND CONDITIONS

Description and Justification

Several subgroups within the larger population of individuals affected by drug use disorders require special consideration and often specialised care. These groups with specific needs include **adolescents, women, pregnant women, people with medical and psychiatric comorbidities, sex workers, ethnic minorities and socially marginalised individuals**. A person may belong to more than one of these groups and have multiple needs.

Components

The implementation of adequate strategies and provision of appropriate treatment for these patients often require targeted and differentiated approaches to contacting services and entering treatment, clinical interventions, treatment settings and service organization, which best meet the specific needs of these groups.

6: ADDICTION TREATMENT AND THE CRIMINAL JUSTICE SYSTEM

Description and Justification

Drug-related crimes are highly prevalent, and many people are incarcerated for drug-related offences. These include offences to which a drug's pharmacologic effects contribute; offences motivated by the user's need for money to support continued use; and offences connected to drug distribution. A significant number of people in criminal systems worldwide are drug dependent.

Drug use should be seen as a health condition and, when possible, drug users should be treated in the health care system rather than the criminal justice system. Interventions for drug dependent people in the criminal justice system should prioritize treatment as an alternative to incarceration, or provide drug dependence treatment while in prison and after release. Research indicates that drug dependence treatment is highly effective in reducing crime.

Components

These include: diversion schemes from the criminal justice system into treatment; human rights principles; continuity of services; and continuous care in the community upon release. Neither detention nor forced labour has been recognized as an effective treatment for drug use disorders.

7: COMMUNITY INVOLVEMENT, PARTICIPATION AND PATIENT ORIENTATION

Description and Justification

A community-based response to drug use and dependence can support and encourage behavioural changes. This might imply a paradigm shift from a directive to a more cooperative form of service delivery, for which the active involvement of local stakeholders (government, NGOs, private sector, community leaders, religious organizations and traditional healers), community members, families and the target populations is needed to establish ownership; also necessary is an integrated network of community-based health care services.

Components

These include: active patient involvement; accountability to the community; community-oriented interventions that can increase community support and promote supportive public opinions and health policy, and help reduce discrimination and social marginalisation; mainstreaming drug dependence treatment in health and social interventions; establishing links between drug dependence treatment services and hospital services; and NGOs, which can play a significant role in the provision of services for patients in coordination with the public health system. They can be particularly helpful in the process of scaling up treatment and facilitating rehabilitation and reintegration.

8: CLINICAL GOVERNANCE OF DRUG DEPENDENCE TREATMENT SERVICES

Description and Justification

A drug dependence treatment service requires an accountable, efficient and effective method of clinical governance that facilitates achievement of its goals. The service provided must be based on current research and be responsive to the needs of service user. Policies, programmes, procedures and coordination mechanisms should be defined in advance and clarified to all therapeutic team members, administration and the target population.

Components

These include: service policy and protocols; treatment protocols, which are written documents that outline details concerning procedures for assessment, care planning and provision of treatment; qualified staff; supervision and other forms of support for the prevention of burnout among staff members; financial resources; communication structures and networking between drug dependence treatment services and with other relevant institutions such as general practitioners, specialists and social services; monitoring systems and the updating of services to respond to their clients' evolving needs.

9: TREATMENT SYSTEMS: POLICY DEVELOPMENT, STRATEGIC PLANNING AND COORDINATION OF SERVICES

Description and Justification

A systematic approach to drug use disorders and patients in need of treatment, as well as to planning and implementation of services, requires a logical, step-by-step sequence that links policy to needs assessment and treatment planning and implementation, and to monitoring and evaluation.

Components

These include: the formulation of a **treatment policy** for drug use disorders by relevant authorities in governments for the development of treatment systems and implementation of effective interventions; **linkages** between prevention interventions and treatment services; **situation assessment**; **coordination** between different sectors (health, social welfare and criminal justice); appropriate **balance** between specialised services and primary care; **coordinated care** across different health and welfare services to achieve a **continuum of care**; a **multidisciplinary approach** involving diverse professional groups; **capacity building** by government and training institutions to ensure the availability of trained staff in the future; and **quality assurance, monitoring** and **evaluation**.

Annex 2.

Assessment forms

Assessment data collection form (documents)

This form is to be used for entering findings from document analysis. Types of documents include: internal regulations of facilities, annual reports, treatment protocols or other (name), national laws, government decrees, official guidelines or other official documents (name), non-official guidelines, standards of conduct or other (name).

Types of facilities are psychiatric hospitals, other hospitals, psychiatric outpatient clinics, other outpatient clinics, therapeutic community, other residential addiction treatment center, outpatient facility for addiction treatment, day care center, rehabilitation center, home, shelter or other (name).

Name of facility _____

Type of facility_____

Name of author_____

Function of author_____

Name and date of document_____

Type of document_____

Date and place_____

For each criterion, the present status has to be entered according to the following categories:

A = Adequately met

I = Inadequately met

N = Not met

N/A = Not applicable

A/R = Available upon referral

Comments column: for each criterion that is not met or inadequately met, indicate what the problem is and how the situation could be improved.

Comments on the document (nature of recommendations, etc.)

_____

Criteria	A	I	N	N/A	A/R	Comments
1.1.1 Everyone who requests help with substance abuse treatment receives care in the facility or is referred to another facility where care can be provided						
1.2.1 Anybody in need of treatment can find publicly available information about available options and services						
1.3.1 No person is denied access to facilities or treatment on the basis of economic factors, race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous, or social origin, property, disability, birth, age or other status						
1.3.2 No service user is admitted, treated or kept in the facility on the basis of his or her race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, disability, birth, age, or other status						
1.4.1 The facility can be reached by public transport						
1.5.1 Immediate access to services is provided if there is a risk in case of delaying treatment due to a waiting list						
1.6.1 The services seek to meet patient/client needs (e.g. comorbid disorders, somatic conditions, etc.)						
1.7.1 If a patient wants to be discharged against the advice of therapists, or if his or her behaviour leads to involuntary discharge, a referral for follow-up treatment in another service or for after-care is offered						

Criteria	A	I	N	N/A	A/R	Comments
2.1.1 A standardised instrument for assessment of patient/client is used that includes: somatic status, psychiatric status, social status, legal status, and history of substance use disorders						
2.2.1 Treatment plans are developed on the basis of assessment of patient/client						
2.2.2 Patients/clients participate in the treatment planning process						
2.2.3 Patients/clients are informed of the range of available treatment options and their possibilities are explained fully and clearly, including risks and benefits						
2.2.4 Each consenting patient/client has a comprehensive, individualised treatment plan that includes his or her social, medical, employment and education goals and objectives for recovery						
2.3.1 A personal, confidential medical file is created for each patient/client with their consent						
2.4.1 All patient/client records are confidential and are to be stored safely to guarantee confidentiality						
2.4.2 No information is to be provided to outsiders without patient/client permission (except when ordered by court)						
2.4.3 All patients/clients have access to the information contained in their medical files that is relevant, and they can add written information, opinions and comments to their medical files without censorship						

Criteria	A	I	N	N/A	A/R	Comments
2.5.1 Treatment plans are regularly discussed with the patient/client						
2.5.2 Treatment plans are regularly reviewed and updated by a staff member						
2.6.1 Regular discharge is made on the basis of a standardised procedure taking into account patient/client needs for stabilising treatment results						
3.1.1 All staff members have suitable qualifications and have received relevant training for the services they provide						
3.1.2 A qualified health practitioner is available "onsite" (target) or "on-call" (minimum) at all times						
3.2.1 Professional toxicological advisory assistance is provided in acute intoxication management and treatment						
3.3.1 Detoxification services are available either on an outpatient or residential basis						
3.4.1 Evidence-based pharmacological opioid agonist treatment is available and offered, based on the patient's/client's treatment outcome expectations, e.g. methadone/buprenorphine						
3.5.1 Evidence-based pharmacological opioid antagonist treatment is available and offered based on the patient's/client's treatment outcome expectations, e.g. naltrexone						
3.6.1 The appropriate psychotropic medication (specified in the national essential medicines list) is available at the facility or can be prescribed						

Criteria	A	I	N	N/A	A/R	Comments
3.6.2 A constant supply of essential psychotropic medication is available in sufficient quantities to meet the needs of service users						
3.6.3 Medication type and dosage are always appropriate for the clinical diagnoses of service users and are reviewed regularly						
3.6.4 Service users are informed about the purpose of the medications being offered and any potential side effects						
3.6.5 Service users are informed about treatment options that are possible alternatives to or could complement medication, such as psychotherapy						
3.7.1 Service users are offered physical health examinations and/or screening for particular illnesses on entry to the facility and regularly thereafter						
3.7.2 Treatment and care for blood-borne and other infectious diseases (especially AIDS, hepatitis and tuberculosis) is available at the facility or by referral						
3.7.3 Treatment for general health problems, including vaccinations, is available to service users at the facility or by referral						
3.7.4 When surgical or medical procedures are needed that cannot be provided at the facility, referral mechanisms exist to ensure that service users receive procedures in a timely manner						
3.7.5 Regular health education and promotion are conducted at the facility						

Criteria	A	I	N	N/A	A/R	Comments
3.7.6 Service users are informed of and advised about reproductive health and family planning matters						
3.7.7 General and reproductive health services are provided to service users with free and informed consent						
3.8.1 Counselling and case management are provided on-site or upon referral, including family counselling						
3.9.1 There is an intermediate outpatient/inpatient programme for social reintegration						
3.10.1 Staff give patients/clients information about education and employment opportunities in the community						
3.11.1 Staff inform and support patients/clients in accessing options for housing and financial resources						
3.12.1 Opportunities for vocational training are available						
3.13.1 Relapse prevention medication is prescribed individually upon indication						
3.14.1 Services operate within a network and mutual referrals are possible, based on an contractual agreement between services						
4.1.1 Patient's/client's preferences are given priority when deciding where they will access services						
4.1.2 Patient's/client's preferences are taken into consideration when deciding between available treatment options						

Criteria	A	I	N	N/A	A/R	Comments
4.2.1 Electroconvulsive therapy is not administered without the free and informed consent of service users						
4.2.2 Clear evidence-based clinical guidelines on when and how electroconvulsive therapy can or cannot be administered are available and adhered to						
4.2.3 Electroconvulsive therapy is never used in its unmodified form (i.e. without an anaesthetic and a muscle relaxant)						
4.2.4 Electroconvulsive therapy is not administered on minors						
4.2.5 Psychosurgery and other irreversible treatments are not conducted without both the service user's free and informed consent and the independent approval of a board						
4.2.6 Abortions and sterilizations are not conducted on service users without their consent						
4.3.1 Admission and treatment are based on the free and informed consent of service users						
4.4.1 Clear, comprehensive information about the rights of service users is provided in both written and verbal form						
4.4.2 Service users can nominate and consult with a support person or network of people of their own choosing on decisions about admission, treatment and personal, legal, financial or other affairs, and the people selected are recognized by staff						

Criteria	A	I	N	N/A	A/R	Comments
4.5.1 Telephones, letters, e-mails and the Internet are freely available to service users, without censorship						
4.5.2 Service users' privacy in communications is respected						
4.6.1 Appropriate steps are taken to prevent all instances of abuse						
5.1.1 Separate services are available for adolescents						
5.1.2 Services for adolescents are specifically designed to meet their needs						
5.2.1 Staff involved in treatment obtained special training in gender-responsive services						
5.2.2 Services for women offer segregation from men						
5.2.3 Women caring for children are able to access services						
5.2.4 Specific counselling and social outreach services for women are available						
5.3.1 Evidence-based standards of pharmacotherapy for opioid dependence treatment during pregnancy are available						
5.3.2 Pregnant women are able to access residential services for detoxification or stabilisation as needed						
5.3.3 Women with substance use disorders are screened for pregnancy						
5.3.4 Antenatal services are supported by specialist treatment services						
5.4.1 Drug treatment services screen for common comorbidities						

Criteria	A	I	N	N/A	A/R	Comments
5.4.2 Services are available for people with drug use disorders and comorbidities						
5.5.1 Preliminary assessment and interventions include screening for associated psychiatric disorders						
5.5.2 Adequate psychopharmacological and psychosocial treatments for psychiatric comorbidities are offered on-site or upon referral						
6.1.1 Treatment is offered to the patient/client as an alternative to penal sanctions						
6.1.2 Treatment as an alternative to penal sanctions is not imposed without patient/client consent						
6.2.1 There are written policies stressing that addicted patients/clients in prison and other closed settings have the right to receive health care and treatment, including substance abuse treatment						
6.2.2 There are written policies stressing that drug dependent patients/clients in prison have the right to access services offered by local treatment centres						
6.3.1 For persons already in treatment before incarceration, drug dependence treatment is continued when entering prison/police custody						
6.3.2 Pre-release measures for people with a history of sedative and opioid use include overdose prevention awareness						

Criteria	A	I	N	N/A	A/R	Comments
6.3.3 Psychosocial interventions, including education and vocational training, are provided to support reintegration after release						
6.3.4 Community-based services support the patient/client in accessing housing after release from prison						
6.4.1 People with drug use disorders are not deprived of their liberty without judicial oversight (i.e. suspected, or convicted of a serious crime, or unable to care for themselves)						
7.1.1 Treatment in the community takes the patient's/client's social and medical status into account						
7.1.2 Treatment planning includes patients/clients, caretakers, families and other members of the community						
7.1.3 Treatment is provided with the consent of the patient						
7.2.1 The facility has a systematic strategy for engaging the community for planning, delivering and evaluating services						
7.2.2 Services are updated and revised in response to feedback from patients/clients, relatives and the community, and based on regular evaluation						
7.3.1 Referral networks with other services are established, including NGOs and government services						
7.3.2 Referral networks for specialist interventions are established						

Criteria	A	I	N	N/A	A/R	Comments
7.3.3 Law enforcement is engaged in and briefed about treatment services						
7.4.1 Staff inform service users about options for housing and financial resources						
7.5.1 Staff give service users information about education and employment opportunities in the community						
7.6.1 Service users are free to join and participate in the activities of political, religious, social, disability and mental disability organizations and other groups						
7.7.1 Staff give service users information on available social, cultural, religious and leisure activities						
8.1.1 There are written drug treatment protocols or guidelines for drug prescription and other interventions						
8.1.2 Written criteria concerning intake and discharge exist and are known to patients and families						
8.2.1 Written patient/client records are up to date and signed by treating staff						
8.2.2 Records are used and stored safely to guarantee confidentiality						
8.3.1 Staff members have opportunities to discuss their clinical load with a supervisor or other staff member						
8.3.2 Regular staff meetings take place for all clinical staff						
8.3.3 Staff members are accountable for their clinical work to a supervisor						

Criteria	A	I	N	N/A	A/R	Comments
8.4.1 Accurate and timely financial reports are conducted						
8.4.2 Financial resources are adequate to ensure the viability of the treatment service						
8.5.2 Meetings are held to discuss critical incident reports, where decisions are recorded on any measures to be taken to prevent future similar incidents						
8.6.1 The facility measures outcomes such as retention in treatment and drug use after discharge						
8.6.2 The facility publishes an annual report on trends in drug use, comorbidities and treatment outcomes						
8.7.1 The facility has service providers of both sexes						
8.7.2 Staff members have written employment contracts						
8.7.3 There are clear management structures						
8.7.4 Health care is available for staff members						
8.8.1 Buildings are in good state of repair						
8.8.2 Buildings are accessible to persons with physical disabilities						
8.8.3 Lighting, heating and ventilation provide for a comfortable living environment						
8.8.4 Measures are in place to prevent fire						
8.8.5 The facility meets hygiene and sanitary requirements						
8.9.1 Sleeping quarters provide service users with sufficient living space and are not overcrowded						

Criteria	A	I	N	N/A	A/R	Comments
8.9.2 Men, women, children and the elderly have separate sleeping quarters						
8.10.1 Bathing and toilet facilities are clean and function properly						
8.10.2 Bathing and toilet facilities offer sufficient privacy, and separate facilities exist for men and women						
8.11.1 Food and safe drinking water are available in sufficient quantities, are of good quality and meet with the service user's cultural preferences and physical health requirements						
8.11.2 When service users do not have their own clothing, good-quality clothing is provided that meets their cultural preferences and is suitable for the climate						
8.12.1 The necessary resources, including equipment, are provided by the facility to ensure that service users have opportunities to interact and participate in leisure activities						
9.1.1 There is an appropriate balance between the services provided by the facility and other special services provided by the health care system						
9.1.2 There is an appropriate balance between the services provided by the facility and other special services provided by the social welfare system						
9.1.3 There is an appropriate balance between the facility and services provided by the criminal justice system						
9.2.1 The desired continuum of care seeks to respond to the patient's/client's needs						

Criteria	A	I	N	N/A	A/R	Comments
9.3.1 Treatment is provided by multidisciplinary teams that include physicians, psychiatrists, nurses, psychologists and social workers						
9.4.1 Drug dependence treatment is integrated into the curricula of medical and nursing schools						
9.5.1 A system for intermittent external evaluation of the treatment service exists						

National Minimum Standards for Drug Dependence Treatment in the former Yugoslav Republic of Macedonia

Assessment data collection form (interviews)

This form is to be used for entering findings from individual interviews. Types of interviewees are present service users, family members of users, ex-patients, drug users not in treatment, staff members, external caretakers, family doctors or other (name).

Types of facilities are psychiatric hospitals, other hospitals, psychiatric outpatient clinics, other outpatient clinics, Therapeutic Community, other residential addiction treatment center, outpatient facility for addiction treatment, day care center, rehabilitation center, home, shelter or other (name).

Name of facility _____

Type of facility_____

Name of interviewer_____

Function of interviewer_____

Initials and date of birth of interviewee_____

Type of interviewee_____

Date and place of interview_____

For each criterion, the present status has to be entered according to the following categories:

A = Adequately met

I = Inadequately met

N = Not met

N/A = Not applicable

A/R = Available upon referral

Comments: for each criterion that is not met or inadequately met, indicate what the problem is and how the situation could be improved.

Comments on the interview (language problems, difficulties in understanding, reasons for incompleteness etc.)

_____

Criteria	A	I	N	N/A	A/R	Comments
1.1.1 Everyone who requests help with substance abuse treatment receives care in the facility or is referred to another facility where care can be provided						
1.2.1 Anybody in need of treatment can find publicly available information about available options and services						
1.3.1 No person is denied access to facilities or treatment on the basis of economic factors or of his or her race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous, or social origin, property, disability, birth, age or other status						
1.3.2 No service user is admitted, treated or kept in the facility on the basis of his or her race, colour, sex language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, disability, birth, age, or other status						
1.4.1 The facility can be reached by public transport						
1.5.1 Immediate access to services is provided if there is a risk in case of delaying treatment due to a waiting list						
1.6.1 The services seek to meet patient's/client's needs (e.g. comorbid disorders, somatic conditions, etc.)						

Criteria	A	I	N	N/A	A/R	Comments
1.7.1 If a patient wants to be discharged against the advice of therapists, or if his or her behaviour leads to involuntary discharge, a referral for follow-up treatment in another service or for after-care is offered						
2.1.1 A standardised instrument for assessment of patient/client is used that includes: somatic status, psychiatric status, social status, legal status, and history of substance use disorders						
2.2.1 Treatment plans are developed on the basis of assessment of patient/client						
2.2.2 Patients/clients participate in the treatment planning process						
2.2.3 Patients/clients are informed of the range of available treatment options and their possibilities are explained fully and clearly, including risks and benefits						
2.2.4 Each consenting patient/client has a comprehensive, individualised treatment plan that includes his or her social, medical, employment and education goals and objectives for recovery						
2.3.1 A personal, confidential medical file is created for each patient/client with their consent						
2.4.1 All patient/client records are confidential and are to be stored safely to guarantee confidentiality						
2.4.2 No information is to be provided to outsiders without patient/client permission (except when ordered by court)						

Criteria	A	I	N	N/A	A/R	Comments
2.4.3 All patients/clients have access to the information contained in their medical files that is relevant, and they can add written information, opinions and comments to their medical files without censorship						
2.5.1 Treatment plans are regularly discussed with the patient/client						
2.5.2 Treatment plans are regularly reviewed and updated by a staff member						
2.6.1 Regular discharge is made on the basis of a standardised procedure taking into account patient/client needs for stabilising treatment results						
3.1.1 All staff members have suitable qualifications and have received relevant training for the services they provide						
3.1.2 A qualified health practitioner is available "onsite" (target) or "on-call" (minimum) at all times						
3.2.1 Professional toxicological advisory assistance is provided in acute intoxication management and treatment						
3.3.1 Detoxification services are available either on an outpatient or residential basis						
3.4.1 Evidence-based pharmacological opioid agonist treatment is available and offered, based on the patient's/client's treatment outcome expectations, e.g. methadone/buprenorphine						
3.5.1 Evidence-based pharmacological opioid antagonist treatment is available and offered based on the patient's/client's treatment outcome expectations, e.g. naltrexone						

Criteria	A	I	N	N/A	A/R	Comments
3.6.1 The appropriate psychotropic medication (specified in the national essential medicines list) is available at the facility or can be prescribed						
3.6.2 A constant supply of essential psychotropic medication is available in sufficient quantities to meet the needs of service users						
3.6.3 Medication type and dosage are always appropriate for the clinical diagnoses of service users and are reviewed regularly						
3.6.4 Service users are informed about the purpose of the medications being offered and any potential side effects						
3.6.5 Service users are informed about treatment options that are possible alternatives to or could complement medication, such as psychotherapy						
3.7.1 Service users are offered physical health examinations and/or screening for particular illnesses on entry to the facility and regularly thereafter						
3.7.2 Treatment and care for blood-borne and other infectious diseases (especially AIDS, hepatitis and tuberculosis) is available at the facility or by referral						
3.7.3 Treatment for general health problems, including vaccinations, is available to service users at the facility or by referral						
3.7.4 When surgical or medical procedures are needed that cannot be provided at the facility, referral mechanisms exist to ensure that service users receive procedures in a timely manner						
3.7.5 Regular health education and promotion are conducted at the facility						

Criteria	A	I	N	N/A	A/R	Comments
3.7.6 Service users are informed of and advised about reproductive health and family planning matters						
3.7.7 General and reproductive health services are provided to service users with free and informed consent						
3.8.1 Counselling and case management are provided on-site or upon referral, including family counselling						
3.9.1 There is an intermediate outpatient/inpatient programme for social reintegration						
3.10.1 Staff give patients/clients information about education and employment opportunities in the community						
3.11.1 Staff inform and support patients/clients in accessing options for housing and financial resources						
3.12.1 Opportunities for vocational training are available						
3.13.1 Relapse prevention medication is prescribed individually upon indication						
3.14.1 Services operate within a network and mutual referrals are possible, based on an contractual agreement between services						
4.1.1 Patient's/client's preferences are given priority when deciding where they will access services						
4.1.2 Patient's/client's preferences are taken into consideration when deciding between available treatment options						
4.2.1 Electroconvulsive therapy is not administered without the free and informed consent of service users						

Criteria	A	I	N	N/A	A/R	Comments
4.2.2 Clear evidence-based clinical guidelines on when and how electroconvulsive therapy can or cannot be administered are available and adhered to						
4.2.3 Electroconvulsive therapy is never used in its unmodified form (i.e. without an anaesthetic and a muscle relaxant)						
4.2.4 Electroconvulsive therapy is not administered on minors						
4.2.5 Psychosurgery and other irreversible treatments are not conducted without both the service user's free and informed consent and the independent approval of a board						
4.2.6 Abortions and sterilizations are not conducted on service users without their consent						
4.3.1 Admission and treatment are based on the free and informed consent of service users						
4.4.1 Clear, comprehensive information about the rights of service users is provided in both written and verbal form						
4.4.2 Service users can nominate and consult with a support person or network of people of their own choosing on decisions about admission, treatment and personal, legal, financial or other affairs, and the people selected are recognized by staff						
4.5.1 Telephones, letters, e-mails and the Internet are freely available to service users, without censorship						
4.5.2 Service users' privacy in communications is respected						
4.6.1 Appropriate steps are taken to prevent all instances of abuse						

Criteria	A	I	N	N/A	A/R	Comments
5.1.1 Separate services are available for adolescents						
5.1.2 Services for adolescents are specifically designed to meet their needs						
5.2.1 Staff involved in treatment obtained special training in gender-responsive services						
5.2.2 Services for women offer segregation from men						
5.2.3 Women caring for children are able to access services						
5.2.4 Specific counselling and social outreach services for women are available						
5.3.1 Evidence-based standards of pharmacotherapy for opioid dependence treatment during pregnancy are available						
5.3.2 Pregnant women are able to access residential services for detoxification or stabilisation as needed						
5.3.3 Women with substance use disorders are screened for pregnancy						
5.3.4 Antenatal services are supported by specialist treatment services						
5.4.1 Drug treatment services screen for common comorbidities						
5.4.2 Services are available for people with drug use disorders and comorbidities						
5.5.1 Preliminary assessment and interventions include screening for associated psychiatric disorders						
5.5.2 Adequate psychopharmacological and psychosocial treatments for psychiatric comorbidities are offered on-site or upon referral						

Criteria	A	I	N	N/A	A/R	Comments
6.1.1 Treatment is offered to the patient/client as an alternative to penal sanctions						
6.1.2 Treatment as an alternative to penal sanctions is not imposed without patient/client consent						
6.2.1 There are written policies stressing that addicted patients/ clients in prison and other closed settings have the right to receive health care and treatment, including substance abuse treatment						
6.2.2 There are written policies stressing that drug dependent patients/clients in prison have the right to access services offered by local treatment centres						
6.3.1 For persons already in treatment before incarceration, drug dependence treatment is continued when entering prison/ police custody						
6.3.2 P Pre-release measures for people with a history of sedative and opioid use include overdose prevention awareness						
6.3.3 Psychosocial interventions, including education and vocational training, are provided to support reintegration after release						
6.3.4 Community-based services support the patient/client in accessing housing after release from prison						
6.4.1 People with drug use disorders are not deprived of their liberty without judicial oversight (i.e. suspected, or convicted of a serious crime, or unable to care for themselves)						
7.1.1 Treatment in the community takes the patient's/client's social and medical status into account						

Criteria	A	I	N	N/A	A/R	Comments
7.1.2 Treatment planning includes patients/clients, caretakers, families and other members of the community						
7.1.3 Treatment is provided with the consent of the patient						
7.2.1 The facility has a systematic strategy for engaging the community for planning, delivering and evaluating services						
7.2.2 Services are updated and revised in response to feedback from patients/clients, relatives and the community, and based on regular evaluation						
7.3.1 Referral networks with other services are established, including NGOs and government services						
7.3.2 Referral networks for specialist interventions are established						
7.3.3 Law enforcement is engaged in and briefed about treatment services						
7.4.1 Staff inform service users about options for housing and financial resources						
7.5.1 Staff give service users information about education and employment opportunities in the community						
7.6.1 Service users are free to join and participating in the activities of political, religious, social, disability and mental disability organizations and other groups						
7.7.1 Staff give service users information on available social, cultural, religious and leisure activities						
8.1.1 There are written drug treatment protocols or guidelines for drug prescription and other interventions						

Criteria	A	I	N	N/A	A/R	Comments
8.1.2 Written criteria concerning intake and discharge exist and are known to patients and families						
8.2.1 Written patient/client records are up to date and signed by treating staff						
8.2.2 Records are used and stored safely to guarantee confidentiality						
8.3.1 Staff members have opportunities to discuss their clinical load with a supervisor or other staff member						
8.3.2 Regular staff meetings take place for all clinical staff						
8.3.3 Staff members are accountable for their clinical work to a supervisor						
8.4.1 Accurate and timely financial reports are conducted						
8.4.2 Financial resources are adequate to ensure the viability of the treatment service						
8.5.1 Procedures are in place for reporting incidences with patients/clients						
8.5.2 Meetings are held to discuss critical incident reports, where decisions are recorded on any measures to be taken to prevent future similar incidents						
8.6.1 The facility measures outcomes such as retention in treatment and drug use after discharge						
8.6.2 The facility publishes an annual report on trends in drug use, comorbidities and treatment outcomes						
8.7.1 The facility has service providers of both sexes						
8.7.2 Staff members have written employment contracts						

Criteria	A	I	N	N/A	A/R	Comments
8.7.3 There are clear management structures						
8.7.4 Health care is available for staff members						
8.8.1 Buildings are in good state of repair						
8.8.2 Buildings are accessible to persons with physical disabilities						
8.8.3 Lighting, heating and ventilation provide for a comfortable living environment						
8.8.4 Measures are in place to prevent fire						
8.8.5 The facility meets hygiene and sanitary requirements						
8.9.1 Sleeping quarters provide service users with sufficient living space and are not overcrowded						
8.9.2 Men, women, children and the elderly have separate sleeping quarters						
8.10.1 Bathing and toilet facilities are clean and function properly						
8.10.2 Bathing and toilet facilities offer sufficient privacy, and separate facilities exist for men and women						
8.11.1 Food and safe drinking water are available in sufficient quantities, are of good quality and meet with the service user's cultural preferences and physical health requirements						
8.11.2 When service users do not have their own clothing, good-quality clothing is provided that meets their cultural preferences and is suitable for the climate						

Criteria	A	I	N	N/A	A/R	Comments
8.12.1 The necessary resources, including equipment, are provided by the facility to ensure that service users have opportunities to interact and participate in leisure activities						
9.1.1 There is an appropriate balance between the services provided by the facility and other special services provided by the health care system						
9.1.2 There is an appropriate balance between the services provided by the facility and other special services provided by the social welfare system						
9.1.3 There is an appropriate balance between the facility and services provided by the criminal justice system						
9.2.1 The desired continuum of care seeks to respond to the patient's/client's needs						
9.3.1 Treatment is provided by multidisciplinary teams that include physicians, psychiatrists, nurses, psychologists and social workers						
9.4.1 Drug dependence treatment is integrated into the curricula of medical and nursing schools						
9.5.1 A system for intermittent external evaluation of the treatment service exists						

Annex 3.

Chapter 2: Key Principles and Standards for the Treatment of Drug Use Disorders

Drug Use Disorders can be effectively treated using a range of pharmacological and psychosocial interventions. These interventions have been developed with the support of scientific evidence and their effectiveness has been tested using scientific standards used in developing treatments for other medical disorders. The goals of treatment are to:1) reduce the intensity of drug use desire and drug use, 2) improve functioning and well-being of the affected individual, and 3) prevent future harms by decreasing the risk of complications and reoccurrence.

Many interventions that are commonly used in working with affected individuals do not meet standards of scientific evidence of effective treatment. Such interventions are ineffective or can even be harmful. This distinction between effective and ineffective intervention has important financial implications. In many countries, resources available to work with affected individuals are limited, therefore priorities for resource allocation must be carefully evaluated. The scientific standard can be used to make an important differentiation between interventions that are worth supporting and those that are not. That means the determination which activities should be developed and prioritized for funding from public resources and which activities should not be funded because they do not meet the minimum standard for effective treatment.

The three questions listed below can lend assistance to these important funding determinations:

1. Is there evidence that proposed activity results in or contributes to the reduction of compulsive drug use (symptom reduction) or reduces the risk of returning to drug use in someone who has succeeded in stopping the use of drugs?
2. Is there evidence that such activity results in or contributes to improvements in physical, psychological and/or social functioning and well-being?
3. Is there evidence that such activity can decrease or contribute to the reduction of risks of health and social consequences from drug use?

In addition to these criteria that have a clinical focus, the activity should adhere to agree upon international ethical standards:

1. Must be consistent with UN Declaration of Human Rights and existing UN Conventions
2. Must be designed to promote individual and societal safety
3. Must be designed to promote personal autonomy
4. Shall build over the existing experiences in evidence based standards definition

The International Standards on the Treatment of Drug Use Disorders defines a set of requirements and attributes (standards) that must be in place to initiate any form of outreach, treatment, rehabilitation, or recovery services, regardless of the treatment philosophy that is used and the setting it is used in. This is critically

important, because individuals with drug use disorders deserve nothing less than ethical and science-based standards of care that are available similar to the standards used in treatment of other chronic diseases.

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

Description: Drug use disorders can be treated effectively in the majority of cases if people have access to a wide range of services that cover the continuum of needs that patients may have. Treatment services must match the needs of the individual patient at the specific phase of their disorder to include outreach, screening, inpatient and outpatient treatment, long-term residential treatment, rehabilitation, and recovery-support services. These services should be affordable, attractive, available in both urban and rural settings, and accessible with a wide range of open hours and the minimal wait time. All barriers that limit their accessibility to appropriate treatment services should be minimized. Services should not only offer addiction treatment, but also provide social support and protection and general medical care. The legal framework should not discourage the people affected from attending treatment programs. The treatment environment should be friendly, culturally sensitive and focus on the specific needs and level of preparedness of each patient, the environment that encourages rather than deters individuals from attending the program.

Standards:

1.1. Essential treatment services for drug use disorders should be available through organization of treatment interventions at different levels of health systems: from primary health care to tertiary health services with specialized treatment programs for drug use disorders.

1.2. Essential treatment services are in place that include brief interventions, diagnostic assessment, outpatient counselling, outpatient psychosocial and evidence-based pharmacological treatment of drug use disorders, outreach services and services for management of drug-induced acute clinical conditions such as overdose, withdrawal syndromes and drug-induced psychoses.

1.3. Essential treatment services for drug use disorders should be within reach of public transport and accessible to people living in urban and rural areas.

1.4. Low threshold and outreach services, as part of a continuum of care, are needed to reach the 'hidden' populations most affected by drug use, often non– motivated to treatment or relapsing after a treatment program.

1.5. Within a continuum of care, people with drug use disorders should have access to treatment services through multiple entry points.

1.6. Essential treatment services for drug use and drug-induced disorders should be available during a sufficiently wide range of opening hours to ensure access to services for individuals with employment or family responsibilities.

1.7. Essential treatment services should be affordable to clients from different socio-economic groups and levels of income with minimized risk of financial hardship for those requiring the services.

1.8. Treatment services should be gender-sensitive and tailored to the needs of women including specific child-care needs and needs in pregnancy.

1.9. Treatment services should provide access to social support, general medical care and referrals to specialized health services for the management of complex co-morbid health conditions.

1.10. Treatment services for drug use disorders should be oriented towards the needs of served populations with due respect to cultural norms and involvement of service users in service design, development and evaluation.

1.11. Information on availability and accessibility of essential treatment services for drug use disorders should be easily accessible through multiple sources of information including internet, printed materials and open access information services.

Principle 2: Ensuring ethical standards in treatment services

Description: Treatment of drug use disorders should be based on the universal ethical standards – respect for human rights and dignity. This includes responding to the right to enjoy the highest attainable standard of health and well-being, ensuring non-discrimination, and removing stigma. The choice to start treatment should be left to the individual. Treatment should not be forced or against the will and autonomy of the patient. The consent of the patient should be obtained before any treatment intervention. Accurate and up to date medical records should be maintained and the confidentiality of treatment records should be guaranteed. Registration of patients entering treatment outside the health records should not be permitted. Punitive, humiliating or degrading interventions should be avoided. The individual affected should be recognized as a person suffering with a health problem and deserving treatment similar to patients with other psychiatric or medical problems.

Standards:

2.1. Treatment services for drug use disorders should respect in all cases human rights and dignity of service users, and humiliating or degrading interventions should never be used.

2.2. Informed consent should be obtained from a patient before initiating treatment and guarantee the option to withdraw from treatment at any time.

2.3. Data should be Patient strictly confidential, and registration of patients entering treatment outside the health records should not be allowed in all cases. Confidentiality of patient data should be ensured and protected by legislative measures and supported by appropriate staff training and service rules and regulations.

2.4. Staff of treatment services should be properly trained in the provision of treatment in full compliance with ethical standards and human rights principles and norms, and show respectful, non-stigmatizing and non-discriminatory attitudes towards service users.

2.5. Service procedures are in place which require staff to adequately inform patients of treatment processes and procedures, including the right to withdraw from treatment at any time.

2.6. Any research in treatment services involving human subjects should be subject to review of ethical committees, and participation of service users in the research should be strictly voluntary with informed written consent ensured in all cases.

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

Description: Drug use disorders should be seen primarily as a health problem rather than a criminal behavior and wherever possible, drug users should be treated in the health care system rather than in the criminal justice system. Even though individuals with drug use disorders may commit crimes, these are typically low-level crimes used to finance the drug purchase, and this behavior stops with the effective treatment of the drug use disorder. Because of that, the criminal justice system should collaborate closely with the health and social system offering choice to enter treatment as alternative to criminal prosecution or imprisonment. Law enforcement and courts professionals and penitentiary system officers should be appropriately trained to effectively engage with the treatment and rehabilitation efforts. If prison is warranted, treatment should also be offered to prisoners with drug use disorders during their stay in prison and after their release as the effective treatment will decrease the risk of reoffending following the release. Continuity of care after release is of vital importance and should be assured or facilitated. In all justice related cases people should be provided treatment and care of equal standards to treatment offered to anyone else in the general population.

Standards:

3.1. Treatment for drug use disorders should be provided predominantly in health and social care systems, and effective coordination mechanisms with criminal justice system should be in place and operational to facilitate access to treatment and social services.

3.2. Treatment of drug use disorders should be available to offenders with drug use disorders and, where appropriate, be a partial or complete alternative to imprisonment or other penal sanctions.

3.3. Treatment of drug use disorders as an alternative to incarceration or in criminal justice settings should be supported by appropriate legal frameworks.

3.4. Criminal justice settings should provide opportunities for individuals with drug use disorders to treatment and health care that are guaranteed in health and social care systems in a community.

3.5. Treatment interventions for drug use disorders should not be imposed on individuals with drug use disorders in criminal justice system against their will.

3.6. Essential prevention and treatment services should be accessible to individuals with drug use disorders in criminal justice settings, including prevention of transmission of blood-borne infections, pharmacological and psychosocial treatment of drug use disorders and comorbid health conditions, rehabilitation services and linking with community health and social services in preparation for release.

3.7. Appropriate training programs for criminal justice system staff, including law enforcement and penitentiary system officers and court professionals should be in place to ensure recognition of medical and psychosocial needs associated with drug use disorders and support treatment and rehabilitation efforts.

3.8. Treatment of drug use disorders in criminal justice system should follow the same evidence-based guidelines and ethical and professional standards as in the community.

3.9. Continuity of treatment for drug use disorders should be ensured in all cases by effective coordination of health and social services in communities and criminal justice settings.

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

Description: Evidence-based practices and accumulated scientific knowledge on the nature of drug use disorders should guide interventions and investments in treatment of drug use disorders. The same high quality of standards required for the approval and implementation of pharmacological or psychosocial interventions in other medical disciplines should be applied to the treatment of drug use disorders. To the extent possible, only the pharmacological and psychosocial methods that have been demonstrated effective by science or agreed upon by the international body of experts should be applied. The duration and the intensity (dose) of the intervention should be in line with evidence-based guidelines. Multidisciplinary teams should integrate different interventions tailored to each patient. Organization of ttreatment for drug use disorders should be based on a chronic care philosophy rather than acute care interventions. Severe drug use disorder is very similar in its course and prognosis to other chronic diseases such as diabetes, HIV, cancer, or hypertension. A long-term model of treatment and care is most likely to promote a life-long recovery, a sustained cessation of drug use, absence of drug-related problems, and enhanced physical, psychological, interpersonal, occupational, and spiritual health. Existing interventions should be adapted to the cultural and financial situation of the country without undermining the core elements identified by science as crucial for effective outcome. Traditional treatment systems may be unique to a particular country or setting and may have limited evidence to its effectiveness beyond the experience of patients and their clinicians. Such systems should learn from and adopt as much as possible of the existing evidence-based interventions into their programs and efforts should be made to formally evaluate whether such treatments are effective and carry acceptable risks.

Standards:

4.1. Resource allocation in treatment of drug use disorders should be guided by existing evidence of effectiveness and cost-effectiveness of prevention and treatment interventions for drug use disorders.

4.2. A range of evidence-based treatment interventions of different intensity is in place at different levels of health and social systems with appropriate integration of pharmacological and psychosocial interventions.

4.3. Health professionals at primary health care are trained in identification and management of the most prevalent disorders due to drug use.

4.4. In treatment of drug use disorders health professionals at primary health care should be supported by specialized services for substance use disorders at advanced levels of health care, particularly for treatment of severe drug use disorders and patients with co-morbidities.

4.5. Organization of specialized services for drug use disorders should be based on multidisciplinary teams adequately trained in the delivery of evidence–based interventions with competencies in addiction medicine, psychiatry, clinical psychology and social work.

4.6. The duration of treatment is determined by individual needs and there are no pre-set limits of treatment or there are no limits that can not be modified according to the patient needs.

4.7. Training of health professionals in the identification, diagnosis and evidence-based treatment of drug use disorders should be in place at different levels of education and training of health professionals including university curricula and programs of continuing education.

4.8. Treatment guidelines, procedures and norms are regularly updated in accordance with accumulated evidence of effectiveness of treatment interventions, knowledge about the needs of patients and service users and results of evaluation research.

4.9. Treatment services and interventions for drug use disorders should be adapted for relevance to the socio-cultural environment in which they are applied.

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

Description: Several subgroups within the larger population of individuals affected by drug use disorders require special consideration and often specialized care. Groups with specific needs include but are not limited to adolescents, elderly, women, pregnant women, sex workers, sexual and gender minorities, ethnic and religious minorities, individuals involved with criminal justice system and individuals that are socially marginalized. Working with those special groups requires differentiated and individualized treatment planning that considers their unique vulnerabilities and needs. For some of these subgroups, special considerations will need to be addressed directly in every setting on the treatment continuum.

In particular, children and adolescents should not be treated in the same setting as adult patients, and should be treated in a facility able to manage other issues such patients face, and encompass broader health, learning, and social welfare context in collaboration with family, schools and social services. Similarly, women entering treatment should have special protection and services. Women are vulnerable to risk of domestic violence and sexual abuse, and their children may be at risk of abuse therefore a liaison with social agencies protecting children and women are helpful. Women may require women-focus treatment in a safe single-sex setting to obtain maximum benefit. Treatment programs should be able to accommodate children needs to allow parents caring for children to receive treatment, and support good parenting and child care practices. Women may need training and support on issues such as sexual health, contraception.

Standards:

5.1. The needs of special subgroups and conditions are reflected in service provision and treatment protocols, including the needs of women, adolescents, pregnant women, ethnic minorities and marginalized groups such as the homeless.

5.2. Special services and treatment programs should be in place for adolescents with substance use disorders to address specific treatment needs associated with this age and to prevent contacts with patients in more advanced stages of drug use disorders, and separate settings for treatment of adolescents should be considered whenever possible.

5.3. Treatment services and programs for drug use disorders need to be tailored to the needs of women and pregnant women in all aspects of their design and delivery, including location, staffing, programme development, child friendliness and content.

5.4. Treatment services are tailored to the needs of people with drug use disorders from minority groups, and cultural mediators and interpreters are available whenever necessary in order to minimize cultural and language barriers.

5.5. A package of social assistance and support in order to achieve means of sustainable livelihoods needs to be integrated into treatment programs for people with drug use disorders living in the street, unemployed, homeless and rejected by their families.

5.6. Outreach services should be in place to establish contact with people who may not seek treatment because of stigma and marginalization.

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

Description: Good quality and efficient treatment services for drug use disorders require an accountable and effective method of clinical governance that facilitates the achievement of treatment goals and objectives. Treatment policies, programmes, procedures and coordination mechanisms should be defined in advance and clarified to all therapeutic team members, administration, and target population. Service organization needs to reflect current research evidence and be responsive to service user needs. Treating people with drug use disorders who often have multiple psycho-social and sometimes physical impairments is challenging, both to individual staff and organizations. Staff attrition in this field is recognized and organizations need to have in place a variety of measures to support their staff and encourage the provision of good services.

Standards:

6.1. Treatment policies for drug use disorders are based on the principles of universal health coverage, best available evidence and developed with the active involvement of key stakeholders including the target populations, community members (families), non-governmental organizations, religious organizations.

6.2. Written service policy and treatment protocols are available, known to all staff and guide delivery of treatment services and interventions.

6.3. Staff working at specialized services for drug use disorders should be adequately qualified, and receive ongoing evidence-based training, certification, support and supervision. Supervision and other forms of support are needed for the prevention of burnout among staff members.

6.4. Policies and procedures for staff selection, recruitment, employment and performance monitoring are clearly specified and known to all.

6.5. A sustainable source of funding is available at adequate levels and proper financial management and accountability mechanisms are in place. Whenever possible, costs for staff education and for evaluation should be included in the relevant budget.

6.6. Services for the treatment of drug use disorders should network and link with relevant general and specialized health and social services in order to provide a continuum of comprehensive care to their patients.

6.7. Adequate record systems are in place to ensure accountability and continuity of treatment and care.

6.8. Service programmes, rules and procedures are periodically revised on the basis of continuous feed-back, monitoring and evaluation processes, as well as the constantly updated data on the drug use trends in populations.

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

Description: As a response to a complex and multifaceted health problem, comprehensive systems must be engaged to facilitate effective treatment of drug use disorders. A variety of services should be integrated in the case management of these patients, with the mainstreaming of primary health care delivery and multidisciplinary activities. A coordinating team should include psychiatric and psychological care, municipality social services support work, support for housing and job skills/employment, legal assistance, and specialist health care (HIV, Hepatitis, other infections). The treatment system must be constantly monitored evaluated and adapted. This requires planning and implementation of services in a logical, step-by-step sequence that insures the strength of links between (a) policy, (b) needs assessment, (c) treatment planning, (d) implementation of services, (e) monitoring of services (f) evaluation of outcomes and (g) quality improvements.

Standards:

7.1. Treatment policies for drug use disorders need to be formulated by relevant governmental authorities on the principles of universal health coverage, best available evidence and with active involvement of key stakeholders including the target populations, community members (families), non-governmental organizations, religious organizations.

7.2. Links between drug use prevention, drug dependence treatment, and prevention of health and social consequences of drug use are established and operational.

7.3. Treatment planning is based on estimates and descriptions of the nature and extent of the drug problem, as well as of the characteristics of the population in need.

7.4. Roles of national, regional and local agencies in different sectors responsible for the delivery of treatment for drug use disorders and rehabilitation are defined and mechanisms for effective coordination established.

7.5. Quality standards for drug treatment services are established and compliance is required for accreditation.

7.6. Mechanisms for clinical governance, monitoring and evaluation are in place including clinical accountability, continuous monitoring of patient health and well-being, and intermittent external evaluation.

7.7. Information on the number, type, and distribution of services available and used within the treatment system for planning and development purposes.

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