Practical Guidance Toolkit

How to implement and scale up opioid substitution therapy (OST)

(Based on the experience of selected EU countries: Bulgaria, Estonia, Germany, Latvia, Lithuania, Poland, Portugal and Romania)
The following document is an output of the workshop “How to scale-up and implement opioid substitution treatment in the European Union”, which was organized by WHO Office for Europe May 22-23, 2012 in Vilnius (Lithuania).

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

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This document has been produced with the financial assistance of the European Union. The views expressed herein can in no way be taken to reflect the official opinion of the European Union.
# List of acronyms

<table>
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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral (drug/therapy)</td>
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<td>ART</td>
<td>Antiretroviral therapy</td>
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<tr>
<td>ASI</td>
<td>Addiction Severity Index</td>
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<td>CoE</td>
<td>Council of Europe</td>
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<td>CTP</td>
<td>Combined Therapy Programme</td>
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<tr>
<td>DOTS</td>
<td>Directly Observed Treatment, Short Course</td>
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<tr>
<td>EAHC</td>
<td>European Agency for Health and Consumers</td>
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<tr>
<td>ECDC</td>
<td>European Centre for Disease Prevention and Control</td>
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<td>EMCDDA</td>
<td>European Monitoring Centre for Drugs and Drug Addiction</td>
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<td>EU</td>
<td>European Union</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>HBV</td>
<td>Hepatitis B Virus</td>
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<tr>
<td>HCV</td>
<td>Hepatitis C Virus</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IDU</td>
<td>Injecting Drug Use / User</td>
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<tr>
<td>MMT</td>
<td>Methadone Maintenance Treatment</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<tr>
<td>NSP</td>
<td>Needle and Syringe Programme</td>
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<td>OST</td>
<td>Opioid Substitution Therapy</td>
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<tr>
<td>SHI</td>
<td>Social Health Insurance</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Opioid substitution therapy\(^1\) as an effective intervention for opioid dependence treatment and HIV prevention

Scientific research data suggest that opioid dependence is a chronic illness with frequent relapses. Opioid dependence is now often compared with other chronic diseases, such as hypertension, diabetes and asthma (McLellan A.T. and al., 2000, WHO, 2004). There are no particular “cures” for chronic diseases. Nevertheless, with appropriate long-term therapy and medical care, together with behavioral change in patients, it is possible to eliminate or reduce symptoms and reach high quality of life. Opioid substitution therapy (OST) in this context is recognized as a cost-effective strategy, which allows for the achievement of high retention rates of IDUs in therapeutic programmes, significant reduction of illegal opioid use and reduction of injecting risk behavior. Both methadone and buprenorphine have been included in the WHO XIV Edition of the Model List of Essential Medicines (WHO, 2005b).

OST has been recognized as an effective tool to prevent HIV among injecting drug users (IDU) and to increase the adherence of eligible people with HIV/AIDS to anti-retroviral (ARV) therapy (WHO, 1998; WHO, UNODC, UNAIDS, 2004; WHO, 2005a). Methadone and buprenorphine have proven highly effective in the treatment of opioid dependence and HIV prevention (WHO, 2004cd). The effectiveness of OST with methadone and buprenorphine in reducing illegal opioid use and injecting risk behavior, increasing quality of life, improving health and reducing criminality has been observed not only in economically developed countries (Amato L, Minozzi S, Davoli M. et al., 2008, Mattic RP, Kimber J, Breen C. et al. 2008, Gowing L. Farrell M, Bornemann R et al. 2008, ), but also in lower income or resource constrained countries and across different cultures, such as in China, Indonesia, Iran, Thailand, Lithuania, Poland and Ukraine (Lawrinson P., Ali. R., Buavirat A. et al., 2008, Schaub M., Subata E., Chtengelov V. et al.,2009).

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

According to the WHO, UNODC and UNAIDS Technical Guide (2009) an OST coverage of less than 20% of opioid dependent people is considered as low, of 20-40% as medium and

\(^1\) Here we use the term Opioid Substitution Therapy (OST) to refer to the treatment of opioid dependence and the prevention and treatment of HIV/AIDS among injecting drug users, using methadone and buprenorphine. Therapy implies that pharmacological treatment is supported by psychosocial counselling.
above 40% as high. More quality indicators of OST in relation to its impact to HIV prevention has been indicated in the same document, including indicators on the average dose of methadone or buprenorphine, duration of treatment etc.

The two main modalities of outpatient treatment in Europe are psychosocial interventions and OST. Psychosocial interventions include counselling, motivational interviewing, cognitive-behavioural therapy, case management, group and family therapy and relapse prevention. They are mostly provided, depending on the country, by public institutions or by non-governmental organisations. Psychosocial interventions offer support to users as they attempt to manage and overcome their drug problems, and they are the main form of treatment for users of stimulant drugs, such as cocaine and amphetamines. They are also provided for opioid users, often in combination with OST. According to a 2008 survey of national experts, most European countries report the availability of outpatient psychosocial treatment to those who seek it (EMCDDA, 2011a).

OST is the predominant treatment option for opioid users in Europe. All EU countries have adopted a legal basis for substitution therapy, which can be accessed at the EMCDDA website2. OST is generally provided in specialist outpatient settings, and is increasingly provided in prisons. Also, office-based general practitioners, often in shared-care arrangements with specialist centres, increasingly play a role. OST is available in all EU Member States, as well as Croatia and Norway. In Turkey, OST in the form of combination buprenorphine-naloxone was introduced in 2010. Overall, it is estimated that there were about 700,000 persons on OST in Europe in 2009 (EMCDDA, 2011a).

The vast majority of OST is still provided in the 15 pre-2004 EU Member States (about 95 % of total), and numbers in these countries continued to increase between 2003 and 2009 (Figure 1). Among these countries, the highest increases were observed in Finland, with a three-fold increase, and Austria and Greece where treatment numbers doubled.

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Figure 1 Clients on opioid substitution therapy in the 15 pre-2004 and the 12 newer EU Member States — estimated numbers and indexed trends (EMCDDA, 2011a)

In the 12 countries that joined the EU more recently, the number of OST clients nearly tripled between 2003 and 2009, from 6,400 to 18,000. Relative to the index year 2003, a steep increase can be noted in 2005-2007, but from this date onwards there has only been a very slight increase. Proportionally, the expansion of OST in these countries over the six-year period was highest in Estonia (16-fold from 60 to over 1,000 clients, though still reaching only 5 % of opioid injectors) and Bulgaria (eight-fold), while there was a three-fold increase in Latvia. The smallest increases were reported in Slovakia and Hungary, and client numbers in Romania remained practically unchanged. Increased provision of OST may be linked to several factors, including response to high levels of injecting drug use and related HIV-transmission, alignments with the EU Drugs Strategy³ and the funding of pilot projects by international organizations, such as the Global Fund and UNODC.

A comparison of the number of clients on OST with the estimated number of problem opioid users suggests varying coverage levels throughout Europe. Of the 16 countries for which reliable estimates of the number of problem opioid users are available,

nine report a number of substitution treatments corresponding to 40% or more of the
target population. Eight of those countries are pre-2004 EU Member States, and the
remaining one is Malta. Coverage reaches 32% in the Czech Republic and Hungary. Of the
five countries with coverage levels below 30%, four are newer Member States and the
remaining one is Greece, with an estimated coverage of 23%.

Countries in Central and Eastern Europe report efforts to improve access, quality and
provision of OST. In 2010, clinical guidelines for the treatment of opioid dependence with
methadone and buprenorphine were issued in Lithuania. Geographical availability of OST in
Latvia is expanding, with new treatment providers outside of the capital Riga. Regulations
for the financing of OST under national health insurance have been adopted in the Czech
Republic. Lack of funding for OST is however reported as limiting the geographical coverage
in Poland and reducing significantly the number of treatment slots available among the
main providers of substitution treatment in Bulgaria, which are non-publicly funded
organizations (EMCDDA, 2011a).

Overall, it is estimated that about half of the European Union's problem opioid users
have access to OST. The number of OST clients in Eastern Europe remains low compared to
the rest of Europe (the 12 post-2004 EU member states represent only 5% of the total
number of persons on OST within the EU, while representing 20% of the population and
often reporting relatively high levels of opioid use (EMCDDA, 2011a).

In Europe, methadone is the most commonly prescribed substitution medication,
received by up to three-quarters of clients. Buprenorphine is prescribed to up to a quarter
of European substitution clients, and is the principal substitution drug in the Czech Republic,
France, Cyprus, Finland, Sweden and Croatia. The combination buprenorphine-naloxone is
available in 15 countries. Treatments with slow-release oral morphine, codeine (Germany,
Cyprus) and diacetylmorphine (Belgium, Denmark, Germany, Spain, Netherlands, United
Kingdom) represent a small proportion of all treatments (EMCDDA, 2011a).

Over recent years there have been a growing number of studies and
recommendations that methadone and buprenorphine maintenance therapy should be part
of HIV prevention strategies in prisons as an important and highly effective public health
intervention (WHO, 2005c). A systematic review of 21 studies of OST in prison
demonstrated that benefits of prison-based OST are similar to those seen in community
settings (Hedrich D., Alves P. Farrell M. et al., 2011). Practical guidelines for the introduction
of OST in prisons have also been developed (WHO 2007; Kastelic A., Pont J., Stover H., 2008,
UNODC, 2008, WHO, 2009b). While 8 countries in Europe provide OST both in prison and
community at the levels that roughly equals or surpasses the EU average of 50%, 14
countries in central, north-east and south-east countries have no or very low levels of OST
provision (less than 5%) in prisons, while 8 countries are somewhere in between. While
there should be a principle of equivalence in care in the community and in prisons, large numbers of prisoners still do not have access to OST (Larney S., Dolan K., 2009, Stover H., Marteau D., 2012). Legal issues may also hinder the introduction of OST in prison settings. For instance in Latvia, legal provision of OST in prisons is only possible since 1 April 2012. By the end of 2011 OST was provided in at least some prisons in all EU countries, except in Greece, Cyprus, Latvia, Lithuania and Slovakia.

Opioid substitution therapy is one part of the “essential” core package of services and interventions that are proven to prevent HIV transmission in IDU populations and from them to their sexual partners and children. These interventions are supported by scientific evidence, much of it summarised by WHO/UNODC in Evidence for Action technical papers and policy briefs4:

- Needle and syringe programmes (NSP)
- Opioid Substitution Therapy (OST)
- Voluntary Counseling and Testing (VCT)
- Anti-retroviral (ARV) treatment
- Targeted STI prevention
- Condom programming for IDUs and partners
- Targeted Information, Education and Communication (IEC) for IDUs & sexual partners
- HBV/HAV vaccination and diagnosis and treatment of Hepatitis B and C for IDUs
- Diagnosis and treatment of TB for IDUs

Availability of national and international guidance in EU Member States

In the recent years the World Health Organization has published comprehensive “Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence” (WHO, 2009). The guidelines include recommendations, which were developed on the solid basis of systematic overviews of research data (using the GRADE

4 See: http://www.who.int/hiv/pub/advocacy/idupolicybriefs/en/
methodology) and, where such data was unavailable, on expert opinions. The Guidelines provide solid recommendations on 3 levels: on national and sub-national levels for health systems, on treatment programme level for programme managers and clinical leaders, and on patient level for clinicians.

**Glossary of Terms (EMCDDA, 2011b)**

- **Guidance** is a general term that covers documents such as guidelines and quality standards

- **Guidelines** are ‘statements that include recommendations intended to optimize patient care that is informed by systematic review of evidence and an assessment of the benefits and harms of alternative care options (Institute of Medicine, 2011). They are designed to assist carers’ and clients’ decisions about appropriate interventions in specific circumstances

- **Protocols**, in general, are documents that specify the procedures to follow to perform some tasks, typically, those used to conduct a study

- **Standards and quality standards** are principles and sets of rules based on evidence, used to implement the interventions recommended in guidelines. They can refer to content issues, processes, or to structural (formal aspects) of quality assurance, such as environment and staffing composition. In some cases, standards are legally binding

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

- Physically **accessible** - broad geographical distribution e.g. OST should not only be available in the major cities or unavailable in hard to reach locations such as prisons;

- **Affordable** - cost at the point of service should not be a barrier e.g. patients should not be expected to pay for OST or other ancillary services, OST should be available to disadvantaged populations;

- **Equitable** and **non-discriminatory** - there should be no exclusion criteria except medical ones e.g. OST should not be limited to those over a certain age or only to those opioid dependent individuals who are HIV infected or who have “failed” other drug dependence treatments

- **Non-rationed** - supply of OST should be determined by need and not limited by cost or other considerations – ideally there should be no waiting lists

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In 2010 EMCDDA collected 143 national drug dependence treatment guidelines from 30 countries and developed a “Best practice” portal (EMCDDA, 2011b). Out of these, 57 guidelines from 24 countries contained recommendations on OST, 18 guidelines were published after 2009. Importantly, OST guidelines if compared with guidelines for other treatment modalities had the highest proportion of references to randomised clinical trials and the Cochrane library (especially UK and Germany). Most guidelines specified the ideal dosage at the beginning of treatment. Most agreed on the need of direct supervision of dispensing in the initial phases of treatment and specified conditions in which take-away doses can be given. Most agreed that OST should be offered to pregnant women, with the preference of methadone, though evidence suggests that buprenorphine may also be beneficial in this particular subgroup. Guidelines concur that psychosocial support should be routinely offered and, finally, there is a general convergence of national guidelines with WHO Guidelines (EMCDDA, 2011b).

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

The reasons for OST being underdeveloped in new EU countries include:

- Overall low priority for dependence treatment in the context of limited budget for health services;
- Unwillingness of health care administrators and/or professionals, e.g. psychiatrists, to be involved with injecting drug users (IDUs);
- Political/ideological arguments about legitimacy and effectiveness of non-abstinence orientated and harm reduction programmes;
- Low quality of existing OST programmes with limited effectiveness.

The treatment of drug dependence in some of the newer EU countries is emerging from the shadow of practice dominated by the Soviet psychiatric discipline of “narcology”, rather than evidence-based practices of “western” European countries. Following the traditional treatment concepts, OST, after being introduced in existent “narcological” infrastructure, was (and in other non-EU post-Soviet countries still is) often implemented

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5 By 2012 narcology has been retained as a separate from psychiatry speciality in Latvia with the licence for specialised medical practice granted after 4 years of post-graduate residential training in narcology. In Lithuania and Estonia after 1990 substance dependence treatment was assigned to psychiatrists. Narcology is still a separate medical specialty and service in most of post-Soviet countries.
as an abstinence-aimed short-term therapy, isolated from other services rather than implemented as a long-term public health intervention in good cooperation with infectious disease and social services.

Inherited characteristics of health care systems in post-Soviet countries included (and in some non-EU post-soviet countries still include) vertical programming, with specialised and distinctly separate services for HIV/AIDS, sexually transmitted infections, other infectious diseases and, vitally for countries where HIV is predominantly transmitted by drug injection, specialised services for people with drug and alcohol problems.

Though old attitudes and views with a rigid demarcation of responsibilities are being eroded, psychiatrists (and narcologists) may still feel reluctant to get involved in HIV/AIDS work. Moreover, in some new EU countries the tradition is inherited that clinical decisions are based on the opinions and instincts of senior physicians, rather than on evidenced-based medicine (e.g. systematic reviews of relevant scientific research including meta-analysis typified by the Cochrane Collaboration), though this tradition is also subject to change. On the other hand, the tradition and experience of involving of general practitioners in opioid dependence and HIV care is not yet available in most of the new EU countries.

Two distinctive approaches to implementing OST are described in the below box.

<table>
<thead>
<tr>
<th>Two approaches to implementing OST</th>
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<tbody>
<tr>
<td>Abstinence-orientated (at the most extreme: in Russian Federation OST is prohibited by law)</td>
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<tr>
<td>In more moderate form: OST of limited duration (long term detoxification), aimed at abstinence</td>
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<tr>
<td>Targeted to selected groups motivated to abstinence (quitting drugs)</td>
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<tr>
<td>Lower dosages</td>
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<tr>
<td>Restrictive</td>
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<td>Isolated – e.g. from infectious disease specialists, social services etc.</td>
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<td>Outcome – drug free patients</td>
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<tr>
<td>Public health intervention – effective strategy for HIV/AIDS (hepatitis B and C, TB etc.) prevention and control</td>
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<tr>
<td>Relevant to the majority of opioid dependent IDUs (not just those motivated to abstinence)</td>
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<tr>
<td>Higher dosages</td>
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<tr>
<td>Inclusive</td>
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<tr>
<td>Good communication and cooperation with other, e.g. infectious disease specialists, social services etc.</td>
</tr>
<tr>
<td>Outcome –patient retention, improved health and social functioning, reduced substance use and injecting, reduced risk of HIV etc.</td>
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</tbody>
</table>
Rationale and method of the development of current Guidance

While there are general WHO Guidelines in place and many countries have introduced their own national ones, these guidelines often tend to focus on clinical issues (such as dosage, eligibility criteria, treatment of specific patient groups etc.). There is a need for a different type of guidance dealing with practical issues and focusing on “how to” questions, providing tools for addressing common challenges to scaling-up and implementing quality OST services.

The recommendations of the above mentioned guidelines provide solid cornerstones on which principles should be prioritized while implementing and scaling-up OST on the national and sub-national levels, as well as ensuring quality at the OST programme and patient levels. Nevertheless, individual policy makers and program leaders often face practical barriers on how to implement and scale-up OST in their country, region or city. And, indeed, in many instances specific solutions regarding overcoming barriers for implementation and scaling-up of OST, as well as improving the quality of treatment, are found in national or local conditions.

There are also valuable experiences of successful guidelines implementation that were documented in various countries, including assessing the implementation of guidelines through a set of indicators for quality assurance (Denmark) or developing special instruments assessing “the implementability” of guidelines (Netherlands); engaging key professionals in the promotion of change through associations of professionals (Finland, Germany, Slovenia); providing continuous learning through inclusion of OST guidelines in training curricula of psychiatrists and in post-graduate training courses (Baltic States); producing a range of “how to” guides to help with the implementation of guidance at local level and developing a “shared learning database” (UK) with ideas and tips for successful guidelines implementation (EMCDDA, 2011b).

<table>
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<tr>
<th>There are precedents in “old” European countries for rapid OST scale up: In France nobody was being treated with OST in 1995. Three years later in 1998, 60,000 patients were being treated (mainly with buprenorphine) and 84,500 by 2003. In 2005 99,446 clients were receiving OST, 16,850 of them methadone. Germany had, in 1988, just 200 patients on OST. This number increased to 1,000 in 1992 and 10,000 in 1994. By 1996, there were 70.000 OST clients in Germany.</th>
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<tr>
<td>In order to discuss the situation of quality, accessibility and coverage of OST in Europe, as well as the need and the contents of regional level practical guidance, WHO</td>
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Regional Office for Europe convened a workshop in Vilnius, Lithuania during 22-23 May 2012 on how to implement and scale-up opioid substitution therapy. Representatives from selected EU countries (Bulgaria, Estonia, Germany, Latvia, Lithuania, Poland, Portugal, and Romania), partner organizations (EMCDDDA, Executive Agency for Health and Consumers) and observers (Council of Europe and European Centre for Disease Prevention and Control) participated in the workshop.

Workshop participants indicated the need for the development of regional level practical guidance toolkit on how to implement and scale-up OST. It was agreed that there was a need for a different type of guidance, dealing with practical issues and focusing on “how to” questions, and which would provide tools to address common challenges to scaling up and implementing quality OST.

It was agreed that the Guidance would be a practical toolkit aimed at following continuous steps of practical actions by health authorities, administrators and OST programme leaders in overcoming obstacles for implementation and scaling-up of OST. It would incorporate “case studies”, “best practices” and “success stories”, tips from EU countries, particularly the ones shared at the workshop. Ultimately, this guidance would enable EU countries (and, perhaps, also non-EU countries in Europe) and sub-national regions, administrative units and health care institutions still facing the challenge to improve the quality and scale-up of OST, to become familiar with other countries’ successful experiences and to be able to replicate these successes in their local contexts and settings.

The target group for this practical guidance would be policy and decision makers on the national, regional and local levels as well as administrators of health care institutions and leaders of OST sites. This guidance contains documented inputs on how countries scaled-up and implemented OST and dealt with challenges.

The structure of the Guidance is based on the “how to” questions, which were reflected and discussed in country presentations and discussions during the above mentioned workshop. Recommendations, when available, include specific short descriptions of experiences on how challenges were overcome in respective countries.
1. How to develop national OST Clinical Guidelines?

National OST Clinical Guidelines are important in setting the same standards for clinical practice of OST across the country. Without National Clinical Guidelines the actual implementation of OST can vary considerably, depending on attitudes and ideological considerations of leaders/administrators of OST sites and staff. The development of National OST Clinical Guidelines ideally includes the following steps:

- Initiation of a multidisciplinary specialist working group, e.g. by Ministry of Health, professional association, university clinic etc.;
- Use of existing WHO and other European country guidelines as a model, which already include appraisal of available evidence, expert opinion when evidence is not available and patients’ perspective;
- Approval of the National Clinical Guidelines by National Authorities (e.g. Ministry of Health, National Health Insurance), though this is not a necessary requirement in some countries.

Developing OST Clinical Guidelines (Estonia)

In Estonia HIV prevalence is one of the highest in the European Union. Country OST Guidelines were first developed as part of overall drug treatment guidelines and are available since 2001. A newer version was issued by the Estonian Psychiatric Association in 2007. Guidelines included restrictive indications for OST and provided limited clinical guidance. In 2010, the National Institute for Health Development, an institution under the Ministry of Social Affairs which is responsible for the implementation and funding of OST in the country, approached the Estonian Psychiatric Association with the offer to support the development of updated OST guidelines. The Estonian Psychiatric Association did not have sufficient human resources and consequently interest to lead the development of the guidelines on OST, a phenomenon which could be quite common across different countries. Continuous communication between the National Institute for Health Development and the Estonian Psychiatric Association resulted in a mutual agreement that specialists from the Institute will develop a draft of OST Guidelines, based on WHO guidelines and selected guidelines from different EU countries. The Association will review and adopt the Guidelines and recommend its use among its member psychiatrists.
2. How to encourage professionals to use international and national guidelines?

Existence of national clinical guidelines does not mean that they are used by OST professionals. There could be barriers related to the social, organizational and economic context. There could be resistance from professionals and patients. In some newer EU countries the tradition is prevalent that clinical decisions are based on the opinions and instincts of senior physicians, rather than on evidenced-based medicine (e.g. systematic reviews of relevant scientific research including meta-analyses, e.g. Cochrane library). Medical practitioners might not have a habit of seeking answers to their clinical dilemmas in evidence-based guidelines and literature. Another barrier could be the unavailability of evidence-based literature in local languages and the limited number of clinicians and OST site leaders that are able to access international guidelines and research papers in English or other languages.

Many steps could be undertaken to encourage OST professionals to use existing national and international guidelines, including:

- To initiate the development of national clinical guidelines;
- To translate international guidelines into the national language;
- To ensure wide availability of guidelines to practitioners through printed hard copies and electronic copies through the internet;
- To incorporate recommendations and performance indicators from the international and/or national guidelines into health care institutions’ internal treatment policies and quality assurance procedures;
- To introduce systematically national guidelines to new staff at new OST sites and to staff already in place by formal training courses;
- Together with professional associations and universities develop courses on OST or substance dependence treatment and seek accreditation for them in medical universities;
- To include training on clinical guidelines into the postgraduate training of physician residents in psychiatry;
- To implement the system of continuous on-site training, e.g. intervision sessions, analysis of case studies, etc.
Intervision sessions as a method of on-site training and mutual support for OST specialist teams (Estonia, Latvia and Lithuania)

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

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

Discussion during intervision sessions could disclose to what extent real OST implementation is done in line with clinical guidelines.

The Estonian Institute for Health Development has allocated a budget in 2011 and 2012 to convene intervision sessions at all OST sites of Estonia by inviting “outside” facilitators. The Vilnius Centre for Addictive Disorders (Lithuania) has included intervision sessions at least twice per year as a mandatory part of on- site staff training.

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6 Intervision Guidelines were prepared by Franz Trautmann (Trimbos Institute, the Netherlands) in the implementation of the UNODC project “HIV prevention among IDU and prisons in Estonia, Latvia and Lithuania 2006-2010” and are available in English, Estonian, Latvian, Lithuanian and Russian language at UNODC internet site: http://www.unodc.org/balticstates/en/publications/pharmacologicaltreatment.html
3. How to start new OST sites?

The establishment of a new OST site might meet resistance or unwillingness from many stakeholders, including politicians, administrators, health care staff, NGOs and the neighbourhood due to many reasons. The experience of countries on how they usually start new OST sites might therefore be useful. The usual steps to facilitate a new OST site of national or sub-national agencies and institutions might include:

- To enhance motivation of the site’s staff and administration, e.g. through provision of “seed” funding for renovation of premises to meet security needs, equipment, and maximum comfort to deliver services for staff and patients, etc.
- To provide technical assistance in the development of sites’ internal protocols and procedures on OST, regulations on the control of narcotic medications;
- To integrate OST as much as possible into existing services (including private clinics), especially if the OST site is in a small town serving only a few patients;
- To implement the systematic initial training of multidisciplinary staff on OST;
- To implement the system of continuous mentoring and supervision of the new OST site by experienced practitioners/centre through site visits, e-mail and telephone communication;
- To secure mechanism of funding for continued operation of OST site;
- To raise awareness of benefits of OST site for the community.

Improving access to OST (Latvia)

By 2008 there was 1 OST site for methadone treatment in the capital Riga, which was established in 1996. In the framework of the UNODC regional project “HIV prevention and care among IDU and prisons settings in Estonia, Latvia and Lithuania 2006-2010” in the course of 2009-2011, Latvian health authorities implemented activities which increased the number of health care facilities providing OST up to 10 in 2011.

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

Staff members were sometimes offered site visits to neighbouring countries’ OST sites. Specialists from OST sites were invited to practical workshops on different topics: clinical aspects of OST, provision of psychosocial assistance and case management in a multidisciplinary team of specialists, basics of motivational interviewing, OST for specific populations (women, including pregnant women) and intervision sessions. Technical support was provided by more experienced clinicians at the Riga Centre of Psychiatry and Addiction Disorders, who supervised other physicians in initiating treatment and deciding on the optimal methadone dose as well as developing the internal institutional procedures. OST services in OST sites are funded according to approved schemes from the national health insurance system. Therefore, the sustainability of OST sites was ensured after the UNODC project ended in 2011.

**Introduction of an OST programme at a private mental health clinic (Romania)**

Until 2008 in Romania OST was funded by two public systems: Ministry of Health (services at hospitals and outpatient clinics) and National Antidrug Agency at the Ministry of Interior (outpatient services). There was not sufficient coordination in funding of services and no funds were available for private or nongovernmental medical institutions. Due to chronic lack of funds in the public system and in the context of limited budget for health services, public OST sites were overcrowded with OST patients. The access to OST remained very limited with long waiting lists.

Due to lack of public funding, insufficient staffing and training, the quality of OST programmes at public health care institutions was insufficient. There was a constant risk that such OST programmes could be compromised in the eyes of local communities due to overcrowding of patients, poor management and limited effectiveness. In addition, some injecting drug users developed negative attitudes towards OST (“methadone dependence is worse than heroin”, “methadone is also a drug, more harmful than heroin”). This situation prompted an idea to integrate an OST programme into a private clinic. In 2008 the first private clinic “PsyMotion” in Bucharest started to offer specialized services for patients with opioid dependence along outpatient services of psychiatry and psychotherapy. After introduction of OST with methadone as the abstinence oriented treatment in 2008, later treatment with methadone was diversified depending on the needs of patients, including detoxification, long-term maintenance with methadone and patient stabilization. Buprenorphine is also available for detoxification and maintenance treatment.

Each OST patient is assigned a case manager. He/she signs an agreement with the patient, the individualized plan of therapeutic care (treatment goals, priority issues,
4. How to integrate OST with HIV, HCV and TB services?

One of the core objectives of OST is prevention and management of infectious diseases. The could be challenges as OST in Europe is often provided in the mental health care system and the primary medical specialists are psychiatrists without a tradition to interact with the infectious disease treatment system. With the introduction of OST, there is a need for mental health care centres to establish new models of referral to infectious disease specialists and institutions. On site testing for HIV and HCV, vaccination for hepatitis B might be implemented at some OST sites. There are different ways to integrate OST and infectious disease health care services. They include:

- To develop HIV, HCV and TB testing and treatment and hepatitis B vaccination policies and procedures on the national level, e.g. legal acts, national guidelines on how to integrate national provisions into procedures in health care institutions;
- To develop sound models of mutual referrals and treatment implementation between OST sites and infectious disease treatment centres, e.g. through
case managers, and to incorporate them into internal institution’s policies and procedures;
• To allocate persons at OST sites, who are responsible for administering visits and consultations, referrals and medical records, and to train them properly;
• To provide OST and HIV, HCV and TB care in one location if there are benefits for such a model.

Introduction of integrated treatment (Estonia)
Until 2010 integrated OST/ART was not available in Estonia. As a result, active HIV-positive drug users were often dropping out of ART. To alleviate the problem the first integrated OST/ART programme for HIV-positive injecting drug users was launched in Tallinn in 2010. Integrated treatment is provided based on the DOTS principle and daily contact with medical staff has significantly improved patients’ adherence to ART. Later the possibility of integrated TB treatment was added. The programme was implemented by the Infectious Diseases Clinic of the West-Tallinn Central Hospital and funded by the National Institute for Health Development from the state budget. It was established with the support from UNODC regional project “Prevention of HIV among IDU and prison settings in Estonia, Latvia and Lithuania, 2006–2010”.

Organisation of testing for HIV, viral hepatitis C and other infectious diseases (Lithuania)
Following the comprehensive assessment of all OST sites in Lithuania, performed by the Medical Audit Inspection at the Ministry of Health in 2011, the Ministry of Health has implemented Medical Audit Inspection’s recommendation and issued the legal act, which mandated National Patients Fund to financially support HIV, HCV and syphilis tests for all OST patients at least once per year. Patients are referred for regular infectious disease tests from mental health centres, which provide OST. TB consultation by a pulmonologist is recommended if there are indications and is free of charge for patients as it is also paid by the National Patients Fund.
5. How to facilitate the access of IDUs to OST?

Persons with drug dependence usually tend to feel ambivalent about their drug use and treatment. For instance, they could acknowledge that drug use has a destructive influence on their life. On the other hand, they could be hesitant about quitting drug use for good. Even if the patient is motivated to enter OST, this motivation often tends to be unstable and changing. Some OST sites in new EU countries used to require different kinds of procedures before starting therapy and before the first methadone dose could be dispensed. This usually included prior-treatment requirements for HIV, HCV or TB tests, physician (internist) examination for contraindications etc. Such requirements significantly increased the threshold for treatment, making it too high for many active heroin users. A person coming for medical treatment should expect that the health care institution within a reasonable time period (few hours) to a certain degree manages to improve his/her physical and mental status or provide support in a difficult social situation. Waiting lists to enter OST or very high requirements to initiate the therapy may be factors perpetuating injecting drug use and working contra-therapeutically. Therefore, strategies which strengthen IDUs’ motivation to make practical steps to start OST, providing support and facilitating their entrance to treatment are critical. The following strategies could be helpful in achieving the objective:

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

“GIRUGaia” (GG) is a Portuguese Harm Reduction project directed at people who use drugs and operating in Vila Nova de Gaia\(^7\) since November 2003. It is promoted by Agência Piaget para o Desenvolvimento (APDES)\(^8\) – www.apdes.pt – and it is co-financed by the Portuguese national institute of drugs related-problems – Instituto da Droga e da Toxicodependência (IDT).

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

In 2007, based on information from the action-research, GG created a Combined Therapy Programme (CTP) to help heroin users that already failed several previous attempts to overcome their problematic consumption. Its main purposes are to reduce risks and harm related to drug use and to improve the levels of health and social integration of clients. CTP uses the administration of methadone, which by itself facilitates the reduction of consumption, in order to maintain contact and to trace and support a bigger number of PUD in a steady way. The use of methadone, as it stimulates clients’ daily adhesion to services, also makes it possible to administer medication for tuberculosis and HIV treatment as well as for psychiatric disturbances to people who were strongly resistant to those treatments before their combination with methadone. Guarantee of the effectiveness of this programme is only possible through the involvement of several partners, such as the local service of infectious diseases (Centro Hospitalar Vila Nova de Gaia / Espinho), the pulmonary diseases screening service (Centro Diagnóstico e Pneumológico), the addiction treatment centre (Instituto da Droga e da Toxicodependência, Equipa de Tratamento de Gaia) and the service of collecting and testing of blood (Instituto Nacional de Saúde Dr. Ricardo Jorge). Each of these organizations cooperate with the programme by providing essential services and useful resources for its development, such as: provision of antiretroviral and TB medication, open public pulmonologist and infectious disease consultations, ensuring hours of nursing assistance, blood samples collection, provision of methadone and co-adjuvant medications. This programme extends its local action throughout all urban territories (including the periphery) of the city, offering drug users the possibility to access a proximal service that goes to them, in their everyday life places, and that would be impossible for them to get otherwise (60% of the clients had never gone to a treatment centre when contacted by the team for the first time). Clients are immediately

\(^7\) The third most populous district in the country and one of the most extensive, also.

\(^8\) Piaget Agency of Development (English translation)
admitted in the programme after a technical evaluation of the case made by GG professionals and without the need of being seen (face-to-face) by a physician. This guarantees the immediate integration and future continuity of contact with people that seek help without forcing them to wait until the physician is present since this professional goes to the field only once every two weeks in the best scenario (what would certainly imply the loss of some clients). In order to make this possible, the physician that voluntarily works in the project allows the nurse to give to the client in his first contact a secure dose of methadone (30 mg) and adjusting it smoothly every day until the medical doctor can evaluate the situation in loco. The immediate integration of clients in the methadone programme makes it possible to evaluate the clinical state of clients (mostly hidden drug users in very vulnerable situations) and to offer them the most appropriate treatment. Methadone is highly effective in maintaining clients in treatment, so its combination with ART and tuberculosis therapy makes the latest more effective too. Probably, without this combination in local settings those two therapies would not be possible with highly vulnerable drug users who have great troubles in organizing themselves to get solutions for their health and social problems.

Results of this programme are quite positive and have proved the importance of this kind of proximity intervention with a multidisciplinary and multi-institutional framework oriented by a pragmatic and humanistic approach. Besides contributing to the decreasing of infectious diseases and applying in an effective way the already mentioned therapies, it improves client’s lives and level of health and social integration in several aspects by:

- reducing the use of psychoactive substances (29% of clients have stopped using heroin and cocaine, only 20% kept a daily frequency of heroin use, but reported a decrease in at least half of the amount used);

- lowering the maximum amount of cocaine doses consumed (2, contrasting with the 30 doses mentioned before entering in the programme);

- contributing to changing the route of the administration of illegal substances (44% injected drugs before entering the programme and 16% of them has began smoking instead, 13% decreased the number of injections preferring to smoke in several occasions);

- reducing criminal activity (in 2010, 70% have assumed, in self-revealed delinquency questionnaires, to have ceased their criminal activity since entering the programme);

- bringing clients closer to various kinds of services;

- increasing the number of drug users referred for addiction and for HIV treatment;

- increasing the number of contacts within hidden populations;
- promoting a higher quality of life for drug users;
- promoting individual and public health.

96% of clients have made a blood analysis, 18 of them are HIV positive and only one is not receiving ART; 78% have also made screening for TB. It is important to clarify that GIRUGAIA does not use screening for diseases as a criteria for including or excluding clients from the methadone program for two reasons: because we believe that access to methadone (a medicine recognized like fundamental for opioid addicts) is a fundamental right for those who need it and because it is not effective. Giving access to methadone is the most effective way to connect clients with the health care system.

6. How to ensure the quality of OST?

The quality of OST is essential. Low quality OST is not only less effective in outcomes of treatment and HIV prevention, but could also compromise OST in the eyes of local community, policy makers, administrators, professionals and patients. There are many ways to increase the quality of OST, including:

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

**Case management of OST patients (Lithuania)**

Case managers were introduced in the Vilnius Centre for Addictive Disorders in 2007. In principle, they are professional social workers with a master’s degree in social work, though trained nurses, psychologists could also function as case managers. The case manager is the only staff member, which should be routinely approached by an OST patient to address problems. For example, if a patient needs a consultation of the psychiatrist on OST site, he/she approaches the case manager and then the case manager arranges the consultation. The case manager has a workload of maximum 30 patients.

The case manager is responsible:
- To collect and file all the obligatory documents before the initiation of treatment (patient’s ID, status of medical insurance, etc.);
- To store and update medical files;
- To assess the individual social, legal, etc. needs of the patient;
- To develop/agree with a patient and other specialist team members on a treatment plan and setting specific objectives in that plan (e.g. to register at labour exchange, to apply for a night shelter, to show up for HIV, TB, HCV tests, etc.);
- Together with a patient to review regularly (every 3 months) the implementation of treatment objectives, to discuss which were achieved and what were the obstacles to for unachieved objectives; to update the next 3 month treatment plan;
- To liaise with other specialists in the OST team and external services (medical, social, legal, etc.) to facilitate, if needed, appointments with external specialists (e.g. by telephone) and, if needed, to intermediate with other services or support in representing the interests of the patients;
- To develop social skills of patients (by daily communication with a patient and through specially targeted exercises);
- To decide on when urine/saliva tests for drugs or alcohol breathalyser tests are administered;
- To recommend for physicians on when and for how many days take-home medications (methadone, buprenorphine) should be given (usually as a reward in proportion to positive behaviour change).

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

Among the benefits of the introduction of the case management approach was the reduction of the demand for psychiatrists and the reduction of their workload. It is important as in many countries it is difficult to find a well trained psychiatrist to work in dependence treatment clinics. With introduction of case management patients receive an individualized care and a close observation. In this system even small positive behavioural changes could be assessed and acknowledged by social workers, documented and reinforced.

Case management by outreach programs (Bulgaria).

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

7. How to increase the compliance of OST patients?

OST patients may often have criminal records and time spent in penitentiary institutions in their life history. They might also have co-morbid mental conditions, such as antisocial personality disorder, schizophrenia, depressive and anxiety disorders. Motivation for treatment and attitudes to injecting drugs among OST patients is often unstable and fluctuating. Therefore, virtually all OST sites in all countries have problems with patients’ compliance. While it will most probably never be possible to reach a 100% compliance of OST patients, various measures could be considered by OST site leaders and staff as a potential to increase the compliance among patients. These measures might include:

- To develop approaches which facilitate IDU enrolment into OST;
- To have a vision of OST as a patient-friendly service, with clear limits for unacceptable behaviour;
- To establish a system of recognizing the most urgent needs of patients and developing an individualized multidisciplinary treatment plan addressing those needs, including services outside the institution;
- To develop routine practices, when specific treatment objectives are agreed with the participation of the OST patient;
- To promote clear and transparent expectations and behaviour rules from patients on behalf of the OST staff and communicate them to patients;
- To facilitate positive behaviour change, e.g. through increased take-home medication, acknowledgment of small positive behaviour changes or other incentives;
- To establish a system allowing patients to travel inside the country, EU and non-EU countries;
- To explore OST patients’ opinion (including anonymous surveys) about the satisfaction with services, working hours of the site, organization of therapy process etc.;
- To encourage formation of self-help groups of patients.

**Travel of patients within EU countries**

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

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

It is illegal to carry methadone or buprenorphine to the Russian Federation in spite that patient will have all necessary documents from a prescribing physician and medical institution. Patients should be well informed about risks of taking methadone or buprenorphine there.
8. How to set the system of individualized treatment planning and coordination of external services?

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

Ideally there should be a therapeutic alliance between the OST multidisciplinary team and a patient. The therapeutic alliance would include a mutual agreement on treatment objectives and implementation of an individual treatment plan to reach them. In maximizing the individual approach, policy makers and OST site leaders might be willing to consider how:

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

Addiction Severity Index as an instrument for a standardised comprehensive assessment of OST patients (Latvia, Lithuania)

The Addiction Severity Index (ASI) is a short semi-structured questionnaire, which was designed to collect and assess information from patients’ life history related to dependence syndrome. It is important for designing an individual treatment plan. ASI was developed by the group of researchers at the Treatment Research Institute (Philadelphia,
USA), lead by Tom McLellan in 1977. Since then, the questionnaire has been modified many times and has been translated into many languages.\(^9\)

ASI has 7 domains: medical status, employment/support status, drugs and alcohol issues, legal status, family/social relationships and psychiatric status. It takes up to about 1 hour to fill data from the interview with a patient into the web-based database. The software allows to compile a standardized patient assessment report in MS Word and to print it for medical files. The software also allows to generate a Master Problem list for a patient and to develop a standard form of individualised treatment plan to be discussed and agreed with a patient.

Latvian and Lithuanian versions of questionnaires and the web-based database were developed as well as OST staff trained during the UNODC regional project “Prevention and care of HIV among IDU and prison settings in Estonia, Latvia and Lithuania”. They are used in an everyday clinical practice at some OST sites.

9. How to monitor access, quality and outcomes of OST on the national level?

In order to sustain and achieve adequate funding for OST in the country/region it is essential to gather and provide regularly information on the accessibility of OST to patients and coverage of IDU population, on the quality and outcome indicators. To reach these goals OST national monitoring systems might be implemented and used. The process of the development of a monitoring system might include the following aspects:

- To incorporate WHO/UNODC/UNAIDS Guidance indicators for HIV prevention into national monitoring systems;
- To incorporate EMCDDA treatment demand indicators;
- To monitor outcome indicators of OST;
- To monitor continuously the extent and progress of OST impact on HIV prevention on the national and local level.

Monitoring of OST at the national level (Bulgaria)

\(^9\) UNODC TREATNET I project has adopted the UNODC version of ASI and also developed a training module for its use in clinical practice, which can be found at [www.unodc.org/treatment/en/training-package.html](http://www.unodc.org/treatment/en/training-package.html)
OST program managers prepare quarterly reports to the NCA on the activities of the programmes and the trends in their development, as well as an annual report with an assessment of the efficiency of the programme including conclusions according to a template prepared by National Centre of Addictions.

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

10. How to make OST available in prisons?

In several EU countries OST is not available in prisons. There might be an increased risk of transmission of HIV and viral hepatitis C is greater prisons due to the availability of drugs there, unsafe injecting and sexual practices, and also unavailability of specific prevention programmes, e.g. access to sterile injecting equipment such as needle and syringe programmes (NSPs). It is important that OST is continued for all patients in prisons and it should be possible to initiate OST in prisons on the same indications as in health care institutions in the community. It is also important that systems should be available to transfer patients on OST after their release to community health care institutions in order to prevent their relapse into injecting drug use and associated risks (HIV, overdose). Some EU countries were successful in implementing and expanding OST in prisons and in development of cooperation with OST sites outside prisons. The implementation of OST in prisons should follow different stages, including:

- To develop and implement advocacy strategies supported by the Ministry of Health in order to influence decisions by Ministry of Justice and prison administrations;
- To develop internal procedures of OST in prisons based on existent National and International Guidelines and country legal basis for substitution treatment;
- To implement introductory training of multidisciplinary staff and prison guards;
- To implement a system of continuous training of the multidisciplinary staff, including training on site (e.g. intervisits sessions);
- To establish mentoring and supervision by more experienced service providers through site visits, telephone and e-mail communication,
- To establish a system when a slot at an OST site is secured in the health care facility before the release of a patient from prison, etc.
**Introduction and scaling up of OST in prisons (Estonia)**

Treatment and rehabilitation of diagnosed drug dependent persons is most effective in special designated prison units. In the Estonian Prison Service these units were located in Tartu, Viru, Harku and Murru prisons and there were more than 200 places in total. Drug users, who do not need or do not want intensive treatment and/or rehabilitation, receive services on general basis from health care and social departments. The biggest national treatment and rehabilitation unit with 174 places is located in Tartu Prison.

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

OST in the Estonian Prison Service started in 2008 by the decision of the Ministry of Justice, which was done in line with the National AIDS Programme. In the first two years the number of the treatment cases was low. In 2008 there were only 2 cases of methadone assisted opioid withdrawal treatment. In 2009 there were 4 cases of methadone assisted opioid withdrawal treatment and 8 cases of opioid substitution therapy. In 2010 the number of cases increased significantly to 59 methadone assisted opioid withdrawal cases and 64 OST cases. In 2011 the increase continued and by the end of the year 99 inmates received methadone assisted withdrawal treatment and OST was provided in 118 cases. Funding for methadone is allocated from the regular budget of penitentiary institutions.

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

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

During the recent years prison service has put a lot of effort in developing and improving the drug treatment and rehabilitation services in prisons. In every prison there are staff members experienced to work with drug users. As mentioned earlier, in 3 prisons there are specialized psychosocial treatment units where high importance is given to motivating the inmates to face their problems arising from dependence and participate in treatment and rehabilitation programmes.

In the coming years the prison service expects further increases in the number of clients on OST in prisons.

### OST in the penitentiary system (Germany)

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

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

Law enforcement (police, courts, probation) is usually supportive of OST, as significant access of IDUs to OST might lead to a reduction in crime rates, demand for illegal heroin and other substances and overloading of courts with criminal cases. OST should be available for continuation in police custodies after arrest of OST patients. In some countries, injecting drug users for minor criminal offences are referred by courts to probation and court mandated treatment instead of imprisonment. In these cases, after assessment of the patient’s condition, OST could be offered as one of the options in the spectrum of treatment modalities. Building the collaboration with law enforcement might include various steps, e.g.:

- To develop an advocacy strategy to approach Ministry of Interior in order OST should be allowed for continuation in police custodies;
- To develop a mechanism of continuation of OST in police custodies in cooperation of police and health care services;
- To implement cooperation between OST and police in encouraging referrals from police to OST and other types of care;
- To implement cooperation with courts and probation services by accepting patients to court mandated treatment and offering OST as one of the standard treatment options;

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

A Roma settlement on the outskirts of Vilnius has for a long time been the semi-open drug dealing and drug injecting scene. The police have been trying to suppress the scene for a number of years with increased efforts. It reached some success in arresting a number of drug dealers. Drug dealing (mostly heroin) in spite of all efforts still persisted. In order to suppress the drug scene, the police have implemented increased and continuous efforts to arrest all drug users that visited the Roma settlement. The number arrested during one year
reached 1600. There was a big public concern for a number of years about how to solve the drug problem in the Roma settlement, but no easy answers were available.

In 2010 there was a 4 month waiting list to enter OST at Vilnius Centre for Addictive Disorders. In order to explore the demand for OST in June 2010 Vilnius county police headquarters initiated a 4 month agreement with the Vilnius Centre of Addictive Disorders and the Government’s Drug Control Department. According to the agreement Vilnius county Police provided information on the availability of OST and referred arrested IDUs to drug treatment on a voluntary basis. Vilnius Centre for Addictive Disorders promptly assessed patients with written referrals from the police and accepted them into dependence treatment. Additional funds were allocated by the Drug Control Department to accept patients into OST without any waiting list in the framework of this short term project.

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

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

Thus, time-limited joint and coordinated actions by police and health authorities proved effective in attracting injecting opioid users into treatment. Comprehensive health care and social services contributed to positive changes in their behavior, quality of life and health, reduction of criminality. The Vilnius county police headquarters developed a strong positive attitude towards OST as one of the potential components in addressing the persistent drug problem in the city (Subata E., Malinauskaite A., Astrauskiene A., 2011).
12. How to meet the legal requirements on the control of opioid medications and reduce the diversion of opioid medications?

Methadone and buprenorphine are controlled medications. Diverted medications might be injected and traded on the black market. Measures should be enforced to prevent diversion of controlled medications at the national and programme level, though these measures should be balanced with the flexibility of dispensing medications and individualised management of patients in OST. In order to reach the reduction of diversion of medications, the following measures should be implemented:

- To develop national legal acts, which would reduce diversion of controlled medications and ensure flexibility and attractiveness of OST to patients;
- To implement internal institutional procedures on acquiring, turnover, dispensing and reporting of controlled medications;
- To appoint staff members, responsible for the control of opioid medications in the institution;
- To implement a system of supervised administration of methadone and buprenorphine in the initial phases of treatment;
- To provide medications for home use on an individual basis after assessment of risk of diversion;
- To enforce by internal procedures the legal responsibility for the diversion of medications to patients themselves etc.

13. How to improve the public image of OST among professionals, IDUs and the general population?

In many countries the image of OST among the general population, professionals and IDUs is poor. This may be related to the poor quality of OST programmes and persistence of myths. Many myths are persistent, in particular about methadone, such as that OST is nothing else than continuation of intoxication with drugs and traps people in a cycle of dependency; opioid medications are toxic; or methadone develops dependence which is “worse” than heroin dependence. In some countries abstinence-oriented treatment is traditionally more common and valued. Sometimes abstinence-oriented treatment specialists and patient communities do not want to accept OST as a valid treatment option. In order to improve the image of OST, certain steps should be undertaken, including:
• To develop strategies to reduce the grouping of OST patients near OST sites with big number of patients through decentralization, integration of OST into existing health care services, referral of stable patients to primary health care centres and general practitioners, also transferring them to mobile OST units;
• To develop fact-sheets on OST addressing prevalent myths and misconceptions designated to health and social care professionals at large and also to the general population, and make them widely available;
• To develop information leaflets for patients and drug users, addressing myths and misconceptions of OST among patient and IDU;
• To encourage a continuous dialogue between OST specialists and patient communities and abstinence-oriented drug treatment communities in order to diminish the ideological gap between them;
• To develop strategies for communication with the mass media;
• To encourage formation self-help groups of OST patients and their role in advocacy.

Promotion and qualification of self-help activities (Germany)

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

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

In order to decentralize the most problematic patients and to improve the public image of OST and the Centre, in 2010 the mobile clinic for dispensing methadone was built and introduced. The mobile clinic based on a bus dispensed methadone at 2 sites, which were approved by the city authorities. The determination of locations to dispense methadone has met some resistance from community. Several locations had to be changed before acceptable sites in the community were found. Since then, most problematic OST patients were transferred to the mobile clinic to take their methadone for 5 days per week under supervision. Due to limited funds the mobile clinic did not operate during weekends. On weekend days, patients came for methadone to the main site for supervised intake to ensure 7 days per week supervised intake and to prevent diversion. In the mobile clinic patients were not urine screened and it was considered a site with a lower threshold of OST. New patients were admitted to OST through the main site. They were continuously observed for at least 2 months and if they demonstrated a problematic behaviour they could be considered for the transfer to mobile clinic. At the mobile unit a breathalyser was used for determination of alcohol intoxication and appearance of intoxication was not tolerated. Patients had to undergo scheduled routine health examinations (HIV, HCV, syphilis, TB, consultation of psychiatrists) at the main site. If there were positive behaviour changes, a patient could be transferred again to the main OST site and eventually he/she could qualify for consideration for take-home medicines.

The mobile unit was staffed with the nurse and 2 social workers. Psychiatrists occasionally could also go to the mobile clinic to see their patients.

The same mobile clinic provides harm reduction services (needle exchange, rapid HIV testing, counselling) for IDUs and commercial sex workers in another 2 sites in the city (Roma community and railway station).

Introduction of the mobile clinic allowed reducing the grouping of the most problematic patients around the centre, decreasing a potential “market” for psychoactive substances and improving the image of OST in the eyes of the neighbourhood and city authorities.
14. How to avoid the risks of OST for staff, other patients and the OST site?

As mentioned before, many patients in OST have a criminal history and may have spent time in prisons before. There may be patients with co-morbid mental disorders. Patients sometimes show up at an OST site with alcohol or stimulant intoxication and may be aggressive towards other patients or staff. To ensure maximum safety of OST some measures should be considered at the national and programme levels, including:

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

Minimising risks for staff and other patients (Latvia)

New OST sites in Latvia, established during 2009-2011 by using small grants provided by the UNODC project were equipped with safety doors, safe-boxes and alarm systems to ensure the security of medical supplies, as required by national legal acts. Alarm buttons were installed at methadone dispensing offices in case of aggressive behaviour of patients. The latter were almost never used, but increased the nurses’ subjective feeling of being more secure. Nurses were instructed about safer behaviour patterns in case of any serious aggressive behaviour or open robbery. New OST sites in Latvia chose to implement a friendly and open nurse and patient face-to-face office setting, where nurse administrated methadone and buprenorphine over the desk and supervised consumption of medication. The model of the first site in Riga since 1996 was different. The nurse was separated from a
patient by the plastic and glass wall and she administrated methadone through a small window.

OST staff in new sites believed that a friendly setting in methadone dispensing offices promoted more open communication between staff and patients, increased cooperation and ultimately reduced risks of destructive and aggressive behaviour.

Minimising risks for staff and other patients (Lithuania)

In some of the post-2004 EU countries alcohol consumption could be a serious problem for some OST patients. Some patients, while being on OST for a longer period of time, increase their alcohol consumption, which can progress to the level of dependence. Keeping in mind that at least 50-80% of OST patients are infected with HCV, alcohol consumption is a serious additional risk factor for the development of liver cirrhosis. Physicians and social workers were encouraged to discuss this topic in their consultations with patients, including discussion on abnormal liver enzymes when available. In case of alcohol dependence and binge drinking, in-patient detoxification from alcohol was offered while OST continued. Detoxification from alcohol had to be offered for some OST patients repeatedly, with subsequent treatment in psychosocial programmes, self-help groups or with medications (disulphiram).

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

The enforcement of this requirement has met strong resistance in some patients. Nevertheless, the implementation of this treatment policy led to overall positive behavioural changes among patients. Most of them learned to attend OST site without previous consumption of alcohol early in the morning and interfered with binge drinking late in the night. During the implementation of this policy some patients had to be hospitalized due to severe alcohol withdrawal symptoms and underwent detoxification.
15. How to engage the general practitioner in the provision of OST?

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

Treatment by a GP might be considered as less stigmatising than when offered in specialized addiction or psychiatric services. Treatment by a GP often implies that heroin dependence is treated just like another chronic disease, such as hypertension or diabetes.

Moreover, a GP is in a better position than a psychiatrist to manage frequent concomitant HCV, HIV infections and other physical co-morbidities and implement prevention measures and testing for these infections. GPs are also in a good position to care for opioid dependent pregnant women and their newborns.

OST, if provided in primary health care by a GP, can become accessible for IDUs in small cities and remote places, where there is little or no access to mental health care specialists. The OST may be integrated into existing infrastructure of primary health care centres. Therefore, it could be relatively inexpensive. With the involvement of GPs, OST potentially ensures the access to OST even in remote localities and rural areas. The experience from several countries, including Germany, France, Norway, Croatia, is valuable for other countries to consider how to implement and scale-up the OST through GPs in primary health care. The involvement of GPs should be increased with the following steps:

- To establish national funding schemes for GPs, who provide OST;
- To establish a system training for GPs on assessment of patients with dependence and their treatment, including OST;
- To develop a support system to GPs from specialists in dependence and psychiatry;
- To provide a possibility to GPs to refer more “difficult” patients to OST in specialized and more intensive services.
Provision of OST by GPs (Germany)

In Germany in 2011 of the 8,122 GPs who were qualified to treat dependence only 2,703 provided OST. Over the years, this number of GPs did not change, while the number of patients increased. 28.2% of GPs had less than 3 patients in OST, 52.7% had from 4 to 50 patients, 17.2% had from 50 to 150 patients, and 1.9% had more than 150 patients on OST. OST is also provided by specialised services, though the greatest number of patients receives OST from GPs. Roughly about 80% of patients received methadone or levomethadone, 19% buprenorphine. Only 0.4% of patients were treated with diamorphine and 0.3% codeine and dihydrocodeine.

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

While GPs provide OST and medical care, by legal requirements each patient in OST should receive mandatory psychosocial assistance. For psychosocial assistance GPs usually refer to psychosocial programmes, which are run by NGOs or municipal services. There is a problem with this requirement, as some patients do not need psychosocial assistance. On the other hand, psychosocial assistance is not clearly defined, thus it could be of unknown quality and effectiveness.

If a patient has co-morbid mental conditions, or is non-compliant, in big cities a GP may refer him/her to community specialised treatment programmes (Mikels I., Stover H., Gerlach R., 2007).

16. How to find optimal ways to fund provision of OST?

Ways of funding OST could be complicated and come from different sources. Medical insurances often fund only the medical component of treatment, while psychosocial assistance is not (sufficiently) financially reimbursed. At the same time, OST patients, especially those who have injected heroin for many years, could need intensive social support and social reintegration efforts. If the OST is expected to be effective, funding of a multi-disciplinary and well-coordinated approach is a must.

Funding of HIV, HCV infection and TB treatment, as well as treatment of most other physical and mental disorders usually follows the patterns, which are general to non-IDU populations. The only requirement is that an OST patient has a health care insurance. In
some of new EU countries many IDUs do not have a health insurance. Often there could be a situation when an IDU is not officially employed, or not officially registered at the labour exchange office or homeless. Naturally, counselling and support from a social or outreach worker to regain personal ID documents (if they were lost) and to register at labour exchange, is vital in ensuring that patient is eligible for comprehensive health care services.

The following strategies of funding are useful in ensuring funding for OST implementation and scale up:

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

### Funding of substitution treatment (Germany)

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

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

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


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