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Community-based services for people who use drugs in Southeast Asia

Trainer's manual

Module 2: The community-based drug treatment and care approach

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Contents

Module 2: The community-based drug treatment and care approach

Notes on presenting this module:

The text that accompanies each slide in the manual provides background information and explanation. It is up to you to decide how much of this you think is appropriate to share with each training group.

Icons

Throughout this manual icons will be used like road signs to guide you in delivering the training and using the course materials.

 ***Handout***

The *Students' Manual* will have copies of the activity handouts and references, where indicated. Students can also make copies if they do not want to write in the book or they want to share handouts with their colleagues.

 ***Optional learning activity***

There many activities throughout the course. Some of these are simple discussions and some are more involved group activities. Many of the activities are also designed to be used as assessment tasks.

 ***Assessment***

This symbol indicates that you have the option of using the activity as an assessment task.

 ***Let's take a closer look at ...***

Drug and alcohol use prevention, treatment and care are complex. Presenting the course content requires that you have some more detailed knowledge to underpin what you teach. For this reason, at some points, more detailed information, which may be useful in presenting the course, has been included. These notes are for the trainer and it is up to you whether you wish to use any of it in your facilitation.

 ***References and further reading***

Throughout the manual, references will be provided to indicate where material has come from, to substantiate points of view and to provide further reading should you or the students want to pursue an area of interest further.

 ***Internet resource***

Internet addresses will help direct you to additional resources should you or the students want to pursue an area of interest further.

 ***Key point***

This icon indicates that the following information is a 'key point', that is, it has been highlighted because there is a particularly important piece of information for participants to understand and remember. It is worth giving emphasis to key points when they arise in the training course.

Topic 1 – Principles of the community-based approach

Read pages 3-9 of (United Nations Office on Drugs and Crime, 2014a).

➔ Slide 1 – Module 2: The community-based drug treatment and care approach

Community-based drug dependence treatment needs to respond to the needs and resources of communities. Service providers, practitioner and community workers should work to mobilize resources in the community to meet their clients' needs. Community-based treatment needs to involve (and go beyond) the local community in order to address the complex variety of needs of drug-dependent people; for instance service providers need to work with law enforcers and law agencies, including at the national level. The coordinated active involvement of community-based agencies, government (state, regional and local) religious organizations, cultural groups, community leaders, businesses, drug use treatment centres of all modalities and other organizations is essential. Community stakeholders can play an active role in promoting treatment services and other critical supports (e.g. job opportunities for people in recovery, education, resources), along a continuum of care both for treatment and prevention (Jacka et al., 2014; United Nations Office on Drugs and Crime, 2008a).

➔ Slide 2 – Module 2: The optimal mix for services

The optimal mix for services

Nearly 90 per cent of people who have used drugs DO NOT develop problematic or dependent drug use.

(Remember, according to the UNODC *World Drug Report 2014*, only around 10-12 per cent of illicit drug users went on to develop dependence or become 'problem drug users').

Most people with problematic drug use do not need long term residential treatment. The approach is based on the WHO *Optimal Mix for Mental Health Services*.

This service pyramid shows that hospitals and specialist drug and alcohol clinical services are the most expensive way to provide services to PWUD. However, they are also the kinds of services that are needed by the least number of PWUD – those who have the most severe dependency conditions.

On the other hand, informal services (self-care and community care) are the services that are most often required by PWUD and are also the cheapest services to set up and deliver. However, many countries often establish the most expensive and intensive institutionally–focused kind of services.

☞ The essence of the community-based treatment model is to ensure that the intensity of care provided matches the severity and complexity of the problems experienced by the individual drug user.

➔ Slide 3 – 12 principles of community-based treatment

Twelve principles of community-based treatment

🗎 Ask the participants to refer to their *Handout – Discussion of 12 principles of community-based treatment and the principles of harm reduction*.

Ask for volunteers to read the 12 principles and the following quote from the International Harm Reduction Association. You may want to share the reading among different participants.

Ask the participants how this might apply to community-based treatment and care providers and:

- note any points they raise that are not covered in the following information;
- refer back to those participants' points when they are relevant as you work through your presentation of the 12 principles.

Handout – Twelve principles of community-based treatment and harm reduction

1. Continuum of care from outreach, basic support and harm reduction to social reintegration, with no "wrong door" for entry into the system.
2. Delivery of services in the community – as close as possible to where drug users live.
3. Minimal disruption of social links and employment.
4. Integrated into existing health and social services.
5. Involve and build on community resources, including families.
6. Participation of people who are affected by drug use and dependence, families and the community-at-large in service planning and delivery.
7. Comprehensive approach, taking into account different needs (health, family, education, employment, and housing).
8. Close collaboration between civil society, law enforcement and the health sector.
9. Provision of evidence-based interventions.
10. Informed and voluntary participation in treatment.
11. Respect for human rights and dignity, including confidentiality.
12. Accept that relapse is part of the treatment process.

Harm reduction practitioners accept people as they are and avoid being judgemental. People who use drugs are always somebody's son or daughter, sister or brother or father or mother. This compassion extends to the families of people with drug problems and their communities. Harm reduction practitioners oppose the deliberate stigmatisation of people who use drugs. Describing people using language such as 'drug abusers', 'a scourge', 'bingers', 'junkies', 'misusers', or a 'social evil' perpetuates stereotypes, marginalises and creates barriers to helping people who use drugs. Terminology and language should always convey respect and tolerance.

Human rights apply to everyone. People who use drugs do not forfeit their human rights, including the right to the highest attainable standard of health, to social services, to work, to benefit from scientific progress, to freedom from arbitrary detention and freedom from cruel inhuman and degrading treatment. Harm reduction opposes the deliberate hurts and harms inflicted on people who use drugs in the name of drug control and drug prevention, and promote responses to drug use that respect and protect fundamental human rights.

(Cook, 2010)

➔ Slide 4 – "No wrong door"

Continuum of care from outreach, basic support and harm reduction to social reintegration, with "no wrong door" for entry into the system

"No wrong door" means that PWUD can enter the service system at any point. For example, they can:

- be assessed in the community and stay in the community, with the help of health or social workers;
- go directly to a health centre or drug treatment clinic;
- go directly to a hospital;
- be referred from one to the other.

➔ Slide 5 – Delivery of services in the community

Delivery of services in the community

- Treatment and care services should be delivered in the community as close as possible to where PWUD live.
- A community-based approach helps to reduce the stigma and discrimination experienced by PWUD.
- A community-based approach helps to 'mainstream' community-based treatment and care. It does not involve sending drug users away somewhere else and out of sight. So the community sees drug services as part of the normal range of health and welfare services and this helps the community to better understand the facts about drug problems.
- Providing services in the community helps to make interventions easier to access and more affordable. This is consistent with the principles contained in the United Nations Committee on Economic Social and Cultural Rights Convention on the Right to the Highest Attainable Standard of Health:
    - Availability. Functioning public health and healthcare facilities, goods and services, as well as programmes, have to be available in sufficient quantity. They must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups.
    - Accessibility. Health facilities, goods and services have to be accessible to everyone without discrimination; they must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact.
    - Economic accessibility (affordability). Health facilities, goods and services must be affordable for all. Payment for healthcare services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses relative to wealthier households.

      (United Nations Committee on Economic Social and Cultural Rights, 2000)

➔ Slide 6 – Minimal disruption of social links

Minimal disruption of social links and employment

When treatment is provided in the community it is less disruptive to the client's life than other treatment options, such as residential or in-patient treatment:

- It is less likely to interrupt the client's connections with their family, work or social life.
- Treatment in the community helps the client to remain self-reliant and maintain their independence.

Community-based treatment and care is integrated within the existing healthcare system (hospitals and clinics) and provides the opportunity to choose the least intrusive and most appropriate type of service for each client. Similar to a 'triage', for example, if a person wants to undertake an uncomplicated drug withdrawal process, even if they have coincidental mild medical or psychiatric conditions, they are unlikely to need hospitalization. However, they could be managed safely, effectively and less expensively in a community residential withdrawal facility, or even a home-based or outpatient withdrawal service.

☞ In some countries, involuntary or compulsory treatment may be recommended or mandated by law through a court order or sentence (law enforcement) as an alternative to prison. Treatment may also be recommended under physical health or mental health provisions where the person's substance use disorder may be considered harmful to themselves or others. Research suggests involuntary or compulsory treatment generally results in poorer treatment outcomes than for voluntary treatment.

In March 2012, twelve UN Agencies issued a joint statement on compulsory drug detention and rehabilitation centres, in which:

> UN entities call on States to close compulsory drug detention and rehabilitation centres and implement voluntary, evidence-informed and rights-based health and social services in the community. (Bergenstrom & Bezziccheri, 2013)

➔ Slide 7 – Integrated into existing services

Integrated into existing health and social services

- People with drug-related problems often have multiple service needs across a range of personal, social and economic areas (medical, vocational, psychological, legal, etc.).
- Drug treatment services should build on and integrate with existing health and social agencies to provide a continuum of care.
- Community-based services offer PWUD help to improve the overall quality of their lives and well-being through social support for rehabilitation and reintegration into the community.

➔ Slide 8 – Involve and build on community resources

Involve and build on community resources, including families

Identify community assets:

- An important first step towards involving and building on community resources is to make an assessment of what resources or assets are available in a particular community. An example of guidance and tools for identifying community assets and resources can be found at http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/identify-community-assets/main

Family inclusive practices:

- Community resources service delivery – develop the skills and attitudes of community-based treatment and care workers to take into consideration both the needs and the value added by engaging families and children within treatment and other services.
- Organization – develop organizational guidelines for family-sensitive policies and practices, culturally appropriate services, processes for interacting with other services, family-sensitive physical environments within services.
- Systems and services –build knowledge and partnerships for community engagement and family-sensitive policies and practices across services and sectors.
- Policy – prioritise community engagement and family-sensitive practices within policies, facilitating structures and resources, across sectors.

(ReGen, 2013)

➔ Slide 9 – Participation of PWUD, families & community

> *"If only those with power ... would listen and incorporate the experience of those who have first-hand knowledge of the reality of the situation on the ground – the results would transform the ideas of leadership and decision-making."*
>
> Mary Robinson, Former UN High Commissioner for Human Rights
>
> (Cook, 2010)

Participation of people who are affected by drug use and dependence, families and the community-at-large in service planning and delivery

Civil society engagement is well recognised for the significant improvements it has made in many areas, particularly in responding to the global HIV pandemic. The involvement of people living with HIV and of non-governmental organizations (NGOs) is included at even the highest levels of governance in some multilateral agencies.

Involving people with local experience from the community, and especially PWUD, in national, provincial and local decision-making about community-based treatment and care is crucial in ensuring that policy, planning and implementation is informed by the evidence, experience and pragmatism that is the essence of community-based responses.

The involvement and participation of people who are affected by drug use, families and the community-at-large in service planning and delivery is also critical to preventing and addressing the stigma, violence, discrimination and human rights violations experienced by PWUD.

Civil society engagement in international processes should not be seen as a token gesture or an empty entitlement. People working at the local level with affected communities are often those best placed to assess the situation on the ground, and to help develop targeted and specific strategies to respond to the issues they face (Cook, 2010; Cook & Kanaef, 2008; Stoicescu, 2012).

Let's take a closer look at raising awareness among women who use drugs

Raising awareness can be an important first step in community involvement. Strategies to raise community awareness among women who use drugs and treatment options can include:

- posting informational material in a variety of locations where women gather;
- holding community forums that provide information and education on the topic.

(United Nations Office on Drugs and Crime, 2004)

➔ Slide 10 – Taking into account different needs

Comprehensive approach that into account different needs (health, family, education, employment, and housing)

Providing services in the community helps to make interventions more available and acceptable to those who require them, including those with special needs. This is consistent with the Convention on the Right to the Highest Attainable Standard of Health:

- Availability – Functioning public health and healthcare facilities, goods and services, as well as programmes, have to be available in sufficient quantity. They must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups.
- Acceptability – All health facilities, goods and services must be respectful of medical ethics and be culturally appropriate (i.e. respectful of the culture of individuals, minorities, peoples and communities), sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned (United Nations Committee on Economic Social and Cultural Rights, 2000).

Let's take a closer look at services that people who use drugs might need

People with drug dependence and other related problems need a wide range of services. Community-based treatment and care may include the following, depending on the needs identified in the community:

- a wide range of coordinated services along a continuum of care (from outreach and detoxification to aftercare);
- assessment and case management;
- psychosocial support such as counselling, motivational interviewing, and cognitive behavioural therapy;
- lifestyle and personal counselling (individual and/or group settings);
- professionally-assisted pharmacological treatment (e.g. withdrawal management, pharmacological treatment of opiate dependence, treatment of co-occurring disorders);
- harm-reduction interventions such as needle and syringe exchange programmes;
- public education and advocacy;
- housing support if needed;
- structured programmes provided through community-based day treatment or evening programmes;
- linkages to sustained recovery management services;
- coordination of non-specialist services to meet clients' needs.

(United Nations Office on Drugs and Crime, 2008a)

➔ Slide 11 – Close collaboration between sectors

Close collaboration between civil society, law enforcement and the health sector

The coordinated active involvement of community-based agencies, government (state, regional and local), religious organizations, cultural groups, community leaders, businesses, drug use treatment centres of all modalities and other organizations is essential. Community-based treatment needs to involve but then also go beyond the local community in order to address the complex variety of needs of drug-dependent people. For instance, service providers need to work with law enforcers and law agencies, including at the national level (United Nations Office on Drugs and Crime, 2008a).

When law enforcement officers, healthcare professionals, drug treatment staff and social welfare workers work in partnership, carry out planning and make decisions collaboratively they can complement each other, share information, identify issues, and collectively protect and promote public health outcomes for key populations, including for PWUD.

Communication is a key ingredient in successful multi-sectoral approaches. Communication can be informal or formal through regular meetings. These informal and formal links help to develop respect and trust between partners and provide a context where problems can be identified and resolved before they get serious enough to require high-level administrative intervention.

➔ Slide 12 – Evidence-based interventions

Provision of evidence-based interventions

Providing and monitoring evidence-based interventions within the community helps to ensure that interventions are effective and meet appropriate quality standards, while doing no harm. This is consistent with the Convention on the Right to the Highest Attainable Standard of Health:

- Quality – As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation (United Nations Committee on Economic Social and Cultural Rights, 2000).

➔ Slide 13 – Informed and voluntary participation in treatment

Informed and voluntary participation in treatment

Brief discussion activity on informed consent

To start the discussion, **read the following statement** to the participants and ask for their responses:

> *"I will first do a complete assessment and then the team will make a plan based on what treatment you need. I don't want you to worry about the details right now; we will take care of you. You can trust me – I am a professional."*

Ask the participants what they think would constitute adequate information for a client to make a decision about engaging with a service or undergoing a treatment.

To qualify as 'informed consent', staff should adequately inform clients of all treatment processes and procedures, develop individual care plans jointly with the client, obtain consent from the client before initiating interventions, and guarantee the option to withdraw from treatment at any time (United Nations Office on Drugs and Crime & World Health Organization, 2008).

Clients' engagement in community-based treatment and care should be informed and voluntary. This is consistent with the Convention on The Right to the Highest Attainable Standard of Health:

> Information accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality. (United Nations Committee on Economic Social and Cultural Rights, 2000)

➔ Slide 14 – Respect for human rights and dignity

Respect for human rights and dignity, including confidentiality

Drug dependence treatment services should comply with human rights obligations and recognize the inherent dignity of all individuals. This includes ensuring that:

- drug and alcohol treatment and rehabilitation services are delivered under a legal framework that guarantees compliance with human rights;
- the privacy of clients is respected – client data are strictly confidential and authorization is requested from the client in writing before their information is used for any purposes other than treatment;
- staff must be properly trained in providing treatment in a way that is respectful, non-stigmatizing and meets the terms of relevant professional and ethical standards;
- medical treatment services are provided whenever required – whether or not the client complies with drug treatment (United Nations Office on Drugs and Crime & World Health Organization, 2008).

Enforcement of criminal prohibitions against drugs often prevents access to health services and to medical treatment. People who use drugs are often those most in need of treatment for infections such as HIV and hepatitis. In some instances, jurisdictions put people on a state registry if they seek healthcare or attend drug-dependence clinics. Drug user registries act as a barrier to healthcare and drug treatment by discouraging people from seeking treatment and permitting or fostering both real and perceived breaches of confidentiality. In some cases, state clinics and doctors routinely share this information with law enforcement agencies.

(International Harm Reduction Association, 2015)

➔ Slide 15 – Accept relapse is a part of the process

Accept that relapse is a part of the treatment process

Drug dependence has often been described as a chronic relapsing condition and has been compared to other disorders, such as Type 2 diabetes mellitus, hypertension, and asthma, which are also chronic conditions often characterised by periods of relapse. While this is debated, it can be a useful way of providing a context for treatment approaches for more problematic forms of drug use (A. T. McLellan, Lewis, O'Brien, & Kleber, 2000).

When clients and workers accept that relapse is part of the treatment process then lapses become opportunities to learn and improve recovery and resilience skills. Relapse should not be used as a reason to exclude an individual from re-accessing treatment services.

Let's take a closer look at the benefits of community-based treatment and care services

Some of the benefits of community-based treatment include the following:

- it is a less invasive approach than other treatments (e.g. residential, hospitalization, intensive treatments, etc.);
- it facilitates clients' access to treatment;
- it is less disruptive to family, working and social life;
- it focuses on social integration from the beginning;
- it is appealing for patients;
- it is more flexible than other modalities of treatment;
- it fosters patient's independence in patients´ natural environment;
- it is affordable for patients, families and the community;
- it educates the community to reduce stigma;
- it focuses on community empowerment.

Bergenstrom, A., & Bezziccheri, S. (2013). *Phasing out drug detention centres in East and South East Asia.*, ID: 653, UNODC Regional Office for Southeast Asia and the Pacific.

Cook, C. (2010). "The global state of harm reduction: Key issues for broadening the response". *The Global State of Harm Reduction*. London: Harm Reduction International.

Cook, C., & Kanaef, N. (2008). "The global state of harm reduction: Mapping the response to drug-related HIV and hepatitis C epidemics". *The Global State of Harm Reduction*. London: Harm Reduction International.

Jacka, D., Lewis, G., Nayton, C., Oppenheimer, E., Szonn, S., Umapornsakula, A., . . . Zargham, A. (2014). *Community Based Treatment and Care for Drug Use and Dependence: Information Brief for Southeast Asia*. Bangkok: United Nations Office on Drugs and Crime.

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). "Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation". *JAMA, 284*(13), 1689-1695.

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UNODC. (2002). *Contemporary Drug Abuse Treatment: A Review of the Evidence Base Drug Abuse Treatment Toolkit.* New York.

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UNODC. (2004). *Substance abuse treatment and care for women: Case studies and lessons learned Drug Abuse Treatment Toolkit.* Vienna: UNODC.

UNODC. (2008a). "Community-based treatment". In M. S. Martindale & M. J. Zarza (Eds.), *Good Practice.* Vienna: Treatnet – International Network of Drug Dependence Treatment and Rehabilitation Resource Centres.

UNODC. (2008b). "Drug Dependence Treatment: Sustained Recovery Management". In M. S. Martindale & M. J. Zarza (Eds.), *Good Practice.* Vienna: Treatnet: International Network of Drug Dependence Treatment and Rehabilitation Resource Centres.

UNODC. (2008c). *Reducing adverse health and social consequences of drug abuse: A comprehensive approach*. Discussion Paper. Vienna.

UNODC. (2014a). *Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in Southeast Asia.* Bangkok: UNODC Regional Office for Southeast Asia and the Pacific.

UNODC. (2014b). *World Drug Report 2014.* Vienna: UNODC.

Topic 2 – The community-based service delivery model

Read pages 10-15 of (United Nations Office on Drugs and Crime, 2014a).

➔ Slide 16 – Components of a community-based approach

The three major components of the model are:

1. Community organizations, including NGOs, help to identify drug users, conduct basic screening of drug problems and refer clients to primary health services as required. Community organizations also focus on preventive education and health promotion, and on the delivery of basic support, reintegration and rehabilitation services.
2. Primary health services are provided at health centres and specialist health services are provided by hospitals.
3. Social welfare agencies and NGOs offer education, vocational and skills training, income generation opportunities, etc.

Community-based drug treatment services enable PWUD to have improved access to a range of quality services from information and education on avoiding the harmful health and social consequences of drug use (especially HIV, hepatitis and sexually transmitted infections), to drug counselling, and assistance in reducing or stopping or drug use.

Clients are referred to whichever services are appropriate, based on an initial screening of drug and alcohol problems, and then referred back to the community for support and aftercare. The model includes providing primary health services in the community, and specialist medical services and psychiatric services in district hospitals or specialist clinics.

Paragraph 8 under the UN "right to the highest attainable standard of health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)" states:

The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

 Activity – Facilitated discussion on the right to health

Read the text in the 'text box' above to the training participants.

Then facilitate a brief discussion with them about this statement by asking questions, such as:

- *"In what ways does this article relate to people who use drugs?"*
- *"How could it be incorporated into a community-based treatment and care approach for people who use drugs?"*
- *"How is this implemented in the sector you work in?"*
- *"What improvements could be made to its implementation in your situation?"*
- *"For this to happen, what changes would need to occur or what resources would need to be made available?"*

Note: These are examples and you are free to use them if they are appropriate, or to frame your own questions to suit your particular audience.

Cook, C. (2010). “The global state of harm reduction: Key issues for broadening the response”. *The Global State of Harm Reduction*. London: Harm Reduction International.

Cook, C., & Kanaef, N. (2008). “The global state of harm reduction: Mapping the response to drug-related HIV and hepatitis C epidemics”. *The Global State of Harm Reduction*. London: Harm Reduction International.

Stoicescu, C. (2012). “The global state of harm reduction 2012: Towards an integrated response”. *The Global State of Harm Reduction.* London: Harm Reduction International.

United Nations Committee on Economic Social and Cultural Rights. (2000). General Comment No. 14: The Right to the Highest Attainable Standard of Health United Nations. Geneva.

(United Nations Committee on Economic Social and Cultural Rights, 2000)

http://www.ihra.net/files/2010/06/01/Briefing_What_is_HR_Indonesian.pdf

http://www.ihra.net/files/2010/06/01/Briefing_What_is_HR_Malaysian.pdf

http://www.ihra.net/files/2010/08/10/Briefing_What_is_HR_English.pdf

Topic 3 – Components and roles of a community-based approach

➔ Slide 17 – Specialist alcohol & drug services

Specialist alcohol and drug services

Specialist alcohol and drug services will vary in the level and intensity of care depending upon the severity of the client's drug use and their other physical, psychological and social needs. Generally they comprise the following:

Outpatient withdrawal

This may be an option for clients who have sufficient personal and social resources and who do not present with any serious medical complications. Typically it involves intensive individual consultations with a health professional over a short period of time, along with ongoing counselling and support. This option is particularly good for clients who are still engaged in employment or study and who do not want to disrupt these important activities.

Home-based withdrawal

Usually, this is provided by a team that includes an experienced nurse and a medical practitioner, and a support person such as a family member or friend at home. Home-based withdrawal is provided where the withdrawal is of mild to moderate severity and uncomplicated by other conditions.

Residential withdrawal

Usually this involves a short stay of 5 days to 2 weeks in a community residential drug withdrawal service or hospital for 1-2 weeks. Residential withdrawal is medically supervised and staffed 24 hours per day. Staff assist during withdrawal, and afterwards, to help prevent relapse.

Residential rehabilitation

Usually this is offered to people who have already completed a drug or alcohol withdrawal programme and who would benefit from longer term therapy and care in a supportive residential environment.

Supported accommodation

This is for people who do not have a stable home environment. It helps them achieve lasting change and assists in their re-introduction to the community. Services usually include, as a minimum, a day support worker from a community-based setting, usually within public housing.

Peer support

Mutual support and information is provided by individuals with a personal experience of alcohol and drug use. Peer support groups or activities are usually established by current or past alcohol and drug users.

Let's take a closer look at important 'informal' services for people who use drugs

In addition to the these formal service components the roles of informal care, drug user networks, peers, faith-based organization, families and NGOs often play an important role in providing services for PWUD. In coordination with the public health system, they can offer outreach services, help scale up treatment, provide support in the community and facilitate rehabilitation and reintegration. If possible, services for PWUD should be offered as "one-stop-shop" – providing a range of services at a single location – in order to meet a variety of the clients' health and social needs. Services should be designed to be sensitive to the needs of special sub-populations, such as women (including pregnant women), children and adolescents, and sex workers.

NOTES:_____

Topic 4 – Working together: Partnerships for implementation

➔ Slide 18 – Community-based service model for PWUD

- PWUD often have multiple and complex needs.
- In order to best assist them to stabilise their lives, reintegrate with the community and recover from drug and alcohol-related problems, a system of durable partnerships and integrated service approaches must be developed between:
  - Drug and alcohol treatment services, specialist health services, social welfare, vocational and income-generation programmes, housing services, mental health care providers, correctional services, and others.
- This is particularly important for vulnerable sub-populations, such as young people and women who may need additional community support, including family and child welfare services.

➔ Slide 19 – Planning for community-based treatment

Planning for community-based treatment and care

Groups that are likely to be affected by the development of the system of community-based treatment and care should be consulted and involved in the process. This will help develop local support and advocacy for treatment. A key objective should be the reduction of any local resistance to the development of a drug abuse treatment service in a local area. When planning developments in treatment, it is important to consult with a broad range of individuals and groups in the community.

 **Brief discussion activity – Key stakeholders to consult when planning community-based treatment and care**

Facilitate a discussion about the kinds of stakeholders that should (or could) be consulted when planning developments in treatment and care in the community. Ask one or several participants to list the suggested key stakeholders on a whiteboard or large sheet of paper at the front of the room. Suggestions could include:

- client advocacy and representative groups;
- clients of existing services;
- clinical staff;
- drug users who are not in treatment;
- existing drug use programme managers and administrators;
- government agencies in the areas of health, social welfare and justice;
- healthcare providers and organizations;
- local community organizations;
- official policy-makers and strategic planners;
- parent groups and other concerned community groups;
- representative bodies of professional groups;
- social welfare and community agencies;
- technical advisers (as required).

➔ Slide 20 – Community-based linkages

Service linkages

To be effective, a community-based approach requires formal and informal linkages between:

- prevention and harm-reduction services in the community;
- drug-dependence treatment services;
- hospital services (e.g. emergency rooms, infectious diseases and internal medicine departments);
- mental health services;
- specialised social services such as housing, vocational training and employment.

The tangible components of this are working linkages, referral pathways, partnership agreements between services and so on. The intangible but equally important components involve the development of qualities such as cooperation, mutual respect and straightforward, authentic communication.

➔ Slide 21 – Integrated care pathways

Integrated care pathways

Community care workers, outreach workers, peer educators, residential care workers, and others in 'frontline' positions in the field of drug and alcohol treatment identify, from their continuing assessment, the particular range of services that their clients need. These services might include medical, vocational, child care, mental health, and financial services, housing support and so on.

Identifying appropriate community-based services, learning where they are, knowing what their scope of service is, who and how to contact, what information is required, etc., are important issues for developing effective pathways for client treatment and care. In addition, service managers and supervisors may be actively involved in negotiating, planning and implementing formal arrangements (such as referral pathways, service partnership agreements, or possibly shared assessment protocols) to facilitate a smoother and more integrated process for clients to access the right service at a particular time.

Essentially, an integrated care pathway is a plan that describes the nature and course of treatment for a particular client, and the anticipated outcomes that are expected. The pathway may relate to several treatment components to be delivered by a single agency programme, or it may include a number of services provided by two or more agencies. Integrated care pathways form part of the set of protocols and documents that describe what a treatment programme intends to do, as well as the intended results.

The components of care available in the different levels of treatment should provide for a coordinated care approach, where there are strong linkages between services so that referrals can be made relatively easily. This will ensure that the client gets the services they need when they need them. Appropriate referral mechanisms are required, as well as feedback to the referral source on the outcome of the referral. Integrated care pathways for treating PWUD is recommended for several reasons:

- People with drug problems may have multiple difficulties that require effective coordination of services.
- Several specialist and generic service providers may be involved in order to optimize the treatment and rehabilitation response.

- A person may have continuing care needs that require referrals to different levels of service over time.

Integrated care pathways resemble a detailed flow chart showing how clients move through the treatment programme. Importantly, integrated care pathways can also show how clients can move from one treatment service to another where there is a need for continuing treatment.

For example, an integrated care pathway for a methadone programme might show how clients flow across the following stages:

- intake and methadone dose induction;
- stabilization/maintenance; reduction/withdrawal;
- community aftercare support.

A special feature of integrated care pathways is called 'variance tracking'. Variance tracking involves monitoring departures from the expected course of treatment and examining their causes, thus improving the pathway of care. In this regard, integrated care pathway initiatives are similar to audit activities (United Nations Office on Drugs and Crime, 2003).

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