Psychosocial Support for Clients of Medication Assisted Treatment Guidance

Prepared for

Drug Control and Access to Medications (DCAM) Consortium

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ABBREVIATIONS

AIVL -	Australian Injecting and Illicit Drug Users League
APMG –	AIDS Project Management Group
ART –	Anti-Retroviral Therapy
DCAM -	Drug Control and Access to Medicines
EU –	European Union
HCV –	Hepatitis C Virus
HIV –	Human Immunodeficiency Virus
ICD-10 -	International Classification of Diseases
IDU –	Injecting Drug Use
INCB –	International Narcotics Control Board
L-AO -	Long-Acting Opioids
MAT –	Medication Assisted Treatment
M&E –	Monitoring and Evaluation
NA –	Narcotics Anonymous
NGO –	Non Government Organisation
ORPACS -	(Opioid Replacement Pharmacotherapy Advocacy and Complaints Service, Western Australia
OST -	Opioid Substitution Therapy
PAMS –	Pharmacotherapy Advocacy and Mediation Service, Victoria
PLHA –	People Living With HIV/AIDS
UNODC –	United Nations Office of Drug Control
USA –	United States of America
WHO –	World Health Organization

1. INTRODUCTION

Background

Medication-Assisted Treatment (MAT), using long-acting drugs such as methadone or buprenorphine, is currently the most effective treatment available for heroin dependence. The provision of MAT for opioid dependent injecting drug users (IDU) is also central to efforts to prevent and manage HIV infections in this population. Retention of clients in MAT promotes access to ARV for PLHA clients, and is associated with significant reductions in rates of HIV seroconversion.[1]

MAT is most effective when clients are retained in treatment for an adequate period of time. [2] When clients stay longer in treatment, the opportunities for psycho-social interventions to take effect are also greater, resulting in better treatment outcomes. [3] [4] [5]

The Guidance Document

This guidance manual (coupled with a training guide) will assist MAT planners, clients and clinicians, staff and service volunteers to understand the value, and the basics for implementation, of psychosocial support for MAT clients.

The guidance document was developed in three phases:

1) In phase 1, a literature review was conducted to identify existing materials which address this issue in the scientific and grey literature, and in published or unpublished training guides.

2) Phase 2 included the development of this guidance document which provides a comprehensive guide to implement psychosocial support for MAT clients. In addition to the guidance document itself, a set of global documents were uploaded to the DCAM website http://www.dcamconsortium.net/ for hyperlinking to the online version of the guidance document.

3) Phase 3 included the development of a training manual with slides to assist MAT clinics in training staff in all aspects of setting up psychosocial support programs within MAT and training staff/ volunteers to provide that support.

Who is this guide for?

This guide is designed to provide instructive information to all levels of MAT implementation, from Health Ministry planners, training bodies and MAT consumer groups, to MAT prescribers, dispensers and other clinic or support staff. Although the many individuals on MAT may require varying degrees of psychosocial support, some may also have mental health issues, which require intensive structured psychotherapies that can only be provided by qualified psychiatrists or psychologists. This guide will highlight that these specialized interventions may be required, but does not attempt to provide explanation or guidance on their delivery. The guide presumes that a clinical psychologist is available for managing complex cases.

What are the guiding principles adopted by this guide that underpin psychosocial support for MAT clients?

Guiding principles and approaches of particular relevance to psychosocial support with MAT provision include the upholding of principles of self determination for MAT clients. While psychosocial support has been shown to optimize treatment outcomes, it should be a support that is offered rather than imposed.

Principles outlines by the UN Drug Control Convention, the Declaration on the Guiding Principles of Drug Demand Reduction and UN human rights and health promotion policies highlight that:

- protection of human rights is critical for preventing HIV as people are more vulnerable to infection when their economic, health, social, or cultural rights are not respected.
- flexible, easy-to-access MAT is critical to meeting the needs of heroin dependent people.[6]

People moving into, and out of, custody should be provided with continuity of treatment with MAT including associated psychosocial support services.

This Guide also accepts the principle of consumer involvement to enhance quality outcomes and as an ethical imperative. The human rights of opioid-dependent individuals should always be respected.

2. KEY CONCEPT AREAS.

Why Use Medication-Assisted Treatment (MAT)?

Medication-Assisted Treatment, using long-acting drugs such as methadone or buprenorphine, is currently the most effective treatment available for heroin dependence. Medicines used for dependency therapy, such as methadone and buprenorphine, have sometimes been labeled Opioid Substitution Therapy or OST. It is important to note that 'substitution' has sometimes been misunderstood and that this has contributed to stigma against, and reluctance to provide, such therapy. In fact, heroin and MAT medications have completely different pharmacological properties. Some scientists prefer to use the term Long-Acting Opioids (L-AOs) or simply 'maintenance agents', highlighting the pharmacological differences between L-AO medications and shorter-acting opioids such as heroin.[7] For the purposes of this document, the American terminology of MAT or 'Medication-Assisted Treatment' has been utilised.

Methadone and buprenorphine are the two most commonly used MAT medications for treating heroin dependence. Buprenorphine is at least three times more expensive than methadone, but can be provided in combination with naloxone (under the trade name Suboxone) which precipitates withdrawal if injected and is thought to reduce drug diversion.

There are numerous benefits attributed to MAT, with some easier to quantify in cost benefit terms than others. The clearest data on cost benefit relates to HIV infections averted: there is substantial evidence that methadone maintenance therapy is effective in reducing HIV among IDUs, and it has been estimated that 5-7 HIV infections are averted per 100 methadone patients per year – therefore methadone maintenance therapy is cost effective.[8] (*Buprenorphine is presumed to have similar HIV prevention benefits, however methadone maintenance is the most widely used and researched regime for the treatment of opioid*

dependence). Further, MAT has been shown to very substantially decrease heroin use and criminal activity, while the risk of opioid overdose death is also substantially reduced.[9]

A North American study of the cost-effectiveness of expanding MAT for heroin dependence concluded that additional capacity costs $8,200 per quality adjusted life year gained in a high HIV prevalence community and $10,900 in a low HIV prevalence community. This is more cost-effective than many widely used medical therapies. They concluded that additional capacity remains cost-effective even if it is twice as expensive and half as effective as current MAT places.[10] [11] [12]

Building on this evidence base, the Australian national pharmacotherapy policy states that the objectives of MAT are to: bring to an end or significantly reduce an individual's illicit opioid use; reduce the risk of overdose; reduce the transmission of blood borne diseases; and improve general health and social functioning, including a reduction in crime. "*These objectives are achieved by engaging and retaining people dependent on opioids in treatment* ".[13]

Within one or two weeks of beginning MAT, most heroin users experience reduced craving, and over a period of time decrease or stop their use of heroin. MAT offers physical stability in contrast to the often dramatic highs and lows that are associated with dependent illicit heroin use.

There are a number of reasons why people who are dependent on drugs such as heroin may be motivated to seek methadone or buprenorphine treatment, including:

- to reduce, and ultimately eliminate, illicit drug use;
- to re-establish their lives and become more functional members of their community;
- due to an acute crisis in their lives;
- for added stability to assist in undertaking HIV or hepatitis C (HCV) treatment;
- to eliminate financial, physical and social costs involved with heroin use and related lifestyle; and/or
- as a requirement of the criminal justice system in their jurisdiction, by way of early referral into treatment programmes.[14]

MAT helps to introduce stability and removes the stress associated with needing to obtain heroin. The risk of contracting blood-borne viruses such as HIV, hepatitis B/C and other harms associated with injecting are reduced. Overall, the goal of these treatments is to improve the health, social and economic outcomes for individual drug users, their families and the community. In addition, people receiving MAT report less criminal activity, improved family ties, fewer attempts at suicide, less criminal convictions and assisted adherence to HIV medication.[15]

Predictors of greater retention include pre-treatment factors such as employment, living with a spouse/family, motivation for treatment, and realistic expectations of the treatment process and outcome.[16] There is evidence that both counselling and support services improve client outcomes in MAT maintenance, if they are sought by the client rather than mandated.[17] Ensuring effective referral pathways is also important.[18]

Also of particular significance is the length of time in treatment and the dose. The longer that a person is in treatment, the less likely they are to use heroin and, therefore, the better the outcome. [19] Individuals maintained on adequately high doses that completely block withdrawal symptoms, stay in treatment longer and use less heroin than those individuals on lower doses.

MAT is a long term rather than a short term treatment. While people do eventually cease MAT, if they do so before they are ready, there is a high likelihood that they will relapse to illicit drug use. Evidence suggests that the minimum period for effective methadone treatment is 12 months, but for some people treatment may be life-long. Therefore, remaining on methadone is not seen as an indication of failed treatment.[20]

The use of MAT is supported by the UN system as an essential element in the management of heroin dependence and the prevention of HIV infection among injecting drug users, and MAT medications are listed by the WHO as 'Essential Medicines'.[21] The INCB has pointed out that MAT "... *does not constitute any breach of treaty provisions, whatever substance may be used for such treatment in line with established national sound medical practice."* [22]

Psychosocial support.

There is substantial evidence that MAT is more effective when services, such as counselling, social services, and medical care, are offered along with it.[23] Evidence-based psychosocial support services can not only benefit clients but also lead to the more cost-effective use of healthcare resources. Adding any psychosocial support to MAT significantly improves the non-use of heroin during treatment and individuals are retained longer in programs that offer a high level of social services.[24] [25] [26] However, where MAT providers are unable to provide psychosocial support, or if a client refuses to use psychosocial services, access to MAT for those in need should not be withheld or delayed.[27]

Broadly speaking, psychosocial support is any non-pharmacological intervention carried out in a therapeutic context at an individual, family or group level.[28] A wide range of psychosocial interventions have been applied in conjunction with MAT which include various forms of cognitive behavioural therapy (CBT), motivational interviewing, group therapy and narrative therapy.[29] Assistance and support can be offered to cover a range of issues such as relapse prevention, coping skills, management of emotional wellbeing, problem solving, skills training, assertion skills - all of which cover a range of different life domains, such as housing, personal financial management, skills retraining for employment, and so on.[30]

There are three broad aims underlying the provision of psychosocial support:

- To encourage engagement and continuance with MAT by addressing barriers that may complicate dependency such as social, medical or economic factors.
- To help support lifestyle adjustment by developing skills to cope with factors that could act as a trigger for relapse or to prevent an occasional lapse from becoming regular drug use.[31]
- To develop behavioural interventions that identify and address strategies to reduce risk behaviours associated with drug dependence, including injecting practices and sexual behaviour. As such, behavioural interventions delivered in conjunction with drug treatment are important to the prevention of HIV transmission. [32]

Psychosocial support is also able to identify potential mental health issues that can be a serious barrier to treatment engagement and result in poor treatment outcomes.

The key to successful pharmacotherapy for opioid dependence is the length of time an individual remains on MAT.[33] To achieve this, an individual must have a sufficient level of motivation to engage in the drug treatment and be willing to attempt to limit illicit drug use.[34] It has been shown that programs that offer a high level of voluntary psychosocial services are able to retain individuals in treatment longer.[35] [36] [37] However, regardless of what services are

provided, a key determinant of a successful psychosocial support intervention is more reliant on the skill of the counsellor, in terms of personality factors such as empathy, emotional warmth, and unconditional positive regard rather than the specific form of psychosocial intervention being carried out.[38] [39] [40]

Meaningful client involvement can also serve a psychosocial support function. Where clients have a 'stake' in services provided for them, a greater sense of connectedness and mutual support is fostered. Avenues should be available for individuals to seek mediation and make comments or complaints about the service they attend.

The WHO makes the following recommendations:

- As a minimum standard, psychosocial support should be available to all opioid dependent clients, in association with pharmacological treatments of opioid dependence. At a minimum, this should include assessment of psychosocial needs, supportive counselling and links to existing family and community services.
- In best practice, a variety of structured psychosocial interventions should be available, according to the needs of the clients. Such interventions may include - but are not limited to – different forms of counselling and psychotherapy, and assistance with social needs such as housing, employment, education, welfare and legal problems.
- Onsite psychosocial and psychiatric treatment should be provided for clients with psychiatric comorbidity.[41]

Understanding heroin dependence

A sound understanding of the basics of heroin dependency provides context for appreciating the role of MAT and the resultant improvement in medical management of all opiate dependent individuals, including detainees and prisoners. .

Drug dependency is a complex condition encompassing a broad range of physical, psychological and social aspects. Clinical guidelines for a definite diagnosis of 'dependence' are detailed in the WHO's International Classification of Diseases (or ICD-10), and require that three or more of the following six characteristic features have been experienced or exhibited:

- a strong desire or sense of compulsion to take the substance;
- difficulties in controlling substance-taking behaviour in terms of its onset, termination or levels of use;
- a physiological withdrawal state when substance use has ceased or been reduced, as evidenced by – the characteristic withdrawal syndrome for the substance, or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
- evidence of tolerance, such that increased doses of the substance are required in order to achieve effects originally produced by lower doses;
- progressive neglect of alternative pleasures or interests because of substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects;
- persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive

functioning – efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.[42]

When people use heroin consistently and over time, the central nervous system undergoes chemical changes in an attempt to stabilise the levels of opiates in the body, and stops producing its own opioids (called 'endorphins'). As a result, increasing doses of heroin are required to achieve the same effect (i.e. 'tolerance').

Tolerance is characterised by a need for markedly increased amounts of the substance to achieve intoxication or the desired effect, and a diminished effect with continued use of the same dose. If a dependent person suddenly stops taking heroin, it takes his or her body a few days to return to normal endorphin production levels. In the meantime, with no heroin or endorphins in the body, the person will experience an uncomfortable period known as 'withdrawal'. The degree of discomfort correlates with the degree of dependency or the size and frequency of a person's usual dose.

While many people may successfully overcome the physical withdrawal symptoms associated with the cessation of heroin and opium use, the complex nature of drug dependency means that they may also experience a range of psychological cravings for some time. This is why 'relapse' can be common for many heroin dependent people. Like many other ongoing conditions, for example, diabetes or arthritis, opioid dependence will need long-term treatment. There is no quick fix or instant cure. For most people it will take a number of attempts to reduce or stop heroin use completely.

Guidance points

- *Psychosocial support is any non-pharmacological intervention carried out in a therapeutic context. MAT programs that offer a high level of voluntary psychosocial services are able to retain individuals in treatment longer.*
- *Evidence demonstrates that voluntary psychosocial support with MAT correlates with improved retention in treatment*
- *Drug dependency is a complex condition encompassing a broad range of physical, psychological and social aspects. Like many other ongoing conditions, for example, diabetes or arthritis, opioid dependence will need long-term treatment. There is no quick fix or instant cure. For most people it will take a number of attempts to reduce or stop heroin use completely.*
- *MAT, using long-acting drugs such as methadone or buprenorphine, is currently the most effective treatment available for heroin dependence. The longer that a person is on MAT, the better the outcome. Retention in MAT maintenance is associated with reduced HIV transmission, heroin use, criminal activity and overdose deaths.*
- *Avenues should be available for individuals to seek mediation and make comments or complaints about the service they attend.*

3. PSYCHOSOCIAL SUPPORT SERVICES WORK WITH MAT

Rationale for providing psychosocial support to individuals on MAT

The reasons why an individual may decide to seek treatment for their opiate dependency are varied. For some, a desire to change their lifestyle, family issues, legal issues, health problems, changes in relationships, growing older, financial issues, sick of using or wanting to be abstinent, or simply boredom have prompted them to seek treatment.[43] However, apart from managing the physical dependency, the psychological and habitual nature of their use presents significant issues when commencing and remaining on MAT.

Drug dependence can be seen as a complex, chronic, relapsing condition that is often accompanied by severe health, psychological, economic, legal, and social consequences. A useful analogy can be made with reference to diabetes where the commonality is that both drugs (MAT and insulin) are dangerous when not used appropriately, require knowledge about what biological processes are affected by taking/not taking it and both require significant changes in behaviour to manage the medication. An individual living with diabetes who requires insulin on a daily basis to remain well requires more assistance than just going to a doctor to be monitored and prescribed insulin. To fully understand and take responsibility for their care, the individual also requires ongoing education about what insulin does, what changes must be made in their diet, how to manage situations where maintaining dietary restrictions may be difficult, (for example drinking alcohol at a party), practicing refusal skills when being offered sugary food as well as guidance or support in how to manage the other numerous changes required in their life.

For an individual living with a drug dependency, coming to terms with lifestyle changes can be similarly challenging and they may need a range of support and assistance in managing this significant personal change to be maintained in treatment. Support may be required relating to their health, interpersonal relationships, finance, housing, employment, legal difficulties and so on.[44] Likewise, for some individuals, social stigma and discrimination, or distrust and suspicion from family members, friends and wider networks may increase the possibility of relapse back to dependent drug use, so recognition of these factors and additional supports may be required to assist clients to address these issues if they are to be retained in MAT. [45]

The importance of a comprehensive and holistic assessment of the client's needs and disabilities is essential to ensure that any psychosocial service is appropriately targeted and designed to meet the specific needs of the individual. Quality psychosocial support services that are offered in the first month of treatment have been shown to be more effective in maintaining clients on MAT for a year or more than services that are offered later.[46]

According to the WHO, there should be a variety of psychosocial interventions available, such as different forms of counselling and psychotherapy, and assistance with social needs such as housing, employment, education, welfare and legal problems.[47] MAT service staff and counsellors should be able to assist clients through referral or in-house assistance in getting other support, such as help with finances, legal problems, domestic violence, accommodation, health concerns, childcare and employment are other services. Likewise mechanisms that allow clients to seek mediation or make comments or complaints about the service offered should also be present.

Forms of psychosocial support services and interventions:

Trained Counsellors

Counselling is a formal process where the counsellor and client work together to identify goals and develop a treatment plan. Sessions may focus on relapse prevention to identify risk situations where relapse is likely, and identify strategies to address these situations. Drug refusal skills may also be developed. Counselling also assists in learning new skills to cope differently with problems or to assist in understanding how the issue may be resolved or managed.[48]

There are different forms of counselling, and drug and alcohol counsellors and agencies will work in different ways to deliver counselling services. However, the development of a therapeutic relationship between the client and therapist should be seen as paramount. It is important that clients can find a counsellor they feel they can trust and with whom they are able to have an open and supportive relationship. Research shows that counselling works best when the counsellor is understanding, supportive and helps clients find their own solutions.

Effective counsellors must be able to demonstrate empathy, emotional warmth, and unconditional positive regard.[49] Consideration should also be given to the match between the client and the counselor, in terms of gender, age, using history, sexuality, cultural and ethnic background.[50]

It is important to note that counselling on its own is unlikely to be enough to change dependent heroin use. However, evidence does show that counselling and support services as a part of MAT treatment has better outcomes. [51]

It should be stressed that counselling should be offered on a voluntary and case by case basis. While some clients may find counselling helpful, stable patients without major life problems may not require this intervention.[52] Further, there is a limit to the benefits of counseling, where too-frequent sessions can produce counter-productive results with a negative impact on retention in treatment.[53]

Various forms of CBT and motivational interviewing approaches have been recommended.[54] [55] However, CBT should only be administered by trained clinical psychologists. Although it has been shown that intensive psychotherapy, such as CBT may produce better outcomes for particular groups of people on reducing illicit drug use and improving psychosocial functioning, [56] [57] [58] it should be recalled that successful psychosocial support is more reliant on the skill of the counsellor, rather than the specific form of psychosocial intervention being carried out.[59]

Ways in which psychosocial support can be offered are varied and contingent on the local setting and budget limitations. According to the WHO, there should be a variety of psychosocial interventions available, including different forms of counselling and psychotherapy. However, even where the range of psychology services are not available, workers trained in 'helping/supporting skills' and who are able to form empathetic relationships with clients can go a long way towards meeting some of the needs of the majority.

Peer Counsellors

Peers are well accepted by other peers within the drug-using community. Peer programmes including peer education and peer group work can be helpful in building strong (trusted,

credible and empathetic) relationships with other individuals on MAT. Peers are able to discuss issues such as harm reduction and relapse prevention strategies, or dealing with family members, and the community and also living with HIV (especially if the peer counsellor is also HIV-positive). [60]

Individuals with good interpersonal skills, who are interested in health-related learning, can be trained to provide support, information and education to their counterparts. Peer counsellors are not nurses or doctors and cannot be expected to know everything. Peer counsellors are not able to provide treatment. However, peers can be trained to assess clients for underlying conditions, such as homelessness or co-morbid mental health issues. All MAT service peer workers should be trained in referring clients to appropriate services when required. [61]

Peer Based Initiatives

Involvement of methadone clients in provision of psycho-social support interventions (including through employment of peer workers, training and employment of peer counsellors and establishment of peer support mechanisms) is also supported in the literature.[62] [63] Peer-based interventions together with MAT may reinforce client support networks which can be important determinants of adherence to treatment.[64] For example, establishing a mentoring ("buddy") system for new clients, using volunteer mentors who have been on the program for a period of time.

Self Help Groups

These groups are voluntary, run by peers, generally small and meet regularly. Clients may find that self-help groups provide emotional support and facilitated discussion can highlight the similarities in problems faced by clients. Although there is little evidence that self-help groups such as Narcotics or Methadone Anonymous are effective in reducing drug use, they are inexpensive and simple to provide. Appropriately trained peer educators may facilitate a self-help group as part of their role. [65] [66]

Family support group:

Family and friends are an important source of support for clients in treatment and, with the clients consent, it can be useful to involve family members and significant others in the client's treatment. Assisting parents and significant others in understanding the client's behaviour change and treatment process allows them to better support the client. Regardless of treatment modality, people do better with good social supports.[67]

Family support groups are beneficial in allowing family members to learn from others in similar situations. During family support group meetings, difficulties faced by parents and other family members can be addressed by learning from others who may have gone through the same experience.

Vocational training and job placement

This intervention includes a range of programmes to help clients to prepare for and secure employment.[68] [69]

Housing

Assistance with housing may be necessary if the client is to be retained in MAT. While there may be risks in accommodating drug users together in institutional settings, stable accommodation in a (illicit) drug free environment is desirable. The strategies adopted will depend on local resources and norms. Housing services can vary from group accommodation for the homeless to more stable, affordable, long-term accommodation.[70]

Activities

The ability of clients to participate in and enjoy leisure activities of their choice is an important aspect of psychosocial support. Programmes can provide access to a range of healthy leisure activities.[71]

Social skills training

Social skills training promotes the acquisition, generalization and durability of skills that are needed in social and interpersonal situations. Training should take place in the context of real everyday life experiences, not in closed, unrealistic settings.[72]

Referral Services

According to the WHO, there should be a variety of psychosocial interventions available as well as assistance with social needs such as housing, employment, education, welfare and legal problems. When psychosocial services are not available, clients should be referred for help with finances, legal problems, domestic violence, accommodation, health concerns, childcare and employment.

Brief Intervention

A Brief Intervention is a quick interaction aimed to arrest a problem or to prevent a problem from developing. In the context of MAT, this intervention might focus on, for example, the risk of overdose when taking MAT and alcohol, or the need for safer sex with partners or other sexual partners. Typically a brief intervention involves a short counseling and education session, but can be less formal and opportunistic depending on the person, the setting, whether the person is open to change, and whether the intervention is building on previous progress. A brief intervention can cover any topic of relevance and importance to the client, and is best done in the context of a strong, respectful professional relationship.

Solution Focused Brief Intervention (SFBI)

Solution Focused Brief Intervention is relatively easy to learn in order to provide basic psychosocial support in the short term. The key feature of SFBI is that it focuses on identifying solutions to the clients immediate needs, rather than on the cause of a particular problem. It is useful in situations where it is unlikely the client will attend a full course of counseling sessions.

Mediation, advocacy and complaint mechanisms

Some jurisdictions have provision for mediation, advocacy and/or complaint mechanisms for MAT clients. Avenues for consumer interaction with their services can be considered part of n holistic spectrum of psycho-social services for MAT clients. These mechanisms vary from client satisfaction surveys and suggestion boxes, through to more formal and engaging mechanisms for processing complaints or suggestions. Many of these services are run by MAT clinics themselves or through a government health authority. In some cases the service is managed by a peer organization (*see section 4 on consumer participation*).

Delivery of psychosocial services

It is beyond the scope of this guidance tool to specify how the range of psychosocial services should be implemented. MAT services vary in terms of resources and capacity. Ideally a 'one stop shop' approach is preferred, where basic training, supervision and services addressing housing, basic medical care and client education, are provided in–house. MAT services operating in resource constrained environments are more likely to need to outsource different aspects of psychosocial support services.

The English framework for psychosocial service delivery

In England, under the National Health Service, the National Treatment Agency for Substance Misuse (NTA) aims to promote evidence-based and coordinated practice, by disseminating best practice. The NTA also aims to improve performance by developing standards for treatment, promoting user involvement, and developing the drug treatment workforce. The NTA's framework for psychosocial interventions is applicable to England's relatively resource intensive efforts to provide evidence based psychosocial support services.

The psychosocial support framework sets out key 'low and high-intensity' interventions that are intended to provide a 'stepped approach' to care with the expectation that the least intrusive, most effective intervention should be provided first. The framework describes key competences for each intervention, advice on the practical measures needed to deliver the interventions, and guidelines to ensure quality training and supervision. [73]

Low-intensity interventions

These interventions are particularly suited to engaging service users in treatment and supporting early changes in drug using behaviour as well as achieving harm reduction goals. Low-intensity interventions can be delivered by both mental health professionals and staff such as case managers or graduate workers if trained and adequately supervised. Persons delivering these interventions act more as a facilitator than a therapist. Typically the intervention would be relatively brief, with an initial assessment followed by three to six further contacts (of around 30 minutes duration).

Examples of low -intensity interventions include:

Motivational interviewing which is a client driven counselling style for supporting behaviour change by helping clients to set and achieve their own goals.

Guided self-help is a self-administered intervention designed to treat anxiety and depression, which makes use of a range of books or a self-help manual. A healthcare professional (or para-professional) facilitates the use of this material by introducing, monitoring and reviewing the outcome of such interventions.

Behavioural activation is one of a group of effective cognitive and behavioural therapies for depression and focuses on encouraging the client to develop more rewarding and task-focused behaviours.

In addition to the training and supervision requirements, additional resource-based elements need to be in place for effective implementation of low-intensity interventions. These vary with the nature of the intervention but in all cases fall broadly into three areas:

- Adequate staff time to deliver the intervention
- Adequate resources to support the delivery of the intervention
- Routine outcome measurement.

High-intensity interventions

High-intensity interventions are defined as formal psychological therapies delivered by a specialist psychological therapist. High-intensity interventions are of longer duration (up to 20 sessions, around 60 minutes each) and are delivered by qualified mental health professionals. Training for high-intensity interventions is beyond the scope of this framework.

For example, Behavioural couples therapy is a behavioural couples-based high-intensity intervention that focuses on promoting abstinence in the drug-using member of the couple. It involves helping to increase positive behavioural exchanges between partners by encouraging them to engage in shared personal and recreational activities. This intervention can be effective in reducing the use of illicit opiates for individuals receiving MAT who have contact with a family member or carer. This is a relatively low demand intervention and only provided by specialist psychologist therapists.

In all cases it is assumed that there is a care plan which has been agreed to, and implemented in a manner that is flexible and tailored to the needs of the client. It is also a given that all interventions are supported by competent supervision of clinical staff to ensure that the interventions are effectively provided.

Successful use of the framework requires more than the simple dissemination of the framework. Specifically, in order to gain the full benefits, services need knowledgeable and skilled individuals who are competent to deliver:

- Training (or at least monitor its delivery by external agencies)
- Supervision
- Evaluation

Training that is delivered by individuals without proper expertise will lead to poor outcomes in just the same way as inadequately delivered treatment will do. The duration of training and its content will vary according to the knowledge and experience of existing staff. It has been shown that adequate supervision is also needed to consolidate training and maximise the benefit of the investment in time and resources. Quality assurance and audit frameworks need

to be in place along with clear protocols for the delivery of the interventions and the right service structures to support their implementation.[74] [1]

Guidance points

- *A variety of structured psychosocial interventions should be available, according to the needs of the clients.*
- *There is evidence that both counselling and support services improve client outcomes in MAT*
- *Psychosocial support should be available but should not be a compulsory component of MAT*
- *Ensuring good referral pathways and access to counselling and mental health services is important*

4. CONSUMER PARTICIPATION IN TREATMENT SERVICES

The Declaration of Commitment on HIV/AIDS, adopted in 2001 by the United Nations General Assembly Special Session on HIV/AIDS, calls for the greater involvement of people living with HIV and of people from marginalized communities and states that the "full involvement and participation [of these persons] in the design, planning, implementation, and evaluation of programmes is crucial to the development of effective responses to the epidemic" (Article 33).[75]

There are a number of reasons to support meaningful involvement of clients in MAT services including the basic tenant that consumer involvement is a right. The 'client' or 'consumer' is a person or group of persons using products and/or systems for purposes, which are outside his or her trade, business or profession. The consumer is the end user of the products/ systems and is usually the one paying for them and so it is only logical that they have a meaningful stake in the service. Consumers are not homogeneous and have a wide variety of needs and abilities.[76] Consumer involvement in policy making and delivery of medical treatments is central to improving the quality of services. [77]

Meaningful client involvement can also serve a psychosocial support function. Where clients have a 'stake' in services provided for them, a greater sense of connectedness and mutual support is fostered. Client participation can also play an important role in encouraging engagement and continuance with MAT. Research has shown that there are general benefits from involving consumers. These benefits include:

- better needs identification and planning, leading to higher quality services and products;
- better quality assurance;
- broader support for health service activities;
- a greater voice for consumers, leading to a greater sense of influence over health services they use. [78]

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[1] For more information on the NTA framework, visit: www.nta.nhs.uk

Consumer participation in MAT services has the potential to improve the quality and targeting of MAT services; improve the treatment outcomes for drug treatment consumers; and increase drug treatment retention rates.

However, in most of the countries where MAT is provided, consumer participation is not evident or not well developed or documented. Although consumers are one of several stakeholders in drug treatment services, in most jurisdictions they lack policy support and/or mechanisms for involvement. Arnstein developed a hierarchical ladder of participation, which can be instructively applied to client participation in MAT programmes. [79] Among the bottom rungs of Arnstein's participation ladder is "Therapy" which is described as " ... *not to enable people to participate in planning or conducting programs, but to enable power holders to "educate" or "cure" the participants"*[80]. The general level of current consumer participation in MAT in most jurisdictions might be described as below and occasionally just above the "therapy rung".

An Australian Injecting and Illicit Drug Users League (AIVL) overview found that a strong foundation (among service providers and clients) for building increased consumer participation exists in drug treatment services in Australia, but there is a lack of knowledge and understanding about consumer participation and its benefits that lead to fear and uncertainty. Consumers are concerned that they will be 'punished' for involvement and service providers are concerned about the impact on their role. [81]

There is evidence that consumer participation is effective and has positive outcomes in health service delivery, but more work needs to be done on educating and supporting service providers and consumers to explore consumer participation in the context of their service.[82] Apart from individual client involvement in treatment decisions, meaningful client involvement means developing structured mechanisms in which clients can provide input into the development of the service.

AIVL identified a hierarchy of potential client involvement, including:

- participation in treatment and care
- employment of consumers by services as consultants and advocates
- participation in service delivery and evaluation
- participation in policy and planning
- participation in education and training
- participation in staff recruitment. [83] [2]

In the context of psychosocial support in particular, each MAT client must have the right to decide whether or not s/he should receive these services and what the goals of these services should be. The right of drug users to self-determination and to an active role in service provision should be upheld in all aspects of MAT planning and implementation, including in the area of psychosocial support.[84]

[2] An additional, more generalized pyramid of participation can be found in; *Nothing about us: "Nothing About Us Without Us*. Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative. Canadian HIV/AIDS Legal Network. 2005.

Case studies of peer involvement in psychosocial service delivery associated with MAT

A. The Buddy System

APMG designed a peer-based psychosocial intervention package to be implemented across 4 MAT clinics in China which included the following elements in each clinic:

• IEC for potential MAT clients and a range of other stakeholders;

• a family support group

• a mentoring ("buddy") system for new clients, using volunteer mentors

• a job-shared, trained and paid peer worker to assist in group and individual counselling, referral and follow-up.

• group counselling of two types provided monthly: peer-led self-help meetings, and professional group therapy (led by the clinic counsellor)

• individual "counselling" provided at two levels as needed: peer worker applying "helping" skills, with appropriate client-driven referral; and, when more difficult issues are identified, these would be referred to the clinic counsellor for individual counselling.

The intervention package design was informed through a process of in-country consultation (with MAT clients, clinicians and other key informants) together with an English language literature review.

The 'mentor' component of this psychosocial intervention package is highlighted for this case study.

The design paired new clients with a mentor ("buddy") on induction and the mentor's role was to explain all the basic elements of the program to the new client, be available for talks as needed about the logistics of how the clinic works, the rules of the program, and client responsibilities. Client-led referral could be processed or assisted by the mentor, or referred to the peer worker or clinic counsellor as appropriate. With prior client consent, mentors could follow up clients if they did not appear for dosing for more than 2 days.

Peer workers provided solution-focused social support functions, freeing counsellor staff to focus on more complex clients requiring case management or more specialised psychological interventions.

The design trained Peer workers to apply motivational interviewing and reflective listening skills for many of the problems faced by MAT clients, and to provide appropriate client-driven referral. Counselling needs to be client-driven and directed at assisting clients to identify, learn and practice alternative behaviours, until such time as leaving the MAT program to recommence illicit drug use is no longer the only solution. Importantly, peer workers were to be trained to identify signs of underlying psychological problems, such as Post Traumatic Stress Disorder and Borderline Personality Disorder. Peer workers were to refer these clients to clinic counsellors but were also equipped with some strategies on how to manage these clients whilst waiting for referral services. They were also to be trained to facilitate peer-led self-help meetings.

It was proposed that 2-3 clients be selected from each clinic to potentially job share the peer worker role. A job share role is suggested in order to not place too much pressure on any one peer worker and to allow flexibility between the workers according to other imperatives in their

lives (for example, if one of the workers is struggling with relapse issues, time off could be negotiated and other workers rostered in).

The project envisaged the selection criteria for these peers to include:

- A stable MAT client who has more than 6 months experience on the program.
- Accepted by and credible within the peer network. It is important that peer educators are respected by their peers, i.e. are not known for informing police, stealing from or lying to their peers
- A non-judgmental approach
- Awareness of how stigma and marginalization affect the target group
- A commitment to HIV prevention and MAT client support activities
- A capacity for listening to and sharing information with peers.
- Able to balance the peer/professional role.
- Able to negotiate and network with other relevant agencies and organisations. The recruitment process was would include an assessment of the person's ability or potential to work with non-peers (other service providers).

Salary or remuneration for peer workers was expected to be sufficient to acknowledge the importance of the role.

B. Peer based mediation, advocacy and complaint mechanisms

Another means of involvement is the role of consumer complaints mechanisms.[85] As noted earlier, avenues for consumer interaction with their services can be considered part of a holistic spectrum of psycho-social services for MAT clients. However, although consumer involvement is noted as desirable in some MAT policy documents, there is little or no instruction on consumer involvement set out in most jurisdictional policies.[86]

MAT clients have a range of questions about their treatment options, the MAT service and/or the type of medication they are having. In efforts to address these questions, some MAT services provide clients with handbooks, which cover questions about treatment options, MAT treatment, what to expect, rights and responsibilities.[3] Many clients have issues around program guidelines, especially as they apply to take away doses, fees and not understanding their rights. Further, the asymmetry of the doctor-patient relationship means that fear of losing access to treatment impinges on the client's capacity to make a complaint.[87]

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[3] See for example:
http://www.camh.net/Care_Treatment/Resources_clients_families_friends/Methadone_Maintenance_Treatment/mmt_client_hndbk.pdf *OR*
http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/0F77A82112802549CA25717D00052C03/$File/opioid_users.pdf

Peer-run confidential services operating outside the government health system can assist in ameliorating such fears in complaint making and can then also impact on service quality, retention and successful treatment outcomes.[88] Constructive response to client problems positively predicts retention.

An example of a peer based complaint mechanism, is the Pharmacotherapy Advocacy and Mediation Service (PAMS), in Victoria, Australia. PAMS is a well established telephone based advocacy, information, mediation, referral and support service for MAT clients, prescribers and pharmacists. PAMS provide a telephone based service with a free call number which operates state-wide.

As a peer based service, any MAT client who calls the PAMS speaks with a worker who has a past or current experience of being on MAT. This has been very well received by clients who report being grateful that they are talking to somebody who "knows what it is like". In turn, PAMS workers are able to represent the client perspective to service providers. PAMS workers also participate in MAT research, project advisory groups and steering committees.

PAMS workers do not provide medical advice to any client, but operate on the premise that client related issues can potentially be resolved before the problem becomes severe. All calls to the PAMS service are confidential and workers do not speak to a service provider on behalf of a client without permission to do so.

In many cases, information provision can assist to preserve the relationship between the consumer and service provider and assist to maintain treatment continuity. In 2007, the majority of cases were seeking help for a problem relating to dosing fee payments or information on take-away doses. The second most documented outcome was the provision of debriefing and support, usually provided in conjunction with other interventions by the PAMS service such as a referral and/or advocacy.[89]

The Opioid Replacement Pharmacotherapy Advocacy and Complaints Service, (ORPACS) in Western Australia operates similarly to PAMS, with some emphasis on:

- Having an understanding of issues specific to both consumers and providers
- Providing consultation and resources
- Creditability and good working relationships between ORPACS, service providers and other key stakeholders as essential for the success of ORPACS.[90]

Guidance points

- *The basis for client involvement or 'consumer involvement' in MAT programming is rooted in strong ethical considerations and can benefit in quality treatment provision.*
- *MAT programmers should ensure that a range of mechanisms for meaningful client involvement are in place as part of the overall psycho-social support component.*
- *Peer run mediation and other peer based psychosocial support services, geared to support retention in treatment, can provide useful support to MAT clients.*
- *Each MAT client must have the right to decide whether or not s/he should receive psychosocial services and what the goals of these services should be.*

5. NETWORKING, REFERRAL AND PARTNERSHIPS WITH OTHER SERVICES.

Partnerships with and between health and welfare agencies

As stated earlier, drug dependence is a complex, chronic, relapsing condition that may be accompanied by severe health, psychological, economic, legal, and social consequences. Many times, clients will need assistance with social needs such as housing, employment, education, welfare and legal problems.[91] Relapse prevention, coping skills, management of emotional wellbeing, problem solving, skills training and assertion skills are all important facets of psychosocial support.

Ideally a 'one stop shop' approach is preferred, where basic support services addressing housing, basic medical care and client education are provided in–house, but some services may need to be outsourced. Depending on resources and human resources, services such as HIV and HCV care, treatment and support, primary health care, sexually transmitted infections and reproductive health, TB treatment, domestic violence, sexual assault, harm reduction education and equipment, skills retraining for employment, childcare, legal advice, housing, and perhaps professional psychological services for clients with psychiatric co-morbidity may need referral to external agencies.[92] For this reason it is imperative that MAT services are well networked with other agencies that are able to provide these services.

MAT services need to be aware of the allied services operating in their area. Information that needs to be collected includes:

- Types of services offered by particular agencies
- Location and hours of operation
- Exclusionary criteria
- Contact information
- Referral criteria
- Cost

MAT staff should familiarise themselves with available services within their respective localities, be acquainted with the systems and develop referral networks. Clients should be provided with referral options and given some insight as to what the client will experience at each service (where this information is not yet available, MAT staff should seek it from the agency itself and from client feedback).

Referrals should always be client driven and appropriate to client needs. In many cases, people who have been known as drug users or MAT clients can feel excluded from a range of health and other services. Where possible, the referral process should aim to remove access barriers by ensuring the client is aware of any criteria used by the service, trying to choose 'user friendly' services as available, and assisting with securing appointments. Ideally, and if requested by the client, peer workers should be available to accompany clients for initial appointments.

Working partnerships with law enforcement

Law enforcement and health workers need to collaborate in order to ensure the effective delivery of MAT programmes and accompanying psychosocial services. To establish partnerships, law enforcement and the staff of MAT programmes need to create routine communication mechanisms to ensure regular dialogue on emerging challenges and issues. Information that may be useful for law enforcement and the staff of MAT programmes to share can include:

- review of the public health objectives and proven benefits of MAT;
- ground rules regarding information sharing, which comply with the codes of ethics and objectives of both services (i.e. respecting confidentiality);
- specific information about the roles of the staff involved in the MAT programme;
- the location of MAT clinics and dosing sites;
- the hours of operation of MAT services;
- the identification of main contact persons within law enforcement and the MAT programmes.[93] [94] [95]

The development of partnership approaches between community service providers (including MAT clinics) and local level law enforcement agencies can be very effective, in terms of crime reduction, cost-effectiveness and positive public health outcomes.[96] [97]

Drug-related crime continues to present a burden to society, one that punitive 'zero tolerance' enforcement efforts alone have failed to curb. Further, the cost-effectiveness of the use of medications in preventing re-incarceration more than offsets the additional costs of providing medications. Evaluations of the net costs and benefits of drug courts across the US show that drug courts save money compared to simple probation and/or incarceration, primarily due to reductions in arrests, case processing, jail occupancy, and victimisation costs.[98] [99]

Arrest and court referral schemes are effective in moving dependent drug users towards social reintegration. MAT providers can work with law enforcement agencies to put greater emphasis on referral to treatment, rather than on the more resource-intensive process of prosecution and imprisonment.

In developing partnerships between local level law enforcement and the health and welfare sectors, MAT service providers can point to evidence demonstrating that criminal behaviour, particularly for property and drug offences, progressively reduces the longer that an individual remains on MAT, and that offending is often high among those individuals who leave such treatment prematurely.[100]

Continuity of MAT and support services for people in custodial settings.

In principle, the same standard and range of medical care available to the community should be available to detainees and prison inmates, whether in custody for a matter of days or years. The WHO recommendations regarding MAT in prisons calls upon authorities in countries where MAT is available in the community to urgently introduce MAT programmes within prisons, and to expand implementation to scale as soon as possible. "Particular efforts should be undertaken to ensure that prisoners on MAT prior to imprisonment are able to continue this treatment upon imprisonment, without interruption."[101] Similarly, where possible, psychosocial supports

associated with MAT provision in the community should be adapted and provided for custodial contexts.[102]

Guidance points

- *Networking, coalition forming and referral are a critical component in providing comprehensive psychosocial support.*
- *Law enforcement plays a vital role in ensuring improved access to MAT and associated psychosocial services through developing partnerships with community health providers, the balanced application of police discretion, and a range of formal and informal diversion methods.*
- *MAT services should be encouraged to work with law enforcement agencies to put greater emphasis on referral to MAT where appropriate.*
- *Particular efforts should be undertaken to ensure that prisoners on MAT prior to imprisonment are able to continue this treatment (with, where possible, appropriate accompanying psychosocial support services) upon imprisonment.*

6. DCAM WEBSITE

Those who wish to understand more about improving access to medical opioids are invited to visit the Drug Control and Access to Medicines (DCAM) Consortium website: http://www.dcamconsortium.net/

The DCAM Consortium has organized an International Coordinating Committee, bringing together a global group of representatives from palliative care, drug dependency treatment, global health, global drug policy, and other organizations to work together to accelerate policy change. The DCAM website is designed to assist all organizations and individuals interested in accelerating policy change to access the data and guidance materials they need.

The DCAM Consortium website provides a short statement on the problem (with a map of global opioid consumption) and the DCAM global and national level solutions, involving a systematic programme of assessment, planning, coordination, and intervention implementation.

The website presents the DCAM *Compendium of INCB Statements on Access to Medicines*, bringing together INCB statements on a range of specific issues related to the need for medical and scientific access to medical opioids and MAT.

A range of resources with direct links is detailed within the DCAM website. These resources are searchable by keyword and by country.

In recognition of World Hospice and Palliative Care Day (http://www.worldday.org/) the Pain & Policy Studies Group (PPSG) is pleased to announce the launch of a new website from the Drug Control and Access to Medicines (DCAM) Consortium. The DCAM Consortium is an international collaboration of experts on drug control regulation, drug treatment, HIV, and pain and palliative care. The participating institutions include:

- The Center for Health Law, Policy and Practice at Temple University Beasley School of Law
- AIDS Projects Management Group, and
- The Pain and Policy Studies Group, University of Wisconsin

The Consortium has been funded by the U.K. Department for International Development to support and contribute to efforts by a range of stakeholders to reduce policy-related barriers that prevent patients from receiving controlled medicines for pain and drug dependency.

The Consortium has a website whose central purpose is to assist all organizations and individuals interested in accelerating access to medicines policy change by providing the guidance materials and data they need. A The DCAM website contains interactive features for exploring opioid consumption data and generating hypotheses about patterns of opioid consumption.

Interactive opioid consumption maps:

- This feature displays opioid consumption data on a global map, with each country color coded by level of consumption
- Allows users to select which drug (codeine, fentanyl, hydromorphone, methadone, morphine, oxycodone, pethidine and morphine equivalence) and year (1964 – 2008) to display
- Provides an immediate visual image of the variation in consumption of opioids across the world

Interactive graphs for exploring opioid consumption trends:

- This feature allows users to explore relationships over time between opioid consumption and other country characteristics, such as Gross Domestic Product or Human Development Index.
- There are several dimensions of these charts that users can make use of to explore these relationships:
    - **X + Y Axes**: Users can select indicators using the drop-down boxes along the chart axes.
    - **Time:** Click the play button to see how the relationship changes over time.
    - **Country:** Select a specific country in the list on the right to highlight its changes
    - **Colors**: Select a different indicator for the colors – currently the colors represent which WHO region each country is from
    - **Size of Bubbles**: Users can change what the size of the bubble represents, currently it represents the size of a countries population relative to one another

Collection of Resources

The Consortium consulted with and collected resources from experts in the fields of pain management / palliative care and HIV/AIDS / Medication Assisted Therapy (MAT) to find examples of best policy and guidance documents for each field. These resources are available

on the new site in a searchable database. DCAM's aim is that this website is the beginning of an ever-expanding central repository for global information on access to opioid medications for pain management and MAT to serve as an information hub for advocates around the world.

9. ANNEXES

Key documents:

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