NIDA International Forum – June 23, 2021 (Day 2)

STEVE GUST: Good morning, everyone. On behalf of the NIDA International Program I'd very much like to welcome you to today's session and to the overall CPPD meeting. I have a very short role here because I know there is a very full agenda, and we are on a fairly tight schedule as we have been generously afforded this time before the main CPPD meeting and as part of that we've agreed that we will try our best to end our meetings Tuesday, Wednesday, and Thursday on time so that it doesn't interfere with the meeting.

Having said that, let me introduce you to the overall chair for today's session, which I think is going to be very interesting and very important. You all know Anja. Anja Busse is a program officer at the Prevention, Treatment, and Rehabilitation section at UNODC's Drug Prevention and Health Branch. NIDA has been very, very much interested in being as much of a partner as we could be in the development of the standards which I think we can all agree is critical and essential as we move forward in addressing the health problems to substance misuse around the world. Having said that, I will turn it over to Anja. Thank you again all for coming and participating.

ANJA BUSSE: Thank you very much, Steve. Really, thanks so much for NIDA and CPPD in this case for hosting us, for having us, for giving us this platform to present today on the international standards for the treatment of drug use disorders. I would like to give the floor first to Giovanna Campello. She is the Chief of the Prevention, Treatment, Rehabilitation Section of the United Nations Office on Drugs and Crime in Vienna, and she will give us some opening words.

GIOVANNA CAMPELLO: Thank you, Anja. Thank you, Steve. Thank you NIDA International and CPPD for having us. It is my great honor to welcome you at the UNODC/WHO Symposium on the International Standards for the Treatment of Drug Use Disorders. And my WHO colleague Dr. Vladimir Poznyak, the head of the Alcohol, Drugs and Addictive Behavior team in WHO cannot be here with us today, unfortunately, but sent his best regards, wishing all an interesting event, and it's a great honor for me to speak on behalf of both of us.

Let me start by extending our gratitude to all of you for participating and thus signaling your interest in science and human rights-based treatment of drug abuse disorders. Let me also thank NIDA International Forum for generously hosting the event and continuously providing a platform for collaboration and exchange of research from all around the world. We use the platform a lot and we hope to continue to do some for a long, long time.

UNODC and WHO are also very grateful to the government of the United States of American for supporting the development of the International Standards for the Treatment of Drug Use Disorders, and Dr. Andrew Thompson, Narcotics Science Advisor at the Bureau of International Narcotics Enforcement Affairs of the US Department of State—a mouthful—a great friend and colleague from INL is here with us today. The International Standards for the Treatment of Drug Use Disorders are a very good example of how by working collaboratively in the framework of the UNODC/WHO program on Drug Dependence, Treatment and Care, for almost 12 years now, WHO and UNODC have demonstrated the capacity to develop technical guidance that is of direct relevance to UN member states, cities, society and people with drug use disorders all around the world. With the complementary mandates of UNODC and WHO, we continue to bring together relevant stakeholders across sectors to address drug

use disorder and its negative health and social consequences in a comprehensive and interconnected way.

Now this week is a special week. It leads up to the 26th of June with the official name of International Day Against Drug Abuse and Illicit Trafficking, or in short sometimes called the World Drug Day. Now this year's motto is "Share Facts and Save Lives" and I invite you all on Friday—actually tomorrow—at the launch of the UNODC World Drug Report. And I believe Share Facts and Save Lives is a motto that also unites the drug use disorder research community and service providers as we are working together to translate science into practice to ensure evidence-based drug use disorder treatment service provision in the framework of quality drug treatment systems that are committed to ensure accessibility and quality of person-centered care and thus save lives.

Share Fact and Save Lives could also have been a guiding vision for the UNODC/WHO International Standards for the Treatment of Drug Use Disorders that we present to you today. All of the speakers in this event were either part of the development, the field testing, or the implementation of the International Standards. I hope all of you listening today are as excited as me to hear from them in this truly international panel. Steve was just mentioning how we have at least 11 time zones represented on the panel today, and I also hope that the symposium will fill you with motivation and enthusiasm to take our message out to your communities and to continue to work hand in hand with UNODC and WHO to ensure qualified and effective responses to drug use disorders, promoting the human rights and the dignity of people with drug use disorders, their families, and their communities.

Let me say that this is especially important in the challenging time like this when we are all going through a global pandemic. Our Secretary General of the United Nations has said that we are only as strong as the weakest in our society, and people with drug use disorder face increased risk of COVID-19-related morbidity and mortality. In this regard, let us all join forces to promote the prioritization of people with drug use disorder in the COVID-19 vaccination schemes whenever and wherever we can.

Improving coverage of substance use disorder treatment is an agreed global development priority outlined in the United Nations Sustainable Development Goal, specifically in Target 3.5. And the implementation of the Standards will help us reach this goal.

In conclusion, I'm very happy to be here today, and on behalf of UNODC Prevention, Treatment and Rehabilitation Section, on behalf of my colleagues in the World Health Organization, I wish you all an inspiring and fruitful event. Thank you so much.

BUSSE: Thank you so very much, Giovanna. And now I would like to give the floor to Dr. Andrew Thompson, who has already been mentioned, from the US State Department. He's the Science Advisor at the Bureau of International Narcotics and Law Enforcement, INL, to also give us some opening remarks, and for a very good reason as Andrew is going to tell us in just a second. Andrew, the floor is yours.

ANDREW THOMPSON: Thank you so much, Anja, and thanks, everyone, for joining us this morning, afternoon, evening, whatever the case may be. Before we dive into the session, I just want to take a minute to talk about why I'm incredibly proud of the projects that you're about to hear about and why I see them as some of the most important things that I've had the privilege to work on in my time with INL.

When we go around the world, one of the most pernicious challenges that we face in the area of substance use prevention, treatment, and recovery support is the stigma that is placed on people who use drugs and people who suffer from substance use disorders. The stigma is seldom something that's outright said; more often, it appears as an implication or an attitude—an attitude that people who are suffering from substance use disorders are somehow responsible for their own suffering, that they aren't deserving of quality care, or that the resources that are being spent on their treatment would be better spent elsewhere.

The UNODC and WHO International Standards begin from a radically different point of view. It's the idea that individuals with drug use disorders deserve nothing less than ethical and science-based standards of care, similar to the standards used in the treatment of other chronic diseases. Yesterday if you were able to attend this forum you heard a little bit about some of the challenges that can arise when training is not backed up or followed up by adequate technical assistance that ensures that whatever principles and practices were conferred during training are appropriately implemented and that without this follow-up we risk backsliding, we risk the implementation of practices that are not effective, and as a consequence, people in governments may lose confidence in treatment and recovery as a viable response to the world drug problem.

So in my view, the International Standards and the quality-assurance mechanisms that are being developed from them, as well as the work of UNODC and the World Health Organization that we're going to hear about today, are an important vehicle for that critical follow-up work. By defining the standards of quality care and taking the time to build treatment systems based on scientific evidence around the world, we're pushing back against the stigma, and more importantly, we're sending an affirmative message that the lives of people with substance use disorder are worth saving. So I just really want to emphasize that that's what I see as the critical value of these projects, but that's enough from me and I'll turn it back to you, Anja, so that we can get on with this and hear from the true experts on the call. Thanks.

BUSSE: Thank you so very much for these opening words and the remarks. It is as much appreciated as much as the support and leadership that we've had from the US State Department and the backup to develop all these end products. If I may ask Christina to start bringing up the first slides, and while we do that let me also say for those that are attending the site event, if you want to have questions or comments, at the bottom of the screen there is a Q&A function, and we would like to ask you to use this Q&A function rather than the chat and we'll try to respond during the session there.

That being said, I'll give the floor to myself to give you a quick background to the development of the UNODC/WHO International Standards for the Treatment of Drug Use Disorders that we are presenting today.

As you know, and the new data will be launched tomorrow as Giovanna said, the world situation with regard to drug use and drug dependence looks at we have roughly 5.4%, 5.5% seems to be the new data of the global population between 15 to 64 who have used at least once an internationally controlled substance in the past year. And of those, over 35 million people are suffering from drug use disorders that would need treatment, but the access to treatment is very, very limited, with only 1 in 8 people having access to treatment, and that still doesn't say anything about the quality.

As Andrew already mentioned, quality of treatment for drug used disorders is often low. It's often well intentioned, but if it doesn't follow scientific evidence, even then it can be ineffective or harmful, so it also would surely not be a good investment of public resources. And also drug treatment systems are also often not designed in line with public health principles. Another reason, really, also to do and develop the Treatment Standards was that there was a need to stop human rights abuses that are committed in the name and the wrong use of the name drug treatment, and what we want to see, of course, is drug treatment that shows symptom reduction, that shows bio psychosocial improvements in individual wellbeing and decreases the risk of negative health and social consequences.

The International Drug Control Conventions asked that all parties, all member states to the UN that have signed the Conventions should take all practical measures for the prevention and treatment for people that suffer from such disorders.

And this lack of quality assurance and standards has also been recognized by the Commission on Narcotic Drugs that asked in 2009 for the development and adoption of appropriate healthcare standards for the area of demand reduction, so for prevention and treatment of drug use disorders.

In the same year, in 2009, UNODC and WHO launched our joint Programme on Drug Dependence Treatment and Care, through which we have been implementing now for nearly 12 years on global, regional, and national level support to member states in improving their responses to drug treatment. In 2016, as an outcome of this joint collaboration, we published and launched for the first time the International Standards for the Treatment of Drug Use Disorders as a draft for peer testing.

This document was immediately recognized at the international policy level and the Commission on Narcotic Drugs passed a resolution encouraging member states to use these standards and for UNODC and WHO to disseminate the standards and support countries in their implementation.

And even at a higher level in international policy making the General Assembly that met for a special session in 2016 also had the standards available and the General Assembly asked for their promotion and implementation.

I also just wanted to add that for a scientific community like the one we are meeting today it's of course very clear that drug use disorders are bio psychosocial health disorders, but I think we should also not underestimate the importance that again the General Assembly in the same outcome document also recognized drug dependence as a complex, multifactorial health disorder.

And as hopefully all of you also know, prevention and treatment are also very much a part of the international development agenda agreed in the sustainable development goals.

Coming back to the Standards that now we're in the years between 2016 and 2020 really had strong scientific and strong policy backup and the field testing of the standards took place in a number of countries, and we will hear from two examples today.

With that, I'm closing my introductory presentations and invite you, of course, to after the session have a look at the Standards that are there to assist member state countries in the development, extension, improvement, quality assurance of both drug treatment services and systems, so they have a service- and system-level component.

And with that, thank you very much for your attention, and we are now going to watch a video from our colleague, Dr. Dzmitry Krupchanka from WHO, who gives you more details about the field testing of the Standards.

DZMITRY KRUPCHANKA: Thank you for the opportunity to present at the NIDA International Forum. And I'm sorry for not being able to make this presentation live because we have in parallel the Forum on Alcohol, Drugs, and Addictive Behaviours going on. But let me take you through the process of developing international standards for the treatment of drug use disorders. As mentioned in previous presentation, it was done within the framework of joint WHO and UNODC program on drug dependence, treatment and care. The document aims to support and guide member states in development and expansion of treatment services for drug use disorders. It would be evidence-based, effective, and ethical.

And we went through quite a long and comprehensive process of the document development, The work started in 2015, when groups of international experts came together, built a skeleton and key elements of the document, then we integrated available WHO and UNODC publications into it. Also looked into additional literature available in the field. Then we also included all available WHO guidelines, recommendations for example, opioid agonist treatment, the community management of overdose, management of mental health conditions, etc.

But then, of course, we realized it's important for documents of this type which is built for global audience that it's not just developed by experts but the countries have a chance to contribute, and countries tried to use it in their settings to ensure the utility and appropriateness of the document. Therefore, after developing the initial draft we initiated the process of field testing.

But then even the initial draft of the document was very well received by the international community. It was mentioned in several high-level resolutions such as the one you see here, the CND Resolution 2016, but what's even more important, it was highlighted and recommended within the U.N General Assembly Special Session on the World Drug Problem, where Standards are recommended for implementation in countries.

Then, as I said, the field testing process was done in nine countries with different health system structures, with different levels of economic development and from different regions, and basically within the field testing we wanted to ensure that the standards are applicable and they have utility and feasibility for implementation in a variety of settings.

A lot of work has been done for the two years when the field testing was implemented. As you see on this slide, more than 1,000 participants provided opinions in the survey and there were more than 40 expert reviews, 300 participants in focus group discussions, and also more than 40 site visits done within the field testing.

I will try to present you results in two slides. Here you see the four dimensions across which the Standards were overlaid. For example, on the utility, if participants in surveys and focus groups think that this is useful, then you see the green bar suggesting that the majority of participants find the document useful, appropriate, comprehensive, and more questionable feasibility where maybe more than 1/3 of the participants in field testing conceded that there are issues related to how to make their system align with the relatively high requirements highlighted in the standards.

And the, of course, there are a range of areas (I don't have time to show you details) but just in this cloud major words associated with the bottlenecks for Standards implementation you see a couple of words like resources, training, systems might be not developed enough, that there might be a lack of professionals and lack of knowledge in the professionals, etc. The range of barriers taken into consideration.

And then also we used this comprehensive material collected during field testing to update the document. And I should say that this update was quite significant. The document was restructured, many new elements added. For example, new subchapter on comorbidities was included. Then many language editing, trying to make language more friendly, more correct, and also expanded interventions in some places, so it's quite a remarkable change.

And the current updated document has five chapters, and I think three chapters play an essential role such as the key principles and standards, the description of treatment systems, and also going into details for a variety of treatment settings such as inpatient, outpatient, outreach, rehabilitation, recovery management. And also key interventions including pharmacological, psychosocial. And then also as I said before, a section on comorbidity of drug use disorders with mental and physical health conditions. And of course, a chapter on the adaptation of the Standards to a population with special needs.

So now when we have this beautiful document in hand, we are very hopeful that countries will be interested to take it and to try to update and reform their systems and to improve access and quality of treatment provided to people with drug use disorders. And with this I think that next speakers will provide more details on country-level perspectives. Thank you for your attention and I hope to see you in future.

BUSSE: Thank you very much, and we will now bring the slides up again. The field testing took place in nine countries, and we have examples and three presenters from two of the countries who will share with us about the field testing experience at national level. And it's my pleasure to give first the floor to Dr. Eva Suriyani and Dr. Kristiana Siste. Dr. Eva Suriyani will present as a psychiatrist at the School of Medicine and Health Science at Atma Jaya University in Indonesia. The floor is yours.

EVA SURIYANI: Thank you, Anja. Good morning, good afternoon, evening, colleagues. I would like to thank WHO, UNODC and NIDA also CPDD for giving Indonesia the opportunity to present the result of the field testing that we conducted from January to May 2018. I would like to give all of you a brief outline of my presentation. I will explain field testing that we tested at Atma Jaya University and University of Indonesia Field Testing Center.

For the Key Informant Survey we got 115 respondents with 70 clinicians and 45 other relevant professions like administrator, public health, and outreach workers, etc. We found that the Standards useful and comprehensive to facilitate improvement in coverage and quality of treatment of drug use disorders while there are some issues regarding the feasibility and appropriateness. There were many participants concerned about the lack of sustainability funding to run the Standards because our national health insurance still doesn't cover drug use disorders. This situation leads to the unaffordability of the treatment for patients who need it. Health facilities that serve drug use disorders are also inadequate and don't reach remote areas. The lack of human resources that can handle these services ranging from outreach workers to specialists.

There is also doubt about the appropriateness of an individual right to get voluntary intervention and could drop out at any time they want. This is difficult in Indonesia because of the low level of education as well as the unwillingness of patients to take the treatment due to their addictive condition.

Move on to another part of the field testing. Five local expert review feel topics were underrepresented for the Standards. It was about eliminating stigma from beginning for health worker to training from their medical institution and for the community through a drug use curriculum in collaboration with the Ministry of Education. The need for coverage by national health insurance systems for the treatment of drug use disorders that we explain earlier. The need for inclusion of intellectual and developmental disability population, special population. The need for more detailed treatment guides from specific drugs, dose, duration, etc. And the need for good coordination with the criminal justice system.

From the two focus groups we encountered several feasibility issues, especially for the Naloxone take-home program which cannot be implemented in Indonesia, as well as the needle exchange program and condom distribution that are not in line with the culture and norm that exist in Indonesia. Public will see the condom distribution and needle exchange as attracting more patients into it. Screening with biomarker that must be done on a massive scale certainly requires no small amount of money. Withdrawal conditions are limited to certain drugs, so we can add Standard with other substances. The existence of family-oriented therapy also turns out to be quite difficult to do because of the patient refusal to involve their family due to the stigma they get. Extra working hours is quite difficult to implement because of the funding. Government should also closely monitor long-term residential treatment setting and access the program's success.

This leads me to our conclusion that the International Standards for the Treatment of Drug Use Disorders are comprehensive and useful to facilitate improvement in the coverage and quality of treatment for drug use disorders. There is a feasibility and appropriateness issue when applying to the standard Indonesian culture and social systems. So many resources like training, human resources, facilities, financial support, policy support are required to implement this Standard.

In the last slide, we have our collaboration center that helped with our field testing and our team. Thank you so much for listening. Thank you, Anja.

BUSSE: Thank you so very much, Eva, and to the entire team for actually embarking on helping us to field test the International Standards. That's much appreciated, and I think later on we will have a presentation on overdose management. Maybe there is also something that you can take home back to Indonesia. I am also happy to share that on family based treatments in the meanwhile we have jointly done a feasibility study in Indonesia that therefore maybe can help already with addressing some aspects around the feasibility that came out as a challenge in the field testing phase. Thank you so very much.

With that let me move us from Asia to Latin America, where also field testing took place. And I would like to give the floor to Dr. Carlos Ibáñez-Peña, psychiatrist and chief of the addiction unit at the School of Medicine at the Universidad de Chile in Chile. And he will talk about the field testing experience in Chile. Carlos, the floor is yours.

CARLOS IBÁÑEZ-PEÑA: Thank you. Thank you for the opportunity of sharing the results of the field testing of the Standards in Chile. I will use the same structure that Eva has just used for the presentation. It took place in 2018.

The first stage was the Key Informant Survey, an online survey that was answered by 150 professionals, both public health and clinical professionals that work in addiction field. They considered that almost all principles were useful and appropriate and only half think that most of the principles were feasible. Most of the informants think the principles are comprehensive enough. The main barriers that the informants identified were insufficient financial resources and trained professionals.

When we interviewed local experts, in general they think that the document was a good one that broadly addressed the treatment of substance abuse disorders. The emphasis on the respect of human rights of the persons in treatment has good principles and has adequate evidence support. They find that the key principles and standards were exhaustive, suitable, and were clinical utility and can be applied in a strategic way in this cultural context. They think that it will help to improve the quality of services in Chile.

The treatment modality settings that were described are in general precise and well explained. They are viable and of clinical utility. Although the pharmacological treatment focused exclusively on populations of substance use disorder, fortunately in Chile and most of Latin America there is not a big problem with opioids while we have a big issue with alcohol and it is very necessary that this aspect is treated in all guides that work with addiction treatment populations.

Although the special populations chapter is suitable, feasible, and clinically useful, it's not exhaustive enough since it does not include many other important special populations. We mention in that report the necessity of talking about dual disorders and comorbidity. The service delivery system chapter could include the concept of universal health, integrated health service networks and interdisciplinary health teams of PAHO. It looks like too much that it's not communicated enough with other health necessities. It's like the parallel networks of treatment systems, either health, physical and mental health not addiction and the addiction system. It's more necessary to explicitly include the coordination, we think, at the system level.

The last part of the field testing I'm going to present is the focus group. We had three focus groups with 17 participants. They find that the modalities and settings described are relevant and appropriate to the national reality, the overemphasis on opiates and the neglect of alcohol and smokable cocaine, which is a problem in Latin America, cross-cutting issues that should appear in several modalities are developed exclusively in one of them, which generates confusion and lack of clarity in the document. There was one setting that described aspects of treatment that are common for many of the settings.

Importance of having manuals and technical guidelines that allow specifically implementing the indicators.

And the community-based outreach and recovery management modalities will signify an improvement of the substance abuse service treatment in Chile. The other modalities, the others settings described, we have already a set of standards and a quality-assurance system that is in place and both the first modalities are not included yet in the quality-assurance systems in Chile, and it's very helpful to have that.

The final conclusion is that the document is comprehensive, appropriateness, feasibility and utility are adequate in general but require some adaptations to implement them in the Chilean context. The utility and appropriateness of almost all criteria is high, although feasibility of the majority of the standards is around 50%. There is overemphasis on opiates and neglect of alcohol and smokable cocaine. And the main barriers identified were insufficient financial resources and trained professionals. Thank you.

BUSSE: Thank you very much for this review of the 2016 version of the Standards from the perspective of Chile which was very, very relevant, and I hope all of you that have been participating in the field testing found that some of the changes or some of the things that you identified were reflected in the 2020 version. so now let's say we make the shift from 2016 field testing and move to 2020 and I would like to give the floor to my colleague Dr. Wataru Kashino, who is the Program Officer at the Prevention, Treatment, Rehabilitation Section of UNODC who will give us an introduction to the current version of the Standards and a little bit about the quality assurance, and then we will have examples following up on how that is working at the moment. Wataru, the floor is yours.

WATARU KASHINO: thank you so much, Anja, for your introduction. Good morning, good afternoon, good evening, ladies and gentlemen, dear colleagues, friends. This is Wataru UNODC program from Japan. It is my great pleasure and honor to be with you today. In my presentation, let me give you an overview of the comprehensive International Standards, and also the development of a mechanism and the tools for their implementation.

The Standards cover treatment setting like community-based outreach, nonspecialized settings, specialized outpatient treatment, specialized short-term inpatient treatment and specialized long-term inpatient and residential treatment, and also the science-based intervention modalities like screening, brief interventions, and referral to treatment, evidence-based psychosocial interventions, pharmacological interventions and overdose identification and management. Treatment of co-occurring psychiatric and physical health conditions, and recovery management.

Let me talk about treatment settings, community-based outreach. To identify targeted populations, engage and provide unconditional community-based services and interventions, encourage access to available treatment modalities. Services can include provisional basic support, needle and syringe programs, condom distribution, overdose prevention, information, education, HIV/hepatitis testing and counseling, and screening and brief interventions. Crisis interventions, legal support. Linkages to other service and support systems. Professor Dietz will be covering this part with a focus on the overdose prevention.

The settings are not specialized for the treatment of people with drug use disorders but to provide brief interventions and refer to specialized treatment, what we call SBIRT. Services can include mental health services, general hospitals, primary healthcare settings, emergency services, sexual health clinics, infectious disease clinics, HIV/hepatitis/TB services, and also social services and welfare agencies, etc.

Under specialized outpatient treatment, it's to help to stop or reduce drug use, minimize negative health and social effects of drug use, identify and manage comorbidity conditions, provide psychosocial support to reduce the risk the risk of relapse and overdose, improve wellbeing and social functioning as part of a long-term recovery process.

Under specialized short-term inpatient treatment is to diagnose clinical conditions due to drug use, possibility of cessation or reduction of drug use, including withdrawal management. Initiate treatment of drug use disorders, motivate the patient to continue with treatment, etc.

Under specialized long-term residential treatment is to reduce the risk of returning to active drug use, maintain abstinence from drug use, improve health, personal and social functioning, and facilitate rehabilitation and social reintegration and learn relapse prevention skills. This setting is mainly for the severe cases with experience of relapses or overdose, etc.

With regard to the science-based intervention and the modalities, SBIRT is consisting of screening for people with drug use in nonspecialized healthcare settings, mainly primary health, emergency room, etc., using a standard set of report tools like WHO ASSIST. Brief interventions for 5 to 30 minutes to enhance motivation to change or to provide individualized feedback, advice, follow-up, etc. And also refer to treatment when more severe drug use is identified, especially through the case managers, patient managers, or more specialized treatment for comorbidity disorders, etc.

Evidence-based psychosocial interventions include CBT, contingency management, community reinforcement approach, motivational interviewing and enhancement of therapy, community-oriented treatment approaches like family therapy, and mutual-help groups.

Pharmacological interventions are for withdrawal management by substance, opioid dependence using longer-acting opioid agonists and antagonists, symptomatic treatment for psychostimulants, cannabis dependence, overdose identification and management, especially opioid overdose using Naloxone, etc.

Recovery management is to maintain benefits in other treatment modalities by providing individualized continuous support and minimize risks associated with drug use, maintain abstinence and reduce levels of drug use, continuing treatment or staying engaged with the recovery community, maintain contact with health/social service network and relapse prevention.

The Standards also cover populations with special treatment and care needs—for example, people with polysubstance use and people with specific health needs like comorbid health conditions and disabilities. And also children/adolescents, elderly people with substance use disorders. The social care and support needs. Women and pregnant women and sexual minorities, sex workers, religious and ethnic minorities, indigenous populations and people in contact with the criminal justice system. Also UNODC in cooperation with WHO and other international experts have been developing technical guidance, documentation or guidelines or training materials, etc., which is widely available.

Also, the Standards outline drug policy system elements because we need to offer the most effective, least invasive and lowest cost drug treatment interventions based upon the amount of the population with different severity of drug use. Based on this model, the majority of the patients with mild or moderate drug use or drug use disorders can be treated in that self-care, informal community care, or other specialized settings at the outpatient level. Based on that, we need to design the treatment system in cost-effective and efficient ways.

Let me briefly talk about the development of the quality-assurance mechanism tools as one of the implementation tools of the Standards.

The background is UNODC in cooperation with WHO organized international expert group meetings since 2016 to date, and the groups reviewed existing technical documents, tools, standards, etc. and made recommendation on how to assess quality sections of the International Standards. As a result, we are finalizing two QA tools for treatment systems and services and also finalizing integrated key quality statements which I will talk to you later, and a Note Verbale sent out to the member states to understand more existing national QA mechanisms and institutions.

These tools are to support the member states in assessing treatment systems and services and to build the capacities to institutionalize QA cycles and to provide technical assistance for improvement of the systems and services and also to be able to track quality improvement over time.

At this moment we have two mandates for treatment assistance and services because drug treatment system policies, planning and financing influences all services and patient outcomes.

For example, AQ system assessment has five standards with 19 criteria, including the overall coordination mechanism, comprehensive needs assessment, whether the drug use disorders treatment system is in line with the model, settings, modality, interventions outlines in the Standards, and there is financing and also planning and monitoring the mechanism is available or not in the country.

QA Service Assessment has six areas, 31 standards, with 164 criteria covering core standards with core management, core care, patient rights standards, organizational standards with interventions, settings, and patient target group standards as applicable to specific treatment services.

This is a structure of quality assurance tool. Standards statement is there and several criteria available, the scoring mechanism and evidence or data assistance needed to collect and check when they are visiting the treatment centers. As a result, we can produce a colored scoring sheet to see status quo and the spaces for other improvement at a glance.

In the course of parallel quality assurance, we identified parallel QA works undertaken by some international or regional agencies and identified a huge overlap in quality standards, methods, evidence, etc. So we agreed to develop a key quality statement for treatment services that are emerging in the to-be-finalized brief.

So far, UNODC completed pilots on QA in Afghanistan and Nigeria, and they organized training in 12 countries and organized training of trainers online already. And the system QA project is ongoing in Pakistan and the QA project is in development in 11 Latin American and Caribbean countries.

This map demonstrates where we have been working in terms of quality assurance and implementations of the Standards and the hopes to expand farther in coming years to promote the implementation of the Standards.

Thank you so much for being with us and for your kind attention. Let me hand over the mic to the experts from Nigeria and Pakistan.

BUSSE: Thank you very much, Wataru, for this quick run through the International Standards and the implementation with quality assurance. And I would like to give the floor next to Dr. Auwal Sani Salihu. He is the head of the Department of Psychiatry at the Aminu Kano Teaching Hospital in Kano, Nigeria, and he will share his experience about quality assurance implementing the Standards at the service level in Nigeria. Dr. Auwal, the floor is yours.

AUWAL SANI SALIHU: Thank you, Anja. Good morning, afternoon and evening, ladies and gentlemen. I'm presenting on Nigeria experience on quality assurance of services. This was from development of assessment to follow-up on assessment to the pilot and follow-up actions after the pilot.

This is the timeline. You can see from March to August of the same year the plan was to have training for quality assurance, assessment tools and then to follow-up actions and then to feedback to services and so on after August of that year. We were able to complete that over that time.

Kano was selected after developing the QA tool because Kano is located in northwestern Nigeria and it has a population of over 2 million. It was selected because it has the diversity which is typical of Nigeria with all the tribes represented within the state and then there are a number of state-run treatment services as well as negative media attention the year before in one of the treatment services. There are two national QA experts members.

The QA exercise. The treatment centers were identified and a letter of intent was sent for their consent to conduct the QA assessment. On arrival to Kano, the QA teams were divided into teams of 2 to 3 members each to visit each of the institutions that were selected for the pilot. For two days, each of the five teams was used to contact all the selected facilities and at the centers, key individuals were interviewed. Case files were viewed, along with various other documents, and a physical tour of the facility was also conducted. Patients were also interviewed.

So each group assessed each center on each criterium in the tool kits. Two scales were used—the 3-point scale and the 5-point scale. The 3-point scale with the met, partially met, and unmet, and then we used the colors also, the rug system, the red bar and the green system. Then after returning from the visit, the two assessors wrote a detailed report and harmonized the scores between themselves. The same QA effort they shared all info, and those who had not visited the center individually scored all criteria for the centers based on the reports. And the scores for each criterium arrived at by different assessors reading the report were then harmonized among all the assessors, and then a final consensus score was arrived for each center on each criteria.

With exceptions of three, all the centers are not drug treatment services. That's one of the findings. And the centers had variable scores, but in many aspects they require tremendous improvement. Some serious negative findings there include the widespread restraint of residents by chains and stocks. And there was a report of unconfirmed sexual abuse in one of the female-only treatment centers. But many of the services were extremely dirty and unhygienic. And there is lack of mental health treatment for clients with mental health problems. And where medication was provided for such clients, it was often by unqualified staff.

The follow-up actions, what was done after the QA. Contact was made with the management of the centers and the State Emergency Management Agency (SEMA), the Health Service Management Board (HSMB) and the Aminu Kano Teaching Hospital management. Advocacy and briefings were held. Immediate actions and assistance to stop abuses and improvement of practice was made. And in particular the unconfirmed sexual abuse was investigated by the QA team and the management of the SEMA confirmed to us that they investigated the same case and punitive measures were taken on the individual involved some years back, when it happened.

A two-day sensitization training was held for the QA pilot site managers and they were supported to do improvement plans with the assistance of the QA teams. And then working with the HSMB of Kano State, we sought medical experts and with the support of UNODC some capacity to improve identification, assessment, and treatment of mental health problems among the clients because most of the clients in those centers are mainly having mental health problems and a few with comorbid substance use disorders, apart from the two centers we said were engaging in drug treatment services.

The implications of the QA exercise in Nigeria. Clarity about the scope of QA so that certain things should not be overdone such as interaction with the management and treatment services manager trying to show that the QA assessment is to improve services, not for witch hunting.

Revision of the QA mechanism and tools in light of the pilot—that has already been done because we have had some serious meetings after that to improve the QA assessment tool. And then capacity building current QA experts. We hope that will continue because continued education will improve that.

Future roll-out of the QA. If not for the pandemic, we should have had additional QA assessment in more sites in Nigeria, but we hope as the situation improves that will be taken. Potential for significant improvement in drug use disorders services if we continue to undertake the QA assessment. Sustainability plans. Officially, if there is no funding mechanism to fund it, and in the light of this, there should be sustainability plans in place for the QA continuity in the country.

Before I close my presentation, I wish to send my gratitude for this opportunity to share Nigeria's experience by the organizers of this program, and I also thank the UNODC, especially Harsheth Virk who is now in Cairo, [Annette Dale-Perera, who has done tremendous work in training of the QA effort, and then my colleagues, the Quality Assurance Gladiators, as we named our group in Nigeria, without whom this presentation would not be possible. Thank you very much.

BUSSE: Thank you so very much for sharing this experience in implementing the Standards and using the accompanying QA tools in Nigeria and how you could show that when we start in the beginning actually it was useful to identify even potential human rights abuses and has helped improve the quality of treatment or at least develop perspective for that. As this was an example at the service level, I would now like to give the floor to Mr. Sabino Sikander Jalal, the Senior Joint Secretary of Narcotics Control at the government of Pakistan, who will share about the QA experience in line with the International Treatment Standards at the system level in Pakistan. Mr. Sabino Sikander Jalal, the floor is yours.

SABINO SIKANDER JALAL: Thank you very much, Anja. I really appreciate this opportunity provided by NIDA and UNODC to present Pakistan's stance on the drug rehabilitation scenario in the country. I would just like to give a brief overview of the situation on ground in the country.

These are a few stats that we have from a drug survey conducted with cooperation from UNODC. This was done some time back, in 2013, so I believe these figures are a little dated but this is what we have till now. We have about 6.7 million people who are, we believe, addicted to drugs. Out of this, 4 million are on hash and 78% of these are men and 22% are women. And 4.25 million of these drug users are considered dependent. And this is an alarming number that about 430,000 people are ones who inject themselves with drugs and 73% share needles and syringes, so this statistic itself has a very, you know, disturbing angle when we realize that this leads to HIV and other dangerous diseases like hepatitis C. So

our situation gets pretty grim when we consider that this number has increased I think by 1/3 over the last few years.

The number of drug treatment facilities in the country are quite, I think, scarce and less than desirable considering our population and the number of people who actually require the treatment and drug rehabilitation. The total number of drug treatment facilities in Pakistan for about 230 million people are just 96. The government treatment facilities are 25 and then there are some privately run treatment facilities which are, as you can see, very little compared to the challenge that we face.

These are the few gaps that we've identified with the feasibility study we conducted with technical assistance from UNODC, and we really appreciate this effort and support from UNODC and I think financial support from our partners INLP. And these are the things that we identified. We found that there's a lack of standardized evidence-based drug-dependence treatment interventions. Currently, the treatment facilities and the health professionals will use these facilities and treat people using more or less the symptomatic method. There is no standardized treatment facilities available in the country. We are trying to work on that to develop standardized protocols for implementation across the county with help from UNODC, of course.

There is a lack of certified drug-treatment professionals, there is a lack of coordination and integration between drug treatment, HIV, hepatitis, TB programs and other key stakeholders such as law enforcement, prisons, education, judiciary, social welfare ministries/departments, and civil society organizations. So you can see the gaps that we have identified and the scale of the enormity of the challenge that we face sort of multiplies when we realize that there is this lack of coordination between the concerned departments.

There is no mechanism for alternate imprisonment for drug-using people with charges of minor offenses. This is very unfortunate that we have no other option but to incarcerate such people. There is a lack of database on drug prevention and treatment interventions. There is an absence of monitoring mechanisms. So you realize that this is, I think, one of the most neglected sectors within the public health sector in the country. Being a developing country, we have very little resources for public health, and this facet of public health, drug treatment/rehabilitation, gets very little attention. So after all these years with help from UNODC, which we really appreciate, we are now helping and trying to put some focus on this very neglected sector.

There is lack of scientific and evidence-based drug interventions, as I said earlier, for educational institutions and community as well.

So there's another very alarming challenge that we face: the drug problem, especially the synthetic drugs. There are more being adopted and used by our educational students in universities and colleges and secondary schools, so this is a very alarming trend that we are observing, this use of synthetic drugs. There is lack of drugs prevention experts and professionals. There is a lack of knowledge and prevention as a science.

After realizing all these gaps within the system, we have formulated a strategy to address these issues over the next five years. We have recommended to establish a mechanism to ensure quality drug treatment/drug prevention services in the country by strengthening coordination basically and networking between relevant stakeholders at the federal influential levels that can play the role in drug

treatment and prevention. We are reviewing and developing drug demand reduction strategies and policies at federal and provincial levels by the regulatory authority member departments.

We are trying to institute some certification and accreditation of the drug treatment/drug prevention professionals and services at federal and provincial levels. We are monitoring drug treatment and prevention services. And we are trying to establish a mechanism for accountability of the service providers.

The DDR quality assurance mechanism that we're trying to accomplish, we've already established a technical committee under my leadership and we have all these relevant departments—the Anti-Narcotics Source, the Ministry of Health and certain other bodies—UNODC, WHO and UNAIDS—and we're trying to firm up the different options that are available for quality assurance mechanisms within the country. We've already drafted a legislative bill to drive the legislative framework/mechanism for drug prevention, and this bill is being sent to the national assembly so we can have a legislative framework available for us in order to implement this strategy and this regulatory mechanism. We have already conducted trainings on DDR regulatory framework and mechanisms at national, federal, and provincial levels by an international trainer organized by our friends at the UNODC.

The trainings are conducted in all four provinces with the senior management, psychiatrists, psychologists and staff, so CSOs, health care commissions, health departments, public hospitals, Institute of Mental Health, AIDS control programs, education departments and social welfare departments—I think basically all the relevant stakeholders within the system.

These are the key findings of those interviews. The quality of substance use disorder treatment: 56% consider that our response is quite poor, which we admit that is quite understandable, because of the reasons I've explained earlier. And the quality of SUD prevention is also poor and quality assurance body, the need for such a body, everybody appreciates that there is a dire need to establish this body. almost 96% of the persons interviewed endorsed this view. There is a quality assurance body for health, social welfare, education and 57% of the interviews supported that. Operationalization of quality assurance mechanism, 82% consider that this is a dire need.

The current status on DDR regulatory framework mechanism is we have established TORs and SOPS and flow charts have been established. Drafted a legislative bill, established a technical committee and we're in the process of getting that bill through to the national assembly for clearance.

Thank you very much for your time. I would once again like to stress this point that with the support of the UNODC and INL, we are trying to establish a groundbreaking regulatory framework within the country, and until we started studying this aspect of the drug rehabilitation/treatment and the feasibility of work that has been done by the consultants at UNODC, these things were, I think, being a public policy practitioner myself, we weren't really aware of the gaps and shortcomings within the system. We have these sporadic outbreaks of HIV in the country and hepatitis C but we are not able to pin that down to drug users and the persons who inject themselves with drugs, but thankfully, with the support from UNODC and INL, we now know the root cause of this problem and we're trying to work it out, and hopefully within due time we'll come up with a framework that will be a game-changer not just for this country but for the region as well. Thank you very much for listening to me. Thank you.

BUSSE: Thank you very, very much not only for your presentation but also for the leadership at country level will lead to institutionalized quality assurance and for having done this very clear analysis of the current situation with regard to treatment services and systems. So thank you very much and we will continue to work together on that.

With this, I would like to say we've looked at the field testing, we've talked about the implementation of the 2020 version of the treatment standards through QA mechanisms, but also I would like to give the floor now to Professor Paul Dietz, who is the Director of the Behavioral and Health Risk Program at the Burnet Institute in Australia, and who has worked with us on the UNODC/WHO Drug Overdose Safely Program implementation and the study in Central Asia and Ukraine, which in a way in the framework of the International Standards gives us an idea of the implementation of the component on community-based outreach in the Standards. With that, Paul, the floor is yours to present the SOS study to us. Thank you.

PAUL DIETZ: Thank you for that introduction, Anja. It's a great privilege to be presenting. Good morning everyone in the US and it's 10 PM here, so it's getting quite late here in Australia. Just a couple of disclosures. The K1 is that I was an unpaid member of an advisory board for a Mundipharma intranasal naloxone product, but it doesn't really have any bearing on this presentation that I'm giving you.

There is a whole series of things that are connected with drug use around the world that are problematic, and overdoes is one of the key ones. And it's a major public health issue that is preventable. And one of the key ways in which we can reverse the effects of opioids like heroin and fentanyl and others is through the use of naloxone.

And the WHO, in recognition of this, produced the Community Management of Opioid Overdose Guidelines in 2014 that really highlighted the potential for naloxone distribution outside of medical settings for the prevention of opioid overdoes mortality.

And that essentially underpins, through a whole series of complicated policy processes, the SOS Initiative, which was established through UNODC and the WHO, and I guess where I come into it is being involved in a multisite study in Central Asia and Ukraine that really aimed to show the feasibility and impact of what we call take-home naloxone with a focus on people likely to witness an overdose. And you can see the results from SOS take-home naloxone kits there. They're about the size of a marker pen.

Ultimately, they're all based on the SOS Initiative targets, which are framed around a 90—90—90 framing that borrows from viruses and infectious diseases where the cascade of care here is to try an ensure that 90% of people are trained in the use of take-home naloxone who might be exposed to an overdose, 90% of those people are supplied and 90% of those people carry it with them.

And here's an outline of the SOS project in and of itself. There's a series of phases: preparation, implementation, and evaluation. I'll be talking about the implementation phase and the evaluation phase here today.

All of the things that I'm talking about today are summarized in this report which is now available on the website which is listed there and it highlights the findings I'll be talking about. Also, it highlights the incredible achievements of what was an incredible chain from each of the countries and the national research partners who do need the take the credit.

Ultimately, the SOS program is built on a training cascade that will allow it to be sustainable and scalable. So ultimately there are level-one trainers who provide training to level-two trainers who then go and train people likely to witness an overdose. And so there's a scalable framework there that can be implemented in low- and middle-income countries because most of our take-home naloxone knowledge is derived from wealthy, high-income countries. And there are the four countries there: Kyrgyzstan, Kazakhstan, Tajikistan and Ukraine. And the aim of the program is to train 15,000 witnesses.

There's a shot of the kit. And inside are two ampules of naloxone and syringes and necessary equipment to deliver the naloxone.

Here's the implementation timing. Ultimately, over 14,000 witnesses were trained. Over 16,000 kits were distributed and a large number of people were trained to provide overdoes response in an incredibly short time, a real testimony to the effectiveness of the chain member program.

Moving on to evaluation on the next slide. Ultimately, there's a series of different activities undertaken, a process evaluation of giving you the figures that came out of that series of focus groups, key informant interviews that we were reporting on in different forums, and training data. But the thing I'll talk to you about today is the noncontrolled observational cohort study that we conducted as part of the roll-out. And here's essentially what it looks like. The fundamental thing is that we tried to baseline information, all the people who were trained, and then we interviewed them again in six months to see what sort of impact the training had had on their overdose responses.

The question for today is whether or not 90% of trainees used naloxone who witnessed overdoses. And extension of the 90—90—90 target we mentioned previously.

Basically we recruited about 1,600 people into the cohort study, and you can see their main characteristics there, and we stratified the people who used drugs from people who didn't identify as using drugs, and you can see they're very similar to the sorts of cohorts you might expect to be coming across people who might have experienced an overdose.

Fundamentally, do 90% of trainees use naloxone witness overdoses? You'll see very clearly that we had a round 35% of the cohort have witnessed an overdose in the six months since they were baselined, and of their responses, just under 90%, 89%, reported using naloxone at the overdose they witnessed. And in 98% of those instances the victim survived, so that's an incredible achievement, in line with the target that we would want to achieve.

What the SOS study has shown is the take-home naloxone could be implemented at scale using the protocol. I didn't present data on the training effectiveness, but we know that the training works and we'll show that in another publication. But importantly, the SOS instances using naloxone at these witnessed-overdose events in line with those expected targets, so it's amazing the outcome from this program.

Ultimately, we're looking at things to increase sustainability in uptake. It's going up in the countries were involved in, but also other countries, and making sure that we disseminate the SOS training, which we'll use more widely. And with that, I would just like to thank all of the people who are involved with the study, as well as the funders, INL, and back to you, Anja.

BUSSE: Thank you very much, Paul, I have to say not only for the presentation but for guiding us through the entire study and being patient with us in moments when it was challenging with the study. So really the SOS study is an incredible achievement. Thanks go everybody who contributed and maybe for the SNDs today to also let you know that there is an additional poster here at the CPPD/NIDA International Conference on the SOS study that links you further through to the report. Thank you.

And with that, it's my honor and pleasure to give the floor to our next speaker, who is going to kind of, in the framework of the International Standards, present to us on the chapter on populations for special treatment and care needs from a clinical perspective. And that is Dr. Marta Torrens She is the head of the Addiction Program at the Universitat Autónoma de Barcelona. Sorry, Marta, for my mixture of English and Catalan. Over to you.

MARTA TORRENS: Thank you very much. Thanks, Anja, for your nice presentation. Good morning, good afternoon, and good evening. Thank you for the opportunity to talk. This is a next step in the treatment of populations of special treatment. And this is how to apply the Standards for this kind of population.

This is International Standards for populations with special care needs. And in this chapter, there are some special preparations for pregnant women with drug use disorders. Then this is how to apply this and how to teach. This is one of the things that various colleagues were talking about this morning, and I think this is very interesting to show our experience in this sense.

This is description of pregnant women with drug use disorders who have special need for treatment. First, their use affects the woman, the mother, but also the fetus. The second, the pregnant woman has the same rights that women that are not pregnant that have drug use disorders. The woman with drug use disorders has the same right if they are pregnant as women without drug use disorders. This is the most relevant issue.

This is how to apply this for teaching the persons involved in the treatment for the woman who has drug use disorders and now she's pregnant. The model has five components: screening, assessment, treatment planning and treatment approach.

In the screening, this is just to say that all the women of child-bearing age, when they came to treatment they must be screened for pregnancy. And if there is some factors or medical conditions—risk of withdrawal, risk of harm to self and to others—she has to be treated professionally.

The assessment is very, very relevant to the accurate diagnosis and to develop the appropriate treatment.

Develop the treatment planning is the woman because of the pregnancy and also the collaboration of the obstetrician and gynecologist and also after that of the pediatrician. Then the treatment approach much have all these components. The treatment approach must be evidence-based. This is very, very valuable. It must include psychosocial intervention and also the cultural and something that is very, very relevant in this case, the stigma. That's very, very relevant.

After that, the baby delivery protocol, also very important the postnatal/postpartum treatment protocol. Don't forget the woman. Don't forget the mother. And also some recommendations about breastfeeding.

They have to know if there is neonatal withdrawal syndrome. They have to manage, they have to know that there is and they have to manage neonatal withdrawal syndrome.

That's the most important thing, and this is what we have done. Training the staff. Training the staff to all remember, those that have contact with the patients, not only the physicians, also all the secretaries, the office managers. This is very important to avoid the stigmatizing of the woman.

BUSSE: Marta, I'm sorry for interrupting, but I was just informed that we will be cut off in three minutes automatically.

TORRENS: Yes, I know. It's very important to train all the staff. This is why they have now, as other have said, we have the WHO Guidelines for them. We have this implemented.

We have to develop for this special population these guidelines to treat accordingly. We had very good experience in Ukraine, very good experience in Argentina, and very good experience in Ecuador. This is the next step from the International Standards. And thank you, I finish here. Thank you.

BUSSE: Marta, thank you so much. I'm sorry for rushing you. And also to you not only thanks for the presentation but for helping us train women health staff already in various countries around the world. Thank you so much for helping us to implement this part of the Standards.

Now if I can have just the last slides and then I will kind of come to a closing of this wonderful international session. I just want to tell you what else we are cooking, what's the next that's going to happen. We are about to develop additional quality assurance, especially with a view to medication-assisted treatment.

Next slide, and I also want to let you know that based on this year's Commission on Narcotic Drugs we have been given additional policy mandates by the international community to promote and disseminate the treatment standards together. So that's important. The new version has already been reinforced by political mandates.

And with WHO we're looking at even more comprehensive development of an implementation package of the Standards to take them in a very strategic way to country level and bring them to use so that they will, as you see they are already not and will never be a document on the shelf but a document that's really there to be used and to support countries.

I also would like to invite you, there is a network on quality assurance in drug treatment on the website of the International Society of Substance Use Professionals, which you can find at ISSUP.net.

I think with that we come to a closing. We really thank you all so much for contributing to the development, to the implementation of the Standards, and to take them into the future. I said if you are interested, a poster on the International Treatment Standards and on the SOS Initiative to stop overdose. It's available also in the NIDA International poster section. And last but not least, I thank really all the donors to the UNODC/WHO program, especially INL, who has supported us in all the components that we presented today. And I would like to thank again NIDA and CPPD for hosting us today and for all the speakers. Thank you so much and thanks for being with us. Maybe we can just put the last slide of my presentation just to say goodbye. Thank you so much.