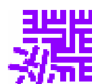
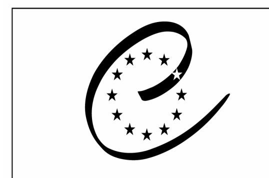


Eesti Uimastipreventsiooni Sihtasutus
Estonian Foundation for Prevention of Drug Addiction

Guidelines for the Treatment of Drug Addiction

Pompidou Group
Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs



COUNCIL OF EUROPE   CONSEIL DE L'EUROPE

Acknowledgements

This publication has been developed with the support of The Council of Europe Pompidou Group Drug Demand Reduction Staff Training Programme (DRSTP II) in close co-operation with the DRSTP National Project Team. The members of the team has been:

Dr. Tarmo Kariis, Managing Director, Estonian Foundation for Prevention of Drug Addiction
Dr. Valdur Jänes , Psychiatrist in chief, Tallinn Wismar Psychiatric Hospital,
President of the Estonian Psychiatric Association
Dr Jaanus Mumma, psychiatrist, deputy chief, Tallinn Wismar Psychiatric Hospital

However, without the devoted work of the national experts the publication would not have been presented. The publishers would therefore like to thank the following national experts who have contributed to the publication:

Prof. Veiko Vasar, Head of Psychiatric Clinic of Tartu University
Prof Jaanus Harro, Head of Department of Psychology of Tartu University
Dr. Peeter Jaanson, Head of Department, Psychiatric Clinic of Tartu University
Assoc Prof. Anu Aluoja, psychologist, Psychiatric Clinic of Tartu University
Milvi igalaan, psychologist, Tallinn Wismar Psychiatric Hospital
Dr. Andres Lehtmets, psychiatrist, Tallinn Wismar Psychiatric Hospital
Dr. Ellu Eik, psychiatrist, Estonian Health Promotion Centre
Dr. Ants Puusild, psychiatrist, Head of Department of Psychiatry of Pärnu Hospital

Dr Pille Varmann, psychiatrist, interpreter

The publishers would also like to thank the Pompidou Group expert consultant **Martien Kooyman M.D.**, **Ph.D**., the Netherlands, who has, over a series of consultations assisted the national Project Team and the national experts in their work in an excellent manner.

Tallinn-Strasbourg, 2001

Tarmo Kariis (the National Project Team Leader)
Chris Luckett (the PG Secretariat)

Foreword

The preparation of the Guidelines for the Treatment of Drug Misuse and Drug Addiction has been supported from the National Program of Alcohol and Drug Addiction and by the Pompidou Group of the European Council. These Guidelines are meant for all professionals dealing with the treatment and rehabilitation of drug addicts.
The British Guidelines for the Clinical Treatment of Drug Misuse and Drug Addiction were used as a model and main source material for the work. The Guidelines present a consensus document that has recommendatory power.

CONTENTS

I FOREWORD

II DIAGNOSIS AND ASSESSMENT
2.1.Aims of assessment
2.2.The diagnosis of drug abuse

III TREATMENT PRINCIPLES AND THE TREATMENT SETTING
3.1.Aims of treatment
3.2. Principles of treatment and responsibility associated with prescribing
3.3.Organization of drug addiction treatment

IV TREATMENT OF DRUG DEPENDENCE AND WITHDRAWAL
4.1.OPIATES
4.1.1.Treatment of the withdrawal syndrome by substitute opiates
4.1.2. Treatment of the withdrawal syndrome by non-opiate drugs
4.2.STIMULANTS
4.3.BENZODIAZEPINES

V PHARMACOTHERAPY IN RELAPSE PREVENTION
5.1.Principles of treatment
5.2. Use of pharmacotherapy for maintenance treatment

VI SUBSTITUTION TREATMENT FOR DRUG ADDICTION
6.1.Principles of substitution treatment
6.2.Indications and contraindications for substitution treatment

VII NON-PHARMACOLOGICAL METHODS OF RELAPSE PREVENTION
7.1.Model of change
7.2.Cognitive-behavioral therapy
7.3.Group therapy
7.4.Family therapy
7.5.Self-help groups

VIII REHABILITATION, DAY CENTRE AND THERAPEUTIC COMMUNITY
8.1Rehabilitation in day center
8.2.Rehabilitation in therapeutic community
8.3.Treatment success

IX COLLABORATION WITH OTHER PROFESSIONALS
9.1. Case management
9.2. Networking

X SECURITY MEASURES AND SAFETY OF THE STAFF
10.1.Security measures for the staff
10.2.Safety of the patient
10.3.Preventing infection with HIV, hepatitis B and C

XI EMERGENCY CARE IN DRUG INTOXICATIONS
11.1.Introduction
11.2.Treatment of opiate (heroin) overdose
11.3.Treatment of overdose induced by other drugs
11.4.Treatment of intoxication psychoses

XII PREGNANCY AND DRUG ADDICTION
12.1.Effect of drugs on the fetus and infant
12.2.Management of antenatal care
12.3.Treatment of health problems in the newborn

XIII YOUNG PEOPLE AND DRUGS
13.1.Legislation
13.2.Principles of good practice

XIV CRIMINAL JUSTICE SYSTEM
14.1.Police custody
14.2.The Probation Service
14.3.The Prison Service

XV APPENDICES
APPENDIX 1 Cognitive-behavioral therapy
APPENDIX 2 Group therapy
APPENDIX 3 Range of detoxification and substitution treatment on different levels of Health Care
APPENDIX 4 Order of determining state and level of intoxication

I FOREWORD

Persons with drug addiction should have access to health care services similar to that of other patients. The responsibility of all doctors is to help patients with general and drug induced health problems in spite of the fact whether the patient is ready to give up drugs or not. At the same time the doctor is not obliged to do more under any circumstances or pressure than it is determined by his or her profession and training.

Prevalence

Drug addiction and criminality connected with drugs is relatively new in Estonia. The misuse of opioids, amphetamine, cannabinoids, benzodiazepines and hypnotics has more or less been present all throughout the XX century, but it has never been so widely spread.
The results of the investigation "Estonia 1998" revealed that 6,3% of the adult population has used drugs and 0,1% was using them at the time of the study, which was four and five

times more than in 1994. About every fifth person in the age group 18 – 24 has the experience of using drugs.

According to the data received in studies "Pupil 95" and "Pupil 99" the percentage of pupils who had used illegal drugs has risen two times in four years (8% and 16%, respectively). The most rapid increase has occurred in using amphetamine (from 0,4% in 1995 to 6,8% in 1999) and cannabis (from 7,2% in 1995 to 12,7% in 1999). The percentage of drug users (29%) is the highest among non-Estonian young males.

Morbidity and mortality

Drug misuse is connected with higher mortality. Long-term follow-up studies in Great Britain have shown that age-adjusted mortality rates in heroin addicts are almost 12 times higher than in the general population. Mortality rates among those addicts who use drugs by injection are 22 times higher than in those addicts who do not. There are no exact data about drug-induced mortality in Estonia but during last few years in Tallinn emergency calls due to heroin overdose are received every day.

During last 6 years the number of mental and behavioral disorders induced by psychoactive substances (alcohol, tobacco and drugs) has increased from 675,2 in 1994 to 800,6 cases per 100 000 in 1999. Drug problems show a more rapid increase than alcohol problems. In 1994 the relation of alcohol-induced cases to drug-induced cases was 1 : 40; the same ratio was 1 : 8 in 1998 and 1 : 4 in 1999.

In 2000, the number of cases of mental and behavioral disorders due to the use of psychoactive substances (drugs) per 100 000 was almost twice as high as in 1999. In 2000. 3770 persons received outpatient or inpatient care due to mental disorders connected with drug misuse. The most rapid increase concerned cases associated with the use of opioids (heroin), stimulants (amphetamine, ecstasy) and volatile solvents.

Cases of mental and behavioral disorders due to psychoactive substances (except alcohol and tobacco) per 100 000 persons (data received from medical institutions)

Year	1994	1995	1996	1997	1998	1999	2000
Cases	16,4	24,5	51,6	72,6	82,2	153,1	275,8

According to the local database of treatment for drug misuse in year 2000 the majority (82%) of persons who have received treatment were male. Average age of the drug users was 22 years and the age group of 18-year old persons was the largest.

In 12% of cases the drug use was started at the age of 14, in 57% of cases at the age of 15 – 19 and in 19% of cases at the age of 20 – 24. Majority (82%) of the patients were Russian, 11% were Estonian. Opioids were used most frequently, in 89% of cases (80% heroin, 9% home-made poppy preparations); stimulants were used in 7% of cases (amphetamines 6%, ecstasy 0,1%, cocaine 0,4%) and cannabinoids in 4,1% of cases (marijuana, hashish).

New directions in drug politics

Estonia has joined all the conventions of the United Nations and international agreements that determine the main directions of drug politics and set international requirements for production, marketing and medical use of psychoactive substances to prevent illegal drug

use and to combat drug smuggling. Estonian legislation follows the requirements of these conventions and agreements.

On June 5, 1996 Estonian State Assembly accepted the law of joining unitary conventions of psychoactive drugs accepted by United Nations in 1961 and 1971 (RT II 1996, 19-22, 84).

II DIAGNOSIS AND ASSESSMENT

Correct assessment is a necessary prerequisite for helping drug addicted persons. Assessment skills are necessary for all specialists participating in the treatment of drug addiction. This will help to achieve continuity of treatment and exchange of information between different levels.

2.1 Aims of assessment

2.2 Diagnosis of drug abuse

2.2.1 History of drug use

The aim is to get a detailed picture about past and present drug use. It should cover the following areas:

- Past and current (last month) drug use
- Medical history
- Psychiatric history
- Forensic history
- Social history
- Past contact with treatment services or the social system

2.2.2 Examination

- **Assessment of motivation**
- **Assessment of general health**
- **Assessment of mental health**
- **Assessment of social and family situation**

2.2.3 Special investigations

- **Laboratory investigations**
- **Urine assessment (short description of different assessment methods)**

Table: Approximate duration of detectability of drugs in urine.

2.2.4 Classification of drug-related mental and behavoiur disorders (ICD-10)

III TREATMENT PRINCIPLES AND THE TREATMENT SETTING

3.1 Aims of treatment and treatment contract

The main goal of treatment and treatment plan

The aim of treatment is to help the person stop misusing drugs. To reach this aim it is necessary to set realistic goals that help to plan the treatment and support the patient's participation in the treatment.

The Treatment plan consists of 3 main parts:

- relief of withdrawal symptoms (detoxification treatment)
- relapse prevention
- social rehabilitation

Goals of treatment
Treatment contract
Treatment team
Support person

3.2 Principles of treatment and responsibility associated with prescribing

Responsibilities of the prescribing doctor

1. It is the responsibility of all doctors to provide care for general health needs and drug-relate problems, whether or not the patient is ready to withdraw from drugs.
2. Full assessment of the patient must be performed, treatment goals set, support person found and treatment contract signed before initiating treatment.
3. Responsibility for prescribing lies on the doctor signing the prescription. Detoxification and maintenance treatment with methadone can be prescribed by psychiatristis only.
4. The prescribing doctor must ensure that the patient complies with the treatment regimen. Clear records of prescribing should be kept.

Deciding whether to prescribe

Withdrawal and detoxification treatment has an important role in the treatment of drug addiction.
Before prescribing the goal of treatment must be clear. It can be as following:

- to reduce and prevent withdrawal symptoms;
- to stabilise patient's drug intake and lifestyle;
- to promote a change in risk behaviour;
- to maintain contact and cooperation with the patient.

Stopping failed treatment

A decision to stop failed treatment must be taken according to the treatment plan that has been agreed with the patient. If the patient is non-compliant, continues to use drugs and does not make any effort to achieve the goals that have been set, the doctor can consider ending treatment.

3.3. Organization of drug addiction treatment

The organization of drug addiction treatment is based on existing institutions of health care and social care and on new structures that will be created for treatment of drug addiction

problems. All different levels of health care must be prepared to deal with problems connected with drug addiction. The system of social care plays the central role in helping persons with drug addiction, responsibility for organizing help lies first of all on local authorities. The role of nongovernmental organizations based on the activity of volunteers is constantly increasing. It is not possible to create an ideal treatment model, but most attention should be paid to bigger cities and crisis areas.

The role of different systems and services in the treatment and rehabilitation of persons with drug addiction could be following.

Psychiatric Care

1. Outpatient care: consultations, detoxification, counselling concerning treatment and rehabilitation, contacts with the network of persons with addiction problems.
2. Psychiatric services of central hospitals: consultations, detoxification, prescription of substitution treatment, monitoring of the treatment course.
3. Psychiatric services of regional hospitals: in addition to the functions carried out by central hospitals diagnosis and treatment of complicated cases (comorbid serious psychiatric disorders like schizophrenia).
4. Specialized psychiatric hospitals: treatment programs for patients needing long-term psychiatric care.
5. Psychiatric services in prison: counselling, treatment programs for drug addiction, drug-free units.

Other health care services

1. Family doctors: general health care for persons with drug addiction, motivating drug addicts for treatment.
2. Emergency care: treatment of life-threatening conditions.
3. Duty personnel of central hospitals: treatment of life-threatening conditions.

Social services

1. Network of persons with drug addiction: all institutions from counselling centers to therapeutic communities. The network is organized by local authorities, collaboration and exchange of information with nongovernmental organizations is important.
2. Public system of special care: nursing homes and units for persons with drug addiction.

Other organizations

1. Crisis phones
2. AA-groups
3. Crisis centers
4. Support centers for persons with AIDS
5. Self-help system for family members of drug addicts

IV TREATMENT OF DRUG DEPENDENCE AND WITHDRAWAL

Many different methods and regimens are used in the treatment of drug-induces withdrawal states. In some cases psychological support, rehabilitation and physical treatment methods are sufficient for successful withdrawal.

The present chapter gives an overview about pharmacological methods used in the treatment of drug-induced withdrawal states. Any drug that has been heavily consumed over a significant period of time may cause withdrawal symptoms when it is stopped. Mental and physical withdrawal symptoms can occur. Recovery from drug dependence is a long process. After finishing treatment of withdrawal symptoms it is necessary to continue treatment for relapse prevention.

4.1 Opiates

4.1.1 Treatment of the withdrawal syndrome with substitute opiates

Methadone

Detoxification with methadone can be performed under short- and long-term treatment regimens lasting from 2 weeks to 6 months. Short-term detoxification should be performed at the hospital as due to rapid dose reduction usually moderate withdrawal symptoms arise. Long-term withdrawal treatment could also be started at the hospital and continued in an outpatient setting.

The medication of choice is Methadone mixture 1 mg/ml (officially registered in Estonia).

Principles for detoxification and substitution treatment with opiates are stated by the act of the Ministry of Social Affairs (see appendix).

Dose titration of Methadone and dose reduction regimens

Initial dose
Rapid detoxification with methadone lasts from 2 weeks to 1 month. This regimen is suitable for patients with high motivation and not very high tolerance. Patient must be prepared for the occurrence of withdrawal symptoms.
Slow detoxification lasts form 1 to 6 months.

Buprenorphine
Buprenorphine is used in many countries for detoxofication and long-term substitution treatment. The drug binds to opioid receptors in the brain and its action lasts at least 24 hours. Buprenorphine is also said to have properties similar to methadone and naltrexone. It relieves withdrawal symptoms and decreases craving for drugs. Buprenorphine is not registered in Estonia.

Levo-alpha-acetylmethadol (LAAM)

4.1.2 Treatment of the withdrawal syndrome with non-opiate drugs

Clonidine/lofexidine
Lofexidine decreases noradrenergic acitivity in the nervous system, inhibiting autoreceptors of the alfa-2 subtype. It is effective in relieving symptoms associated with opiate withdrawal syndrome.
Treatment regimen with lofexidine.

Carbamazepine
Carbamazepine is effective in relieving withdrawal symptoms.
Table: one possible treatment regimen with carbamazepine.

4.1.3 Symptomatic treatment of the withdrawal syndrome
In milder cases of opiate dependency symptomatic treatment can be used for relieving withdrawal symptoms. For the relief of mental disturbances antipsychotics, antidepressants and benzodiazepines can be used. Benzodiazepines can only be used for a short period of time during controlled treatment due to their addictive potential. Physical activity and procedures of physical medicine are beneficial during withdrawal treatment.

4.2 Stimulants
Withdrawal syndrome induced by stimulants (cocaine, ecstasy, amphetamine, metcathinone/ephedrone etc.) in treated by symptomatic medication. There is no indication for substitution therapy in the treatment of cocaine or amphetamine withdrawal. Antidepressants are indicated for the treatment of depressive episodes. In cocaine dependency good results have been achieved with acupuncture, other methods of physical medicine and physical activity. According to the studies psychosocial support appears to be the most effective method during detoxification treatment.

4.3 Benzodiazepines
The misuse of bezodiazepines is widely spread. In some persons benzodiazepines induce strong addiction. Persons misusing alcohol and other drugs are at special risk. Addiction is often a result of patient's uncontrollable self-treatment or bezodiazepines prescribed too easily by doctors. Opiate misusers are at high risk for bezodiazepine dependency as they use them for potentiating the effect of the main drug or for relieving withdrawal symptoms.

Sudden cessation in the use of benzodiazepines can lead to a recognised withdrawal state. Only short-term prescription of substitution treatment with benzodiazepines can be used in the treatment of withdrawal symptoms. Preferance should be given to benzodiazepins with long half-life.

V PHARMACOTHERAPY IN RELAPSE PREVENTION

5.1 Principles of treatment
Long-term treatment and rehabilitation are important for maintaining the effect of successful withdrawal and detoxification treatment. Without adequate maintenance treatment the risk of failure is high. Long-term pharmacotherapy is often necessary but for achieving positive results the main focus lies on psychosocial methods. The treatment is carried out by a multiprofessional team consisting of different specialists.

5.2 Use of pharmacotherapy for maintenance treatment

As different psychiatric symptoms usually persist for a long period of time after the end of detoxification treatment, long-term psychopharmacotherapy is needed during maintenance treatment. The use of antidepressants is indicated as mood disorders often prevail. For relieving anxiety and sleep disorders antipsychotics can be used as monotherapy or be combined with antidepressants. The use of benzodiazepines and barbiturates should be avoided during maintenance treatment as they have a high addictive potential. Before starting treatment the patient and his/her support person must be informed about the effect of the treatment and the possible risks, including interaction with drugs.

If neurological or other symptoms are present, the consultation of different specialists and additional treatment might be needed.

For relapse prevention **naltrexone**, the pure opiate antagonist is used. Naltrexone blocks the positive euphoric effect of opiates. It can be prescribed after successful detoxification treatment under regular supervision of the psychiatrist. Patient and his/her support person must be informed about possible risks associated with misuse of naltrexone. Use of heroin during treatment with naltrexone can cause dangerous complications.

Instruction for naltrexone treatment.

VI SUBSTITUTION TREATMENT FOR DRUG ADDICTION

The goal of long-term substitution treatment is to diminish illegal drug use, the use of drugs by injection and the occurrence of life-threatening intoxications, to prevent the spreading of dangerous infectious diseases, to decrease mortality associated with drugs, to prevent criminal behavior and diminish the costs connected with drug addiction in the society.

Long-term substitution treatment can be prescribed by professionals and institutions who are licensed by the health care department. Substitution must be regulated by unified legal acts. It needs coordinated activity and collaboration of different institutions (social services, police etc.), stable financial support from the government and qualified professionals.

6.1. Principles of substitution treatment

- Adequate dose of the substitute drug must during first months of treatment be titrated by a specialist.
- The substitute drug should be taken under supervision at certain time. Taking substitute drugs at home is possible for patients who have shown good compliance with the treatment program for a long time and are in a good mental state.
- Regular toxicological testing during treatment for the detection of the main drug and other psychoactive substances. In the initial phase of treatment (during first 3 months) the testing must be performed once a week.
- Spreading of substitution drugs to the illegal market must be prevented.
- Studies have shown that substitution treatment without psychosocial support has little effect.

- The use of low-dose substitution treatment is not effective in practice. Doses of 60-120 mg are more effective.
- The assessment of the patient's condition is performed every month.

6.2. Indications for substitution treatment:

- Repeating socially severe opiate dependency untreatable by other methods
- Proven duration of opiate dependency at least 5 years
- Repeatedly failed inpatient detoxification treatment
- Opiate dependency and comorbid chronic psychiatric disorders
- Severe opiate dependency and HIV-positivity
- Deranged behavior (criminal sentences)

Patient agrees with the conditions stated in the treatment contract

Contraindications for substitution treatment

- Age under 20 years (except HIV-positive persons)
- Use of different drugs, alcohol dependency
- Noncompliance with the treatment program
- Asocial lifestyle (homelessness, lack of residential permit)
- Failed substitution treatment during last 6 months

Criteria for stopping substitution treatment

- Two positive tests for drugs during the last month of treatment
- Irregular visits, 5 missed days during last month
- Absence from activities connected with the treatment program without reason
- Stopped substitution treatment for 5 days despite the reason. The situation needs new assessment and dose titration.
- Aggressive behavior and violation of the requirements stated in the treatment contract.
- Intolerance of the substitute drug.
- Continuous dose lowering with the aim of detoxification.

Table: Methadone drug interaction

VII NON-PHARMACOLOGICAL METHODS OF RELAPSE PREVENTION

The aim of treatment and rehabilitation is to help the addicted person to change his lifestyle and way of thinking to remain drug-free in an environment where drugs are easily available.

7.1 Model of change

The change model applied to drug misuse

The change model described by Prochaska and DiClemente is linked to the technique of *motivational interviewing* and has important practical applications for the assessment and treatment of persons with drug addiction.

Pre-contemplation
Contemplation
Decision
Action
Maintenance
Relapse

7.2 Cognitive-behavioural therapy

Cognitive-behavioural therapy is a school of psychotherapy frequently used for relapse prevention. Most of the techniques used in this therapy are also strategies for relapse prevention. A more detailed description of the methods is presented in Appendix 1.

7.3 Group therapy

When group therapy is used in the treatment of drug addiction, it must be clearly structured and concrete goals for therapy have to be set (see Appendix 2). Group therapy includes mechanisms of action that are not present in individual therapy. Group offers more possibilities for social support; it enables to learn from the experience of others and to get feedback about one's own behaviour. Group therapy can be based on different psychotherapeutic schools (psychodynamic, humanistic, cognitive-behavioural, psychodrama).

7.4 Family therapy

Usually the treatment of drug addiction is directed towards the addicted person. Family therapy is concerned with the whole family, the network can also include friends, colleagues and other persons involved. Family therapy is influenced by system theory that lies its focus not on a single person with a problem but on the family and surrounding as a whole. Therapy is directed towards this interactive entity. The goal of the therapy is to help the family find a way to change the system that leads to stopping drugs.

7.5 Self-help groups

Self-help groups, such as Narcotics Anonymous (NA), aim to help drug dependent individuals to become abstinent and revent relapse. The groups are lead not by professionals, but by former drug users. The task of a doctor is to inform the patient about the existing possibilities of getting help.

VIII REHABILITATION, DAY CENTRE AND THERAPEUTIC COMMUNITY

The ultimate goal of the rehabilitation of addicted drug users is to enable them to live independently of the effect of drug and also to be independent of the rehabilitatsion programme. Rehabilitation starts after the addict has stopped using illegal drugs.The basic philosophy of the treatment and rehabilitation is that the addicted person has to learn to help himself with the help of others.
The most commonly used drug free treatment modalities are:day center and therapeutic communities.In the drug free day centres and therapeutic communities there are three basic rules: no use of drugs, alcohol or psychopharmaca, no violence and no sexual acting out among clients during treatment.

8.1. Rehabilitation in day centre
8.2. Rehabilitation in therapeutic community
8.3. Treatment success

Rehabilitation programmes have proven to be successful for half of the residents that take part in them.The longer they remain in the programme,the better the result will be.If they finish the total programme the success of the therapeutic community is approximately 90%'Treatment in rehabilitation programmes costs money.However,leaving untreated drug addicts on the streets or in the prisons detention costs even more

IX COLLABORATION WITH OTHER PROFESSIONALS

Multidisciplinary approached has proved to be most effective in solving problems associated with drug misuse. The present chapter discribes the most important aspects fo integrative care.

First contact
The drug user may come into contact with various professionals. The first contact may occur from his own initiative or from the initative of the others.

9.1 Case management
Every professional who has passed special training can be a case manager for the drug addict.

9.2 Networking
The main principle is the collaboration between different specialists and important persons to help the addicted person. The range of network depends on the patient, on the severity of addiction and on the possibility to include different professionals. Networking is inevitable in complicated cases of addiction.

Network meeting
Goals of the network meeting

Making a plan of treatment
At the beginning of the work an individual plan of treatment and rehabilitation is made. Psychotherapeutic work is also included in the plan.

Main principles of integrative approach

X SECURITY MEASURES AND SAFETY OF THE STAFF

10.1 Security measures for the staff
Communication and work with drug addicts can be affected by the disruptive behaviour of the patients. For a drug addict there may be other reasons for contacting a professional than getting help. Drug users may come to the appointment in a state of intoxication or withdrawal or have inadequate expectations towards the staff. Disruptive and threatening behaviour can occur both during intoxication and withdrawal. In the treatment setting where drug addicts are seen and treated all safety measures should be taken into consideration and staff must be informed about the clear policy of action in case of patient's disruptive behaviour.

10.2 Safety of the patient

Due to their uncontrollable behaviour drug addicts may during withdrawal act in a way that is self-damaging. Uncontrolled craving for drug can lead to drug use during treatment. Chaotic use of different medicines can have serious consequences. Depression and risk of suicide must also be considered during withdrawal.

Safety of the patients in hospital can be achieved by clear policy in the treatment setting (isolation from the environment, supervised consumption of controlled drugs) and special training for the staff.

10.3 Preventing infection with HIV, hepatitis B and C

XI EMERGENCY CARE IN DRUG INTOXICATIONS

11.1 Introduction

Persons misusing drugs are at high risk of overdose, that can possibly be life-threatening. Usually overdose occurs accidentally, but it can also be used for attempted suicide. During last years the mortality and need for emergency care in connection with overdose has significantly increased in Estonia. The overdose of all drugs can cause serious somatic or mental disturbances.
Serious failure in functions of vital organs and drug induced psychotic states are indications for emergency care.

11.2 Treatment of opiate (heroin) overdose

Heroin overdose is a frequent cause of mortality or disability of a drug addict. In case of overdose immediate professional help and admission to an emergency department of a general hospital is needed.

Often the first contact of the drug addict with the health care system occurs due to overdose. If this is the case, it can be seen as a possibility to inform him about possible health hazards associated with drug use and to motivate him for entering detoxification treatment.

11.3 Treatment of overdose induced by other drugs

Amphetamine, ecstasy, cocaine and hallucinogens can also induce severe and life-threatening intoxication that needs professional help and admission to an emergency department.

No specific antidote exists for drugs except heroin. Intoxication is treated according to the general principles of intensive care.

11.4 Treatment of intoxication psychoses

Several drugs can cause intoxication psychoses. These states are often accompanied by inadequate behaviour harmful to oneself or the others. If psychiatric disturbances prevail, the person needs immediate admission to a psychiatric department.
In general, persons with intoxication psychoses recover quickly. When the psychosis persists for a longer period of time, manifestation of other mental disorderd should be considered.

XII PREGNANCY AND DRUG ADDICTION

Together with the spred of drug addiction the number of women using drugs has tremendously increased during last years. During next years the need for detoxofication treatment during pregnancy is also going to increase in Estonia. Evidence from the world practice shows that a well organised treatment provides the best results for the mother and the baby. Well organised treatments need good collaboration between different professionals.

12.1 Effect of drugs on the fetus and infant

Drugs have a damaging effect on fetal growth, course of pregnancy and health of the newborn. Neonatal withdrawal can occur in the children of regular drug users.

12.2 Management of antenatal care

Counselling and treatment should be started as early as possbile. The goal of the treatment is to stabilise or reduce drug use to the lowest possible dose and prevent withdrawal symptoms that can cause fetal distress, pre-term delivery and stillbirth.
Agonists of opioid receptors as methadone and buprenorphine are used in detoxification for opiate dependency. The dose of the substitute drug is reduced slowly and gradually. For prevention of neonatal withdrawal the detoxification treatment should be finished 2 months before delivery.

In cases of benzodiazepine and barbiturate dependency detoxification should also be performed as early as possible.

Users of amphetamine and cocaine are recommended to stop using drugs immediately, as no substitute drug is used.

12.3 Treatment of health problems in the newborn

Treatment of neonatal withdrawal depends on the severity of symptoms. Various scales are used to assess symptom severity. In milder cases pschoparmacologic treatment is not needed and withdrawal signs pass with good care. No consensus has been achieved concerning the drugs used for treating withdrawal states. Different preparations are used in practice.

A HIV-positive mother can transmit the infection to the baby. Caesarean section is recommended for reducing the risk of viral transmission.

The newborn child of a hepatitis-B positive mother should be immunized during first 24 hours for prevention of hepatitis B transmission.

When mother continues to use drugs, breastfeeding is not recommended, as drugs are excretes by breast milk. Breastfeeding is contraindicated when mother is HIV- or hepatitis-C-positive.

XIII YOUNG PEOPLE AND DRUGS

13.1. Legislation

The present chapter is concerning addiction treatment for persons who are under 18 years of age. Addiction treatment of adolescents is regulated by legal acts of Estonia: Child Protection Act, Family Law Act, Mental Health Act and Personal Data Protection Act. Consent from the lawful representative or parents of an adolescent is not necessary for giving emergency care. In such cases decision about treatment should be taken in 10 days. Persons with parental responsibility will be informed and support for any proposed treatment will be sought.

When addiction treatment is needed for an adolescent under 18 years of age, informing, support and consent from persons with parental responsibility is necessary.

Giving information about the child's health status and treatment is regulated by the Mental Health Act and Personal Data Protection Act.

13.2. Principles of good practice

Consent must be obtained from persons with parental responsibility and family should be involved in the treatment process. Treatment is provided in collaboration with other children's and young people's services and substance misuse services according to a concrete plan of action. The responsibility must be clearly determined.

The first task of the person with whom the first contact took place is to inform the parents of the child about the addiction problem. If the problem persists, police, general practitioner and social worker must be informed. Social worker invites members of the local network together with the child and parents.

Outpatient treatment is effective when the child has a good support network and parents are motivated for collaboration. At the beginning of the treatment a contract will be signed by the parent or the person with parental responsibility (social worker or child protection worker).

Different phases of treatment can be distinguished. Active treatment is provided by medical institutions. It includes detoxification and treatment of mental disorders. The child's family is involved in the treatment process since the first phase.

Rehabilitation is given in a separate institution or at home where the child's family or foster family lives. The course of rehabilitation will be followed by a multi-professional team until the child's mental state is stable.

Regular contacts between different professionals dealing with the case help to make correct assessment of the patient and to set realistic goals of treatment.

XIV CRIMINAL JUSTICE SYSTEM

14.1. Police custody

A large proportion of drug misusers come into conflict with the law and are taken into police custody. When the police officer suspects that the detainee misuses drugs, he has the right to take him to a medical institution for his state of intoxication to be determined. Expertise of the state of intoxication is performed according to the regulation No 120 issued by the Government of Estonia, April 2, 2001 (see Appendix 4).

According to the law use of drugs and psychotropic medication without prescription of a doctor is regarded as violation of the law that may be amerced with up to 100 days' salary or sentenced by administrative confinement for up to 30 days (Administrative Law § 158).

14.2. Probation Service

The function of probation services is to supervise community sentences and ex-prisoners after release, including those with treatment as a condition of probation, to help offenders in social adaptation and solving different social problems.

14.3. The Prison Service

In prison the treatment of drug addiction is provided by the hospital or the medical department, preventive work and social security benefits are organized by social workers. The treatment possibilities in prison for drug misusing offenders must be equal to those in the community. Focus lies on preventive actions and early detection of drug addiction.

Prison as a unique operating environment with specific security requirements within which drug services have to be delivered safely and responsibly. Doctors working within prisons should have the expertise and training to be able to provide drug addiction treatment.

A prerequisite for addiction treatment in prison is the build-up of drug-free units.

XV APPENDICES

APPENDIX 1 Cognitive-behavioral therapy in the treatment of drug addiction

Treatment of drug addiction is effective when biological methods are combined with psychotherapy. Psychotherapy for drug addicts must be well-strucutured and goal-oriented. The effectiveness of cognitive-behavioural therapy in the treatment of drug addiction and relapse prevention is well proved. This method is also suitable for comorbid mental disorders, especially mood and anxiety disorders.

Goal of cognitive-behavioural therapy

General principles of cognitive-behavioural therapy

Cognitive model if drug addiction

Releasing stimuli

Addictive convictions

Characteristic features of the therapeutic relation

Techniques of cognitive-behavioural therapy

Motivating

Cognitive techniques

Explanation of the cognitive model

Determination of automatic thoughts and convictions associated with drug use and control

Disputing

Reowning of responsibility

Formation of convictions of control

Analysis pro and contra

Imaginative techniques

Behavioural techniques

Following and planning of actions

Technique of stimulus control

Coping with life problems
Coping with the craving for drugs

APPENDIX 2 Group therapy in the treatment of drug addiction
Group therapies form an important element in the treatment of addoicts.When making a choice out of the various forms of group therapy it is advisable to take the particular characteristics of addicts into account.The types of group therapy which are used in the treatmentof addicts are primarily aimed at strengthening selfesteem,learning, how to cope with emotions and improving personal relationships.
In the groups all participants are encouraged to take in active part.
The various methods which are used are often direct and confrontational.Inderect psychoanalytical orientated groups are in general hardly ever effective when treating people with manipulative behaviour and a strong defence mechanism such as in addicts.

Assertiveness training
Psychodrama
Bonding psychotherapy (the new indentity process)
Rational emotive therapy (RET)
Encounter Groups

APPENDIX 3 Range of detoxification and substitution treatment on different levels of Health Care (ratified by regulation No 20 of the Minister of Social Affairs, March 18, 1998).

APPENDIX 4 Order of determining state and level of intoxication (regulation No 120 by the Estonian Government, April 2, 2001). **in the treatment of drug addiction**