Alliance for Public Health

MEDICAL PSYCHOSOCIAL SUPPORT FOR PATIENTS IN OPIOID AGONIST THERAPY:

AN ANALYTICAL REVIEW

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➲ ABBREVIATIONS AND ACRONYMS

ART	Antiretroviral Therapy
CBT	Cognitive Behavioral Therapy
HCF	Healthcare Facility
HIV	Human Immunodeficiency Virus
MI	Motivational Interviewing
MoH	Ministry of Health of Ukraine
MPSP	Medical Psychosocial Support
OAT	Opioid Agonist Therapy
OUD	Opioid Use Disorder
PHC	Public Health Center of the Ministry of Health of Ukraine
PWID	People Who Inject Drugs
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

➲ CONTENTS

➲ REPORT SUMMARY

This analytical review aims to highlight the importance of medical psychosocial support (MPSS) in the context of opioid agoinist therapy (OAT), analyze international experience, and provide recommendations for Ukraine. The study includes a review of scientific literature, an analysis of statistical data, and a comparative assessment of international practices.

The review emphasizes the significance of MPSS in OAT for treating opioid dependence. OAT, using methadone and buprenorphine, effectively reduces the use of illicit drugs and the risk of infections while improving social functioning. International standards (WHO, UNODC) stress the importance of a biopsychosocial model that integrates medication-assisted treatment with psychological and social support, including cognitive-behavioral therapy (CBT) and self-help groups.

International experience (Australia, Portugal, Germany) demonstrates diverse approaches to OAT, underscoring patient-centered care and a multidisciplinary approach. The effectiveness of MPSS is confirmed by reduced relapse rates, improved quality of life, and better infection control. Ukrainian studies also highlight the benefits of integrating psychosocial services, though their availability remains limited.

In Ukraine, despite legislative provisions, OAT faces challenges. Accessibility remains low, covering only 5.8% of the estimated opioid-using population. Just 16.8% of OAT patients have access to psychosocial support. The ongoing war in Ukraine has exacerbated existing issues, leading to the closure of OAT sites, disruptions in medication supply, and difficulties in providing psychosocial support.

Long-term changes are needed, including the introduction of social worker positions in healthcare facilities, the development of MPSS standards for OAT patients, and models for psychosocial support during self-administered OAT.

In the short term, efforts should focus on sustaining psychosocial services at OAT sites, formalizing mobile outreach teams, providing outreach support, training specialists, adapting to remote service delivery, and securing funding for psychosocial support through international donors.

➲ INTRODUCTION

One of the key approaches to treating opioid dependence is **opioid agonist therapy (OAT)**. This method involves the use of controlled medications (such as methadone or buprenorphine) to alleviate withdrawal symptoms and reduce the risk of relapse. OAT aims to stabilize patients, decrease illicit drug use, lower the spread of infectious diseases (HIV, hepatitis C), and improve the social functioning of individuals with substance dependence. Additionally, OAT helps reduce overall healthcare costs (Fairley et al., 2021[1]).

Opioid Agonist Therapy (OAT) *is a treatment method for opioid dependence that involves the use of opioid receptor agonists (such as methadone or buprenorphine) to alleviate withdrawal symptoms, manage cravings for illicit drugs, and stabilize the patient's condition. This approach facilitates social adaptation and improves quality of life.*

This approach is recognized by the World Health Organization (WHO), the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), and is actively used in many countries around the world as one of the most effective methods for treating opioid dependence.

Despite the effectiveness of OAT, its application without proper medical, psychological, and social support remains limited in achieving long-term positive outcomes. Therefore, in international practice, **OAT is implemented as a comprehensive intervention that includes not only pharmacological treatment but also psychological support and social integration of patients.**

In Ukraine, OAT is regulated by the relevant orders of the Ministry of Health and is primarily implemented as a medical program with limited involvement of psychosocial support, which narrows its potential and prevents it from achieving maximum effectiveness, as seen in countries with developed integrated models. Therefore, an important direction for the development of OAT in Ukraine is **the introduction of medical psychosocial support (MPSS)**, which ensures a comprehensive approach to patient support.

This analytical review **aims** to highlight the importance of medical psychosocial support (MPSS) in the context of opioid agonist therapy (OAT), analyze the global experience of implementing this model, its effectiveness, and the possibilities for adaptation in Ukraine.

Objectives of the work:

1. To highlight the history and development of MPSS in OAT.
2. To explore the practices of implementing MPSS in OAT in various countries.
3. To assess the effectiveness of MPSS based on current research.

[1] Fairley, M. et al. (2021). Cost-effectiveness of Treatments for Opioid Use Disorder. *JAMA Psychiatry*, *78*(7), 767-777. https://doi.org/10.1001/jamapsychiatry.2021.0247

4. To provide recommendations for the Ukrainian healthcare and social services systems on integrating MPSS into OAT programs.

Methodology of analysis. A comprehensive approach was used for the analytical review of medical psychosocial support for patients undergoing OAT, which includes:

1. *Review of academic literature and regulatory acts*
    - Analysis of peer-reviewed publications in international and national academic journals addressing approaches to organizing OAT and its integration with psychosocial support.
    - Desk study of official documents from WHO, UNICEF, UNODC, and other international organizations on the standards for treating opioid dependence.
    - Analysis of Ukrainian legislation and policies in the field of OAT, including Ministry of Health orders, recommendations from relevant ministries, and programs from international donors.
2. *Analysis of statistical data*
    - Study of official statistics on OAT coverage in Ukraine and other countries.
    - Analysis of data on the effectiveness of OAT programs.
3. *Comparative analysis of international experience*
    - Analysis of OAT models in countries with developed psychosocial support systems.
    - Identification of key components of effective programs: multidisciplinary teams, individualized approach, social integration of patients.
    - Comparison of management models and funding sources.

➲ 1. GENERAL OVERVIEW OF OPIOID AGONIST THERAPY

History of Opioid Agonist Therapy (OAT)

Methadone was synthesized in the early 20th century as a synthetic analogue of morphine. The first attempts to use methadone for the treatment of opioid dependence were made in various countries almost simultaneously. In 1959, R. Halliday applied methadone in Canada (Halliday, 1963[2]), and in 1963, American medical doctors V. Dole and M. Nyswander initiated its use in the United States. In Europe, one of the first to use methadone for maintenance therapy was L. Gunne in Switzerland in 1967.

Despite the fact that R. Halliday was the first to use methadone for long-term treatment of drug dependence, he is not considered the founder of substitution therapy. It was V. Dole and M. Nyswander (1967[3]) who developed a fundamentally new approach to treating opioid dependence, which significantly differed from previous methods. Their concept was based on the idea that the primary goal of therapy was not the complete cessation of opioid use, but the stabilization of the physical and mental state of patients.

In the 1960s, Dole and Nyswander initiated a pilot program for the treatment of heroin addiction with methadone. The results showed that this drug helped prevent withdrawal symptoms and did not require constant dose increases with long-term use.

The authors of this method proposed the hypothesis that drug addiction is caused by a disruption in the metabolism of the brain's opioid system. Regular methadone use helps normalize neurotransmitter exchange, ensuring a stable physical and mental state for the patient. Similar to insulin therapy for people with diabetes, OAT does not eliminate the root cause of addiction, but it helps control its manifestations and significantly improves the quality of life for patients.

In 1964, the United States abandoned compulsory drug addiction treatment and began widely implementing the methadone program. This led to a significant reduction in crime related to illegal drug trafficking and helped stabilize the social situation. After 1980, the number of cases of HIV and viral hepatitis infections among people who inject drugs significantly decreased.

Today, the United States has over 750 methadone centers that provide assistance to more than 210,000 people with heroin addiction. Their experience demonstrates the effectiveness of a comprehensive approach to treating opioid addiction, combining medication therapy with psychosocial support (Samsó Jofra et al., 2022[4]).

In Europe, the implementation of OAT occurred approximately two decades later than in the United States. Its spread was largely facilitated by decisions made by members of the European Opiate Addiction Treatment Association, who in the 1980s actively discussed key issues: the choice between short-term and long-term detoxification, the prioritization of approaches—harm

[2] Halliday, R. (1963). Management of the narcotic addict. *British Columbia Medical Journal*, 412–414.

[3] Dole, V. P., & Nyswander, M. E. (1967). Heroin addiction: A metabolic disease. *Archives of Internal Medicine, 120*, 19–24.

[4] Samsó Jofra, L., Puig, T., Solà, I., & Trujols, J. (2022). Interim opioid agonist treatment for opioid addiction: a systematic review. *Harm Reduct J*, *19*(1), 7. https://doi.org/10.1186/s12954-022-00592-x

reduction or specific therapy aimed at complete abstinence—and the integration of treatment for co-occurring, primarily mental, disorders into the process of opioid addiction therapy.

In 1991, a study was conducted examining a group of 513 participants in methadone-assisted treatment for opioid addiction based on self-reports. The study demonstrated significant advantages of methadone treatment compared to detoxification followed by subsequent psychological treatment. It was proven that methadone therapy significantly reduces opioid overdose mortality. (Fairbank et al., 1993[5]).

Thus, opioid agonist therapy gradually established itself as a scientifically grounded method for treating opioid addiction, the effectiveness of which has been confirmed through research and practical experience of its implementation in various countries (Dvoryak, 2016[6]; Metelyuk, 2024[7]).

Development of OAT in the 2000s

Despite the mixed public opinion, OAT gradually gained widespread recognition and adoption worldwide. In the early 21st century, the **International Narcotics Control Board** (INCB) noted that many governments had already chosen OAT as one of the methods for treating opioid addiction. This approach involves the use of substances with similar effects but lower risks, which are prescribed by a doctor to stabilize the patient's condition and reduce the harm caused by the use of illegal drugs. (INCB, 2003[8]).

An important step in the development of OAT was the publication of a joint document by the **WHO, UN, and UNAIDS** in 2004, which summarized scientific data on the effectiveness of this approach. According to the experts' conclusions, OAT is a safe, cost-effective, and evidence-based method for treating opioid addiction. Research confirmed that the success of the therapy depends on the timely initiation, continuous use of medication, and proper dosage. The document presents data showing that OAT benefits both individuals and society as a whole. For patients, it helps stabilize their condition, improve overall well-being, and enhance social functioning. At the societal level, the implementation of OAT contributes to reducing crime rates, lowering medical care and criminal justice costs, and decreasing the spread of HIV and other bloodborne infections. (WHO/UNODC/UNAIDS, 2004[9]).

In 2005, the **WHO** made the decision to include methadone in the List of essential medicines (WHO, 2005[10]), marking a significant step towards international recognition of OAT. This decision

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[5] Fairbank, J. A., Dunteman, G. H., & Condelli, W. S. (1993). Do methadone patients substitute other drugs for heroin? Predicting substance use at 1-year follow-up. *The American Journal of Drug and Alcohol Abuse*, 19(4), 465–474.

[6] Dvoryak, S. V. (2016). *Intehrovana medyko-sotsialna dopomoga khvorym iz zalezhnyustyu vid opioyidiv* [Integrated medical-social assistance for patients with opioid dependence] (Doctoral dissertation, specialty 14.01.17). Kharkiv. https://uacademic.info/download/file/0516U000594/dis.doc

[7] Metelyuk, A. S. (n.d.). *Sotsialna prophylyaktyka VIL zasobamy zamisnoi pidtrymuvalnoi terapii* [Social prevention of HIV through opioid substitution therapy] (Doctor of Philosophy dissertation, specialty 231). Kyiv. https://elibrary.kubg.edu.ua/id/eprint/48427/

[8] International Narcotics Control Board (2003). *Report of the International Narcotics Control Board for 2002*. New York. https://www.incb.org/incb/en/publications/annual-reports/annual-report-2002.html

[9] WHO/UNODC/UNAIDS (2004). Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention. https://www.unodc.org/documents/hiv-aids/Position%20Paper%20sub.%20maint.%20therapy.pdf

[10] WHO (2005). The selection and use of essential medicines. https://iris.who.int/bitstream/handle/10665/43292/WHO_TRS_933_eng.pdf?sequence=1&isAllowed=y

was based on a review of 28 studies involving around 8,000 participants, which confirmed the effectiveness of this approach.

After this, methadone therapy began to be implemented even in countries where it had previously been resisted due to moral and ideological prejudices. Due to its clear advantages and scientifically proven results, maintenance therapy with agonists is now successfully carried out in countries such as China, Iran, Indonesia, and Vietnam (Dvoryak, 2016[11]).

Modern Biopsychosocial Approach

The first studies and attempts to integrate psychosocial support into addiction treatment were conducted in the United States and Canada in the 1970s when methadone substitution therapy began to be widely used for treating heroin addiction. Although at that time the main focus was on pharmacological treatment, it gradually became clear that this was insufficient to reduce relapse rates. Addiction, including opioid dependence, often has a complex nature, involving biological, psychological, and social factors.

Since the systematic implementation of OAT, it has been proven that better results are achieved through psychological and psychotherapeutic support, as measured by indicators such as retention in the program, reduced heroin use, and decreased risky behaviors (McLellan et al., 1993[12]; Simpson & Joe, 1993[13]).

Research also revealed that many patients continued to use drugs even while receiving substitution therapy. This stimulated the development of approaches that combine pharmacological treatment with psychosocial support. The idea was to address the psychological and social consequences of addiction by involving psychologists, social workers, and other specialists (Dennis et al., 2014[14]).

Thus, OAT is based on the biopsychosocial model of health, which recognizes the interconnection between biological, psychological, and social factors. This holistic model emphasizes the importance of considering the complex impact of these factors on the patient's condition (Engel, 1980[15]; Frankel et al., 2003[16]).

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[11] Dvoryak, S. V. (2016). *Intehrovana medyko-sotsialna dopomoga khvorym iz zalezhnyustyu vid opioyidiv* [Integrated medical-social assistance for patients with opioid dependence] (Doctoral dissertation, specialty 14.01.17). Kharkiv. https://uacademic.info/download/file/0516U000594/dis.doc

[12] McLellan, A. T., Arndt, I. O., Metzger, D. S., Woody, G. E., & O'Brien, C. P. (1993). The effects of psychosocial services in substance abuse treatment. *JAMA*, 269, 1953-1959.

[13] Simpson, D. D., & Joe, G. W. (1993). Motivation as a predictor of early dropout from drug abuse treatment. *Psychotherapy: Theory, Research, Practice, Training*, 30(2), 357-368.

[14] Dennis, B., Naji, L., Bawor, M., Bonner, A., Varenbut, M., Daiter, J., Plater, C., Paré, G., Marsh, D., Worster, A., Desai, D., Samaan, Z., & Thabane, L. (2014). The effectiveness of opioid substitution treatments for patients with opioid dependence: a systematic review and multiple treatment comparison protocol. *Systematic Reviews*, 3, 105 - 105. https://doi.org/10.1186/2046-4053-3-105.

[15] Engel, G. L. (1980). The clinical application of the biopsychosocial model. *American Journal of Psychiatry, 137*(5), 535–544.

[16] Frankel, R. M., Quill, T. E., & McDaniel, S. H. (Eds.). (2003). *The biopsychosocial approach: Past, present, future*. University of Rochester Press.

The summary of the information provided earlier in this section, along with data from other sources (Copenhaver et al., 2007[17]; Coviello et al., 2009[18]; Miller et al., 2001[19]) provides grounds to describe the three interconnected components of OAT:

1) medical;
2) psycological;
3) social.

The **medical component** focuses on stabilizing the physical condition of patients through controlled dosing of medications (such as methadone or buprenorphine) and the treatment of comorbid conditions. Key tasks include ensuring stable physical health through regulated medication doses, monitoring and correcting potential side effects, providing medical consultations, and assisting with the treatment of co-occurring conditions such as HIV, hepatitis, or tuberculosis.

This component also includes the assessment and treatment of possible mental health disorders, such as depression or anxiety disorders, which may accompany addiction.

Regular health monitoring of patients helps prevent therapy side effects and reduces risks associated with opioid dependence (Lowe et al., 2016[20]).

The **psychological component** aims to support motivation for treatment, reduce anxiety and depression levels. This component includes individual counseling with a psychologist, group psychotherapy for patient support, and the use of Cognitive Behavioral Therapy (CBT) techniques and Motivational Interviewing (MI).

Studies show that patients who participated in CBT sessions are 30% more likely to remain in treatment programs compared to those who did not receive such support (Dugosh et al., 2016[21]). The successful combination of psychological support with substitution therapy reduces the risk of relapse into drug use.

The **social component** is aimed at rehabilitating patients through assistance in employment, learning new professional skills, and engaging in social activities. Additionally, an important element is combating the stigma surrounding patients. This component, in particular, includes:

- Creating a support network for patients, including family, friends, and mutual help groups, which can contribute to their recovery;
- Assisting in establishing social connections, returning to work, and restoring social functionality;

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[17] Copenhaver, M. M., Bruce, R. D., & Altice, F. L. (2007). Behavioral counseling content for optimizing the use of buprenorphine for treatment of opioid dependence in community-based settings: A review of the empirical evidence. *The American Journal of Drug and Alcohol Abuse*, 33, 643-654.

[18] Coviello, D. M., Zanis, D. A., Wesnoski, S. A., & Domis, S. W. (2009). An integrated drug counseling and employment intervention for methadone clients. *Journal of Psychoactive Drugs*, 41(2), 189-197.

[19] Miller, N. S., Sheppard, L. M., Colenda, C. C., & Magen, J. (2001). Why physicians are unprepared to treat patients who have alcohol- and drug-related disorders. *Academic Medicine*, 76(5), 410-418.

[20] Low, A., Mburu, G., Welton, N., et al. (2016). Impact of Opioid Substitution Therapy on Antiretroviral Therapy Outcomes: A Systematic Review and Meta-Analysis. *Clinical Infectious Diseases: An Official Publication of the Infectious Diseases Society of America*, 63, 1094 - 1104. https://doi.org/10.1093/cid/ciw416

[21] Dugosh, K., Abraham, A., Seymour, B., McLoyd, K., Chalk, M., & Festinger, D. (2016). A Systematic Review on the Use of Psychosocial Interventions in Conjunction With Medications for the Treatment of Opioid Addiction. *Journal of Addiction Medicine*, 10, 91 - 101. https://doi.org/10.1097/ADM.0000000000000193.

- Training staff and conducting educational campaigns to foster a tolerant attitude towards patients.

Support programs are based on developing individualized treatment plans that consider the needs of each patient and provide social support throughout the therapy.

According to the study by Metelyuk (2024[22]), social support plays a key role in providing harm reduction services for people who inject drugs (PWID). It aims to:

- Reduce the frequency or eliminate the use of "street" drugs;
- Address issues arising from substance abuse (legal, social, family, etc.);
- Reduce risky behaviors, particularly the risk of HIV infection, viral hepatitis, and other blood-borne and sexually transmitted infections;
- Decrease the likelihood of relapse into illicit drug use in the future;
- Reduce criminal activity;
- Stabilize the emotional and psychological state of the patient;
- Foster adherence to treatment related to somatic diseases.

***Social support** is a form of organizing social work with recipients of OAT, carried out by members of an interdisciplinary team. The core members of this team include a medical doctor, a nurse, and a social worker.*

The *role of the social worker* in the interdisciplinary team includes:

- Providing preliminary counseling to people who inject drugs (PWID) regarding their potential participation in OAT and offering necessary information on the subject.
- Assessing the patient's needs in the social and legal spheres.
- Collaborating with the psychologist and the patient to develop an individual social rehabilitation plan for PWID.
- Offering individual and group counseling; counseling family members of PWID.
- Assisting in solving social issues faced by OAT patients (document preparation, social assistance, housing search, employment, etc.).
- Actively participating in team meetings.

The *role of the psychologist* (addiction counselor) includes:

- Assessing the psychological condition of OAT patients, and collaborating with the social worker and the patient to create an individual social rehabilitation program.
- Conducting individual and group psychological counseling sessions according to the protocol.
- Providing psychological counseling to the family members of OAT patients; monitoring patients' conditions and evaluating treatment effectiveness in accordance with the procedure for determining the severity index of addiction.
- Supporting the functioning of self-help groups established by OAT patients.

[22] Metelyuk, A. S. (n.d.). *Sotsialna prophylyaktyka VIL zasobamy zamisnoi pidtrymuvalnoi terapii* [Social prevention of HIV through opioid substitution therapy] (Doctor of Philosophy dissertation, specialty 231). Kyiv. https://elibrary.kubg.edu.ua/id/eprint/48427/

Moreover, social support should reflect an approach to service delivery that upholds the rights of OAT patients in the following aspects of life: personal life and confidentiality; attentive, impartial treatment and respect; self-determination and autonomy in choosing the OAT medication; access to high-quality medical and social services (Metelyuk, 2024[23]).

In international practice, OAT is recognized as the first-line treatment for patients with opioid addiction. Clinical protocols in developed countries recommend mandatory social support to ensure a comprehensive approach to treatment and the social adaptation of patients (Bruneau et al., 2018[24]; Schwarz et al., 2024[25]).

The integrated approach, which combines all three components, helps provide more effective and holistic support for patients undergoing OAT, taking into account all aspects of their lives.

[23] Metelyuk, A. S. (n.d.). *Sotsialna prophylyaktyka VIL zasobamy zamisnoi pidtrymuvalnoi terapii* [Social prevention of HIV through opioid substitution therapy] (Doctor of Philosophy dissertation, specialty 231). Kyiv. https://elibrary.kubg.edu.ua/id/eprint/48427/

[24] Bruneau, J., Ahamad, K., Goyer, M., Poulin, G., Selby, P., Fischer, B., Wild, T. C., Wood, E., & Misuse, C. C. R. I. i. S. (2018). Management of opioid use disorders: a national clinical practice guideline. *CMAJ*, *190*(9), E247-E257.

[25] Schwarz, T., Anzenberger, J., Busch, M., Gmel, G., Kraus, L., Krausz, M., ... & Uhl, A. (2024). Opioid agonist treatment in transition: A cross-country comparison between Austria, Germany and Switzerland. *Drug and Alcohol Dependence*, *254*, 111036.

➲ 2. PSYCHOSOCIAL INTERVENTIONS IN THE TREATMENT OF SUBSTANCE USE DISORDERS

WHO Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence (2009)

In 2009, the World Health Organization (WHO) **released the Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence** (WHO, 2009[26]). These recommendations are based on systematic reviews of available literature and consultations with experts from various regions around the world.

In this document, psychosocially assisted pharmacological treatment is defined as a combination of specific pharmacological and psychosocial interventions used to reduce illicit opioid use and associated risks, as well as to improve the quality of life. While psychosocial interventions are varied, only a few specific medications are used for the treatment of opioid dependence.

> ***Psychosocial Support*** *– a broad range of interventions at both the social and psychological levels. Interventions at the social level include assistance in meeting basic needs, such as food, clothing, housing, employment, as well as basic healthcare, friendship, community involvement, and the pursuit of happiness.*
> *Interventions at the psychological level range from unstructured supportive psychotherapy and motivational interviewing techniques to highly structured psychological methodologies (WHO, 2009, p. 47[27]).*

The WHO document describes **two approaches to psychological interventions within OAT**:

1) Cognitive Behavioral Therapy (CBT);
2) Contingency management; in Ukrainian academic discourse, the translation "crisis management" is also used.

Cognitive Behavioral Therapy (CBT) is a leading method in the treatment of various mental and behavioral disorders, including phobias, anxiety, and obsessive-compulsive disorders. It is also effective for depression and eating disorders. In the context of addiction, CBT is based on the principle that addictive behaviors are learned and can be changed.

Cognitive approaches aim to alter addictive behavioral patterns by correcting destructive cognitions that support the addiction or by fOATering a positive perception and motivation for change. Among the common variants of CBT are cognitive therapy and motivational enhancement therapy

Behavioral approaches are based on mechanisms of conditional learning, specifically classical and operant conditioning. They include:

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[26] WH0 (2009). *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence*. Geneva. https://www.who.int/publications/i/item/9789241547543

[27] WH0 (2009). *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence*. Geneva. https://www.who.int/publications/i/item/9789241547543

- methods for extinguishing conditioned responses (e.g., exposure therapy with response prevention);
- methods of instrumental learning (e.g., reinforcement or contingency management through the community), where positive behavior without drug use is rewarded.

Contingency management is an approach that uses a system of rewards and punishments to shape desired behavior through a clearly structured, transparent method. The main focus is on positive reinforcement of desired behaviors.

The main elements of a contingency management program are:

• Clear definition of desired behavior (e.g., abstaining from opioids);

• Regular monitoring of the behavior (e.g., urine drug testing);

• Specified rewards for desired behavior (cash payments, vouchers, permission to receive methadone for self-administration, or participation in a lottery);

• Positive feedback from staff regarding the patient's achievements.

An important element of the comprehensive approach to treating opioid addiction, according to WHO, is **social interventions**. These include the following areas:

1. *Vocational training* – programs that help patients find and maintain employment. They include training in professional skills, creating special conditions for employment, and monitoring drug use in the workplace.
2. *Housing programs* – initiatives aimed at providing stable housing for people with addiction. They can range from temporary group housing for homeless individuals to long-term affordable housing. Having stable housing is often a prerequisite for starting effective treatment.
3. *Leisure* – the opportunity to participate in cultural, sports, or other forms of active recreation. These programs promote social integration and improve the emotional well-being of patients.
4. *Self-help groups* – voluntary associations of individuals who help each other overcome addiction. They focus on supporting abstinence from drugs, providing material and emotional assistance, and forming new life goals. Patients undergoing pharmacological treatment are recommended to participate in such groups, as research shows their positive role in the rehabilitation process.
5. *Social skills training* – teaching methods based on learning theory principles that help patients develop and reinforce effective social interaction skills. It is important that the training occurs in real-life situations rather than in closed or artificial environments.
6. *Traditional and spiritual healers* – in some cases, they may play a role in providing psychosocial support if their methods are acceptable to the patient. While their effectiveness goes beyond the scope of this document, medical staff may consider such approaches when working with patients.

The WHO document also states that doctors and healthcare workers should choose which psychosocial interventions to offer to patients with opioid addiction based on scientific evidence, the suitability of the method to the individual patient's situation, its acceptability to the patient, the availability of trained staff, and cultural appropriateness. At the same time, OAT counselors

should have access to social services and community resources to provide comprehensive support to patients. (WHO, 2009[28]).

As of the beginning of 2025, these Guidelines are under review. Discussions of the results from systematic studies, which will inform the updated Guidelines, are scheduled for October 2025 (WHO, 2015[29]).

WHO document "Community management of opioid overdose" (2014)

In 2014, the WHO released the document "**Community Management of Opioid Overdose**" (WHO, 2014[30]).

These guidelines are aimed at reducing mortality from opioid overdose by providing evidence-based recommendations regarding the availability of naloxone for individuals who may witness an overdose, as well as guidance on resuscitation and pOAT-overdose care in the community.

The document emphasizes the importance of supporting patients, particularly during the process of OAT, and defines **psychosocial interventions** as any non-pharmacological intervention that takes place within a therapeutic context at the individual, family, or group support level.

Such interventions can vary in their level of structure and professionalism. They include:

- *Structured psychological interventions* conducted by specialists, such as cognitive-behavioral therapy (CBT) and insight-oriented psychotherapy.
- *Non-professional psychological and social interventions*, including:
  - ✓ Self-help groups;
  - ✓ Support from traditional healers;
  - ✓ Housing provision;
  - ✓ Financial and legal support;
  - ✓ Assistance in employment;
  - ✓ Informational and advisory assistance.

These measures aim to improve the emotional state and social integration of individuals suffering from opioid dependence and are an essential part of a comprehensive approach to their treatment and rehabilitation.

International standards for the treatment of drug use disorders (2020)

In 2020, the WHO and the United Nations Office on Drugs and Crime (UNODC) presented the ***International Standards for the Treatment of Drug Use Disorders*** (UNODC, 2020[31]). This document is based on the results of field studies and covers a wide range of treatment

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[28] WH0 (2009). *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence*. Geneva. https://www.who.int/publications/i/item/9789241547543

[29] WHO (2015). *WHO updates guidelines on opioid dependence treatment and overdose prevention*. https://www.who.int/news/item/09-02-2025-who-updates-guidelines-on-opioid-dependence-treatment-and-overdose-prevention

[30] WHO (2014). Community management of opioid overdose. https://iris.who.int/bitstream/handle/10665/137462/9789241548816_eng.pdf?sequence=1&isAllowed=y

[31] UNODC (2020). *International standards for the treatment of drug use disorders: revised edition incorporating results of field-testing.* Geneva: World Health Organization and United Nations Office on Drugs and Crime. https://www.unodc.org/documents/drug-prevention-and-treatment/UKR_UNODC-WHO_International_Standards_Treatment_Drug_Use_Disorders_unoff_2020.pdf

approaches, including opioid substitution therapy (OAT) and treatment for disorders caused by the use of various narcotic substances. It is advisory in nature rather than imperative.

Key aspects of the standards:

1. Definition of the core components of effective treatment systems;
2. Description of treatment methods and interventions considering the individual needs of patients;
3. An approach to treatment that aligns with the principles of managing chronic diseases.

The document emphasizes a **comprehensive approach** to service delivery, which includes continuous monitoring and evaluation of effectiveness. It highlights that there is no universal treatment model, and therapy should be tailored to the needs of each patient.

In particular, it recommends the integration of treatment services, specifically:

- ✓ Psychiatric, psychological, and psychosocial support;
- ✓ Social support (housing, vocational training, employment, legal assistance);
- ✓ Specialized medical services (treatment for HIV, hepatitis C, tuberculosis, etc.).

It is worth mentioning that the document outlines different types of interventions at various levels of the service delivery system, which are designed to ensure continuity of treatment and care (**Table 1**).

Table 1. Recommended Interventions to Ensure Continuity of Treatment and Care

System Level	Possible Interventions
Informal Community Care	• Outreach interventions • Self-help groups and recovery management • Informal support from friends and family
Primary Health Care Services	• Screening, brief interventions, referrals to specialists, treatment of substance use disorders • Ongoing support for individuals undergoing treatment/engaged with specialized drug treatment services • Basic healthcare services, including first aid and wound care
Generic Social Welfare	• Housing/shelters • Nutrition • Guaranteed social support (social services and assistance provided without prerequisites or restrictions) • Referral to specialized drug treatment centers and other medical and social care facilities if needed
Specialized Treatment Services (Outpatient and Inpatient)	• Assessment • Treatment planning • Patient management • Detoxification/management of withdrawal symptoms • Psychosocial interventions • Medication treatment • Relapse prevention • Recovery management

Other Specialized Health Care Services	• Treatment by mental health specialists (including psychiatric and psychological care) • Treatment by specialists in internal medicine, surgery, pediatrics, obstetrics, gynecology, and other specialized care • Dentistry • Treatment of infectious diseases (including HIV, hepatitis C, and tuberculosis)
Specialized Social Welfare Services for People with Drug Use Disorders	• Family support and reintegration • Vocational education/educational programs • Income generation/ microloans • Leisure planning • Recovery management services
Long-term Residential Services for People with Drug Use Disorders	• Rehabilitation programs for individuals with severe or complex drug-related disorders and co-occurring conditions • Housing • Vocational training • Protected environment • Life skills training • Continuous therapeutic support • Referral to outpatient treatment/recovery management services

Source: (UNODC, 2020, p. 18 [32]).

The document emphasizes the need for a holistic and intersectoral approach to the treatment of drug addiction, combining medical, social, and legal support to ensure sustainable outcomes.

The standards clearly distinguish key aspects of social support:

- Basic social support
- Specialized social services,
- Long-term social care and support,
- Psychosocial interventions as part of specialized treatment.

Psychosocial interventions are characterized in the document as an important element of outpatient drug addiction treatment programs. They aim to strengthen motivational, behavioral, psychological, and social factors and have proven effectiveness in:

1) Reducing drug use,
2) Minimizing associated risks,
3) Improving treatment adherence,
4) Promoting abstinence,
5) Preventing relapses.

[32] UNODC (2020). *International standards for the treatment of drug use disorders: revised edition incorporating results of field-testing.* Geneva: World Health Organization and United Nations Office on Drugs and Crime. https://www.unodc.org/documents/drug-prevention-and-treatment/UKR_UNODC-WHO_International_Standards_Treatment_Drug_Use_Disorders_unoff_2020.pdf

Effective psychosocial interventions include:

- ✓ Psychoeducation,
- ✓ Cognitive Behavioral Therapy (CBT),
- ✓ Motivational interviewing,
- ✓ Therapy involving close social environment,
- ✓ Motivation enhancement therapy,
- ✓ Family therapy,
- ✓ Situational influence,
- ✓ Dialectical Behavioral Therapy (DBT),
- ✓ Mindfulness-based cognitive therapy,
- ✓ Acceptance and Commitment Therapy (ACT),
- ✓ Trauma-focused CBT,
- ✓ Self-help groups (including 12-step groups),
- ✓ Support in housing and employment issues, etc.

This list is quite broad. The standards reference the ***mhGAP Guidelines*** (2012), which assist in selecting appropriate interventions depending on the type of addiction. For example, for the treatment of stimulant addiction, interventions such as situational influence, cognitive-behavioral therapy, and family therapy may be recommended.

Comparison of approaches to psychosocial interventions in addiction treatment

Comparison of the definitions of psychosocial interventions in WHO recommendations on OAT in 2009 and 2014:

Scope and Coverage

* The 2009 definition broadly defines psychosocial support, covering both social and psychological interventions, with an emphasis on basic needs, social connections, and well-being.

* The 2014 definition specifies psychosocial interventions as any non-pharmacological interventions applied in a therapeutic context at the individual, family, or group level.

Social Aspects

* In 2009, social interventions included assistance with basic life needs (food, clothing, housing, employment), basic medical care, and social integration.

* In 2014, social aspects are detailed through specific support mechanisms such as housing, financial and legal assistance, employment facilitation, and informational support.

Psychological Aspects

* In 2009, psychological interventions ranged from unstructured support to motivational interviewing techniques and structured psychotherapeutic approaches.

* In 2014, psychological interventions include both professional (e.g., cognitive-behavioral therapy) and non-professional approaches (self-help groups, support from traditional healers).

Thus, the 2014 definition became more structured and expanded, clearly outlining both professional and non-professional components of psychosocial interventions.

The comparative analysis of the WHO approaches in the 2009, 2014, and 2020 documents on drug addiction treatment and psychosocial interventions allows for the following generalizations.

1. WHO, 2009 – "Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence"

This document emphasizes **the combination of pharmacological and psychosocial treatment for individuals with opioid dependence**.

Key points include:

- Psychosocial support is considered an **adjunct** to pharmacotherapy.
- Specific methods (cognitive-behavioral therapy, motivational interviewing) are recognized as effective but are not considered standalone treatments.
- **The need for social support is highlighted** to improve treatment adherence.
- The primary focus is on opioid dependence treatment, with other types of drug dependence not being addressed.

2. WHO, 2014 – "Community Management of Opioid Overdose"

These recommendations focus on **reducing mortality from opioid overdose** through expanded access to naloxone and community-level support.

Key aspects include:

- Recommendation for the availability of naloxone.
- Clear protocols for resuscitation and care after overdose.
- Specific attention to **supporting individuals on opioid substitution therapy** (OAT).
- **Expanded definition of psychosocial interventions**, which includes:
    - Structured psychological interventions (CBT, psychotherapy).
    - Non-professional forms of support (self-help groups, housing programs, employment, legal assistance).
- Recognition that **social and psychological factors influence the risk of overdose** and should be integrated into support strategies.

3. WHO/UNODC, 2020 – "International Standards for the Treatment of Drug Use Disorders"

This document offers **a systematic, comprehensive approach to the treatment of all types of drug dependence**. Key differences include:

- Defines **evidence-based approaches** in the treatment of drug dependence, considering both medical and psychosocial interventions.
- Integration of treatment into **primary healthcare** and the broader health system.
- Clear **distinction between levels of care**: basic support, specialized interventions, long-term rehabilitation.
- Strong emphasis on **continuity of care**: treatment should not be limited to short-term programs but must be long-term and systematic.

- **Expansion of target groups**: the document considers not only adults but also adolescents, pregnant women, and individuals in conflict with the law.
- Based on the **principle of "treatment as an alternative to conviction",** which suggests treatment as an alternative to criminal prosecution.

The results of comparing WHO documents are presented in **Table 2.**

Table 2. Comparative Analysis of WHO Approaches to the Treatment of Drug Addiction

Parameter	WHO, 2009	WHO, 2014	WHO/UNODC, 2020
Focus	Opioid dependence treatment	Prevention of overdose mortality	Systematic approach to the treatment of all types of addiction
Approach	Psychosocial support as an adjunct to pharmacotherapy	Emergency response + long-term support for OMT patients	Integration of medical, social, and legal strategies
Key Measures	Pharmacotherapy + CBT, motivational interviewing	Access to naloxone, pOAT-overdose care	Comprehensive long-term treatment system
Role of Psychosocial Interventions	Secondary	Important element of social rehabilitation	Core component of comprehensive rehabilitation
Target Groups	Adults with opioid dependence	Individuals at risk of witnessing an overdose, OMT patients	Adults, adolescents, pregnant women, people in conflict with the law
Duration of Interventions	Short-term programs	Emergency measures + social support	Long-term support system
Integration into Healthcare System	Limited	Partial	Full integration
Legal Aspects	Absent	Minimal	Treatment as an alternative to criminal prosecution

Thus, the evolution of WHO approaches demonstrates **a gradual shift from a medically-centered treatment model** (2009) **to an integrated biopsychosocial support model** (2020), combining medical, social, and legal assistance.

➲ 3. INTERNATIONAL EXPERIENCE IN IMPLEMENTING MEDICAL AND PSYCHOSOCIAL SUPPORT FOR OAT PATIENTS

Australia

General Policy on OAT

Australia was one of the first countries to introduce Opioid Substitution Therapy (OAT). In 1977, the government adopted the first National Policy on Methadone Treatment, which allowed its limited use for individuals with severe addiction. In 1985, National Guidelines for Methadone were developed, and in 1987, they were supplemented with provisions for its use in prisons to prevent HIV transmission.

In 1993, the National Policy on Methadone was adopted, and in 1997, it was updated within the framework of the National Drug Strategy. In 2001, with the growing use of buprenorphine, clinical guidelines for its use were developed. In 2003, recommendations for methadone and naltrexone were issued, and in 2007, a general policy on pharmacotherapy for opioid dependence was adopted (Nicholas, 2022 [33]).

In 2014, new guidelines consolidated previous documents and took into account the experience of using buprenorphine, expanding the concept of pharmacotherapy. Treatment is carried out according to the laws of each state and includes medical, social, and psychological support (Gowing et al. 2014[34]).

Since July 1, 2023, medications for the pharmacotherapy of opioid dependence have become part of the Highly Specialized Drugs (HSD) Program, providing up to 28 days of treatment under favorable conditions. A nationwide program for funding pharmacy services for pharmacotherapy has also been established (AISW, 2024[35]).

Content of medical psychosocial support for patients

The document "National Guidelines for medication-assisted treatment of opioid dependence" (Gowing et al., 2014[36]) defines psychosocial support as an integral part of OAT, as patients with opioid dependence often face complex issues. According to the document, psychosocial interventions can be conducted in both individual and group formats. These services should be accessible to all patients, but refusal of them should not limit access to pharmacotherapy.

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[33] Nicholas, R. (2022). *Opioid Agonist Therapy in Australia: A History.* Adelaide: Flinders University. https://nceta.flinders.edu.au/application/files/6316/5456/3757/Final_version_OAT_History_Report.pdf

[34] Gowing, L., Ali, R., Dunlop, A., Farrell, M., & Lintzeris, N. (2014). *National guidelines for medication-assisted treatment of opioid dependence.* Department of Health for National Drug Strategy. https://www.health.gov.au/resources/publications/national-guidelines-for-medication-assisted-treatment-of-opioid-dependence

[35] AISW (2024). National Opioid Pharmacotherapy Statistics Annual Data collection. https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics/contents/summary#Treatment

[36] Gowing, L., Ali, R., Dunlop, A., Farrell, M., & Lintzeris, N. (2014). *National guidelines for medication-assisted treatment of opioid dependence.* Department of Health for National Drug Strategy. https://www.health.gov.au/resources/publications/national-guidelines-for-medication-assisted-treatment-of-opioid-dependence

According to the document, psychosocial interventions can be conducted in both individual and group formats. These services should be available to all patients; however, refusal of these services should not limit access to pharmacotherapy.

Types of psychological counseling within the support of patients undergoing OAT, recommended for implementation:

1. *Cognitive-Behavioral Therapy (CBT)* – helps patients analyze the connection between thoughts, behavior, and environment, developing new coping skills to address problems.
2. *Motivational Interviewing* – aims to enhance internal motivation for change, using methods of empathy, avoiding confrontation, and supporting self-efficacy.
3. *Contingency Management* – encourages desired behavior (e.g., abstinence from unauthorized drugs) through a reward system.
4. *Community Reinforcement Approach (CRA)* – focuses on engaging social, family, and professional resources to support recovery.
5. *Social Behavioral and Network Therapy (SBNT)* – promotes environmental changes to support a sober lifestyle.
6. *Relapse Prevention* – helps identify and manage risk factors that may lead to a return to substance use.

Psychosocial support also includes:

- ✓ *Financial management skills training, legal consultations.*
- ✓ *Motivational Interviewing (MI)* to work with ambivalence and stimulate behavioral changes.
- ✓ *Support for treatment adherence*, including participation in self-help groups (e.g., Narcotics Anonymous, SMART Recovery), but without coercion.

A key element in the implementation of OAT is the involvement of multidisciplinary teams, which include medical professionals, psychologists, social workers, and case managers.

In particular, the case manager plays a crucial role in ensuring integrated and effective treatment within the OAT program. They develop, coordinate, and regularly review the patient's individual care plans. Important aspects of the case manager's work include timely communication with other specialists about changes in the patient's condition, early post-discharge support, and re-engagement of those who have dropped out of the program.

For patients with multiple needs or serious comorbidities, the case manager ensures multi-functional coordination, involving several service providers to address the patient's complex issues.

Organization of OAT

As of 2025, opioid agonist therapy is one of the most widespread methods for treating opioid drug addiction in Australia. The country has registered 4 drugs used for the pharmacotherapy of people with opioid use disorder: methadone, buprenorphine, buprenorphine-naloxone, and long-acting buprenorphine injections (AISW, 2024[37]).

[37] AISW (2024). National Opioid Pharmacotherapy Statistics Annual Data collection. https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics/contents/summary#Treatment

All facilities that prescribe medications for OAT must be accredited by the Australian Ministry of Health. Doctors and nurses are only authorized to prescribe OAT after successfully completing a mandatory training course on the fundamentals of OAT (NSW Health, 2025[38]). Psychologists and social workers are only authorized to provide services after obtaining the appropriate licensure, as both professions are regulated in Australia.

The implementation of opioid substitution therapy (OAT) programs varies from state to state. Australia has a federal system, which allows each state and territory to implement OAT programs based on local needs, funding, and available resources. These programs operate within public and private clinics, pharmacies, and specialized centers. Despite government subsidies, patients are required to pay for pharmacy services that distribute medications, as well as for regular medical check-ups. These costs become a barrier for low-income groups, especially those living below the poverty line.

Users of OAT programs face stigma both in healthcare settings and in society, which limits access to services and reduces motivation for treatment. Stigmatization also extends to healthcare professionals who work with OAT clients, complicating the recruitment of new specialists. Therefore, Australia places a strong emphasis on combating stigmatization by implementing educational initiatives for both the public and medical staff.

Due to the vast size of the country, many clients live in remote areas, creating logistical challenges in providing regular services. The government has introduced mobile clinics to ensure access to OAT even in the most remote communities, reducing barriers for patients in rural areas (Nicholas, 2022[39]).

In Australia, particular attention is given to OAT for incarcerated individuals. All states in Australia provide some level of OAT in prisons, although not all correctional facilities offer this treatment. It is crucial to note that individuals who were undergoing OAT at the time of their arrest are required to continue therapy during the waiting period or while serving their sentence. Upon release from prison, these individuals are referred to primary healthcare services to continue their OAT prescription and are directed to private pharmacies for dosage management.

Additionally, targeted social support services are provided to assist with reintegration and ongoing treatment.

However, research (Curtis et al., 2023[40]) highlights the issue of treatment disruption after release from correctional facilities, which can negatively impact the effectiveness of therapy and the overall health of former inmates.

Thus, Australia demonstrates a systematic approach to OAT for individuals with opioid dependence, combining medical, psychosocial, and social aspects of treatment. Psychosocial support, which includes various methods such as cognitive-behavioral therapy and motivational

[38] NSW Health (2025). *NSW Opioid Treatment Program (OTP).* https://www.health.nsw.gov.au/pharmaceutical/doctors/Pages/otp-medical-practitioners.aspx

[39] Nicholas, R. (2022). *Opioid Agonist Therapy in Australia: A History.* Adelaide: Flinders University. https://nceta.flinders.edu.au/application/files/6316/5456/3757/Final_version_OAT_History_Report.pdf

[40] Curtis, M., Dietze, P., Wilkinson, A. L., Agius, P. A., Stewart, A. C., Cossar, R. D., Butler, T., Walker, S., Kirwan, A., Winter, R. J., & Stoové, M. (2023). Discontinuation of opioid agonist treatment following release from prison in a cohort of men who injected drugs prior to imprisonment in Victoria, Australia: A discrete-time survival analysis. *Drug and Alcohol Dependence, 242,* 109730. https://doi.org/10.1016/j.drugalcdep.2022.109730.

interviewing, is an integral part of OAT, providing comprehensive support for patients. However, despite the progress, patients still face barriers to treatment access, such as financial cOATs and social stigma, which require further efforts in educational initiatives and social support, particularly for vulnerable groups such as incarcerated individuals.

European Approaches

There is no unified European-wide approach to supporting individuals with opioid dependence in EU countries (Chiu et al., 2024 [41]; EMCDDA, 2022 [42]). There are significant interstate and intra-national differences regarding the involvement of medical professionals in treatment, criteria for patient selection for OAT, clinical guidelines for prescribing medications, monitoring therapy adherence through urine tests, as well as the implementation of psychosocial interventions.

First and foremost, the experience of **Portugal** deserves attention. In the 1990s, the country faced a massive crisis caused by opioid addiction, which led to Lisbon receiving the unofficial title of Europe's 'heroin capital'. However, through the introduction of innovative legislation in 2001, the country managed to radically transform the situation.

The shift from a criminal approach to a healthcare-oriented model has significantly improved the indicators in the fight against drug addiction. Today, Portugal has the lowest drug-related mortality rate in Western Europe — ten times lower than in the United Kingdom and fifty times lower than in the United States. The number of HIV cases caused by injection drug use has decreased by more than 90% (Clay, 2018[43]).

Opioid addiction treatment is widely available in both public and private institutions, including specialized centers, hospitals, pharmacies, and mobile units. Methadone has been used since 1977, and buprenorphine since 1999. Methadone therapy can be started at treatment centers free of charge, while buprenorphine is available in pharmacies with 40% of the cOAT covered by the National Health Service.

Assistance for people with opioid dependence is provided within the national healthcare system, which offers comprehensive outpatient treatment addressing the physical, psychological, and social needs of the patient. Treatment teams, led by doctors or psychologists, provide all services in one location, making access to therapy easier.

Since 2014, Portugal has operated the Referral Network for Addictive Behaviors and Dependencies (RNABD), which coordinates the treatment of people with disorders related to drug use. It includes public centers under the Ministry of Health, as well as non-governmental and private institutions. The RNABD ensures access to quality-controlled services and collaborates with other sectors to provide comprehensive support to this vulnerable population.

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[41] Chiu, K., Pandya, S., Sharma, M., Hooimeyer, A., de Souza, A., & Sud, A. (2024). An international comparative policy analysis of opioid use disorder treatment in primary care across nine high-income jurisdictions. *Health Policy, 141,* 104993. https://doi.org/10.1016/j.healthpol.2024.104993.

[42] EMCDDA (2022). *European Drug Report 2022: Trends and Developments.* Luxembourg: Publications Office of the European Union.

[43] Clay, R. A. (2018). *How Portugal is solving its opioid problem*. *APA Monitor on Psychology, 49*(9). Retrieved from https://www.apa.org/monitor/2018/10/portugal-opioid

Special attention is given to the accessibility of treatment. In every region with a high level of drug use, low-threshold contact centers and mobile teams operate, providing not only treatment but also infectious disease prevention.

For example, in Lisbon, there is a mobile methadone program that serves around 1,200 people daily. Mobile teams, including a doctor, nurse, and social workers, not only distribute methadone but also conduct infection testing, provide safe drug use supplies, and support individuals with coexisting conditions such as HIV and hepatitis.

The Portuguese model is characterized by low-threshold access: patients do not need to abstain from drugs in order to receive help. The lack of strict attendance requirements and flexibility in dosing make this system highly adaptable to the needs of people with addiction.

Psychosocial support is provided within an integrated approach, where social workers must undergo the appropriate licensing. At the same time, peer consultants, who do not have formal higher education, are included in mobile teams. They carry out educational work on safe drug use and safe sexual behavior (Chiu et al., 2024[44]; Clay, 2018[45]; Mullins, 2021[46]; Nicholas, 2022[47]).

In **Germany**, **Poland**, and **Spain**, the treatment of drug addiction combines pharmacological therapy with psychosocial support. The rehabilitation system typically has a two- or three-tier structure, and the choice of methods, treatment plan, and involvement of additional specialists depend on the doctor overseeing the rehabilitation.

In these countries, treatment costs are partially covered by the government through the social insurance system.

For example, in Germany, the opioid substitution therapy (OAT) system is regulated by national guidelines. The first official guideline on OAT was introduced by the Federal Medical Association in 2002, with subsequent updates in 2009/2010 and the latest changes in 2017.

Since 2017, the possibilities for providing OAT have been expanded: in addition to doctors, medication-assisted therapy can also be prescribed by specialists in approved inpatient facilities, hospices, medical rehabilitation centers, and other relevant establishments. In 2023, the range of individuals authorized to dispense medications for immediate consumption in specialized facilities was further extended to include trained non-medical staff under the supervision of a prescribing doctor.

Germany operates a mixed public and private healthcare system with mandatory health insurance, which ensures comprehensive coverage for OAT. The program has been in place since 1992 and covers a wide range of services, including:

- Opioid substitution therapy (OAT)

[44] Chiu, K., Pandya, S., Sharma, M., Hooimeyer, A., de Souza, A., & Sud, A. (2024). An international comparative policy analysis of opioid use disorder treatment in primary care across nine high-income jurisdictions. *Health Policy, 141,* 104993. https://doi.org/10.1016/j.healthpol.2024.104993.

[45] Clay, R. A. (2018). *How Portugal is solving its opioid problem*. *APA Monitor on Psychology, 49*(9). Retrieved from https://www.apa.org/monitor/2018/10/portugal-opioid

[46] Mullins, J. D. (2021). *A Comparative Study of Recovery Ecosystems for Opioid Use Disorder in Portugal and Appalachia*. Undergraduate Honors Theses, Paper 620. https://dc.etsu.edu/honors/620

[47] Nicholas, R. (2022). *Opioid Agonist Therapy in Australia: A History.* Adelaide: Flinders University. https://nceta.flinders.edu.au/application/files/6316/5456/3757/Final_version_OAT_History_Report.pdf

- Harm reduction programs (needle exchange, prevention, testing, and treatment of infectious diseases related to drug use)
- Drug checking services (testing illicit substances)
- Distribution of naloxone for at-home use and appropriate training
- Operation of supervised drug consumption rooms.

In addition to pharmacological treatment, Germany provides patients with a wide range of psychosocial services within the framework of opioid substitution therapy (OAT). These include group and individual counseling, resocialization programs, legal aid, and support from mental health specialists for the treatment of co-occurring disorders such as depression and anxiety (Chiu et al., 2024[48]; Schwarz et al., 2024[49]).

Comparison of Approaches to OAT in Different Countries

The analysis of OAT implementation practices in Australia, Portugal, and Germany reveals a number of common and distinct features.

Common Features:

1. *Patient-Centered Approach*: maintenance therapy focuses on the needs of patients, taking into account their individual histories and contexts.
2. *Multidisciplinary Approach*: OAT involves collaboration between various specialists – psychotherapists, social workers, nurses, and doctors.
3. *Use of Evidence-Based Practices*: emphasis is placed on the importance of using scientifically supported methods and practices that are backed by research.
4. *Support for Patient Autonomy*: therapeutic programs in general, and psychosocial support within OAT, aim to develop self-management skills and encourage active patient participation in the treatment process.

Distinct Features:

1. *Regulatory Frameworks:* in Germany, the healthcare system has strict federal regulations that define how maintenance therapy is conducted, whereas Australia and Portugal offer more room for innovation (in Australia, different states have different OAT programs).
2. *Funding and Accessibility*: In Australia, there is the Medicare system, which partially funds therapy, while in Germany, insurance often covers the full costT of treatment. In Portugal, access to OAT may be limited due to resource shortages in the public sector.
3. *Cultural Characteristics*: Portugal has a strong tradition of family support, which may influence the approach to therapy, while in Australia and Germany, the focus is more on individual therapy.

[48] Chiu, K., Pandya, S., Sharma, M., Hooimeyer, A., de Souza, A., & Sud, A. (2024). An international comparative policy analysis of opioid use disorder treatment in primary care across nine high-income jurisdictions. *Health Policy, 141,* 104993. https://doi.org/10.1016/j.healthpol.2024.104993.

[49] Schwarz, T., Anzenberger, J., Busch, M., Gmel, G., Kraus, L., Krausz, M., ... & Uhl, A. (2024). Opioid agonist treatment in transition: A cross-country comparison between Austria, Germany and Switzerland. *Drug and Alcohol Dependence*, *254*, 111036. https://doi.org/10.1016/j.drugalcdep.2023.111036

4. *Technological Innovations:* Australia actively uses digital technologies in therapy, such as telemedicine and remote counseling, while in Germany and Portugal, these practices have not yet become widespread.

Thus, each of the analyzed countries has its unique approaches and challenges in implementing comprehensive maintenance therapy, but the common goal is to provide quality support for patients. Shared features, such as patient-centered orientation and a multidisciplinary approach, highlight the importance of an individualized approach, while differences in regulatory, financial, and cultural aspects demonstrate the diversity in the implementation of these practices.

➲ 4. EVALUATION OF THE EFFECTIVENESS OF PSYCHOSOCIAL SUPPORT FOR OAT PATIENTS

International studies

The main goal of psychosocial support is to improve the quality of life of patients and their reintegration into society. The effectiveness of psychosocial interventions within the framework of OAT is confirmed by numerous studies that demonstrate improvements in patients' physical and mental well-being.

Improvement in health-related quality of life

For example, a study by Minozzi et al. (2011[50]) found that substitution therapy combined with psychosocial support significantly reduces the risk of relapse. Patients undergoing substitution therapy as part of OAT have a much lower mortality rate compared to those who do not receive such treatment. Methadone therapy, in particular, reduces overdose mortality by 50% (Low et al., 2016[51]).

Other researchers also highlight the improvement in health-related quality of life in patients undergoing OAT (Ghaddar et al., 2017[52]; Nosyk et al., 2015 [53]).

Infection Control

Substitution therapy, combined with psychosocial support, also helps control the spread of infectious diseases such as HIV and hepatitis. The integration of HIV care with OAT has increased the number of patients achieving viral suppression by 30% (Guise et al., 2017[54]).

Social Reintegration

The combined approach of OAT not only improves patients' quality of life but also supports their reintegration into society and reduces stigmatization (Deering et al., 2011[55]). Stigmatization is a key barrier to engaging patients in treatment. Studies show that training medical staff and

[50] Minozzi, S., Amato, L., Vecchi, S., Davoli, M., Kirchmayer, U., & Verster, A. (2011). Oral naltrexone maintenance treatment for opioid dependence. *Cochrane Database of Systematic Reviews*, (2), CD001333. https://doi.org/10.1002/14651858.CD001333.pub3

[51] Low, A., Mburu, G., Welton, N., May, M., Davies, C., French, C., Turner, K., Looker, K., Christensen, H., McLean, S., Rhodes, T., Platt, L., Hickman, M., Guise, A., & Vickerman, P. (2016). Impact of opioid substitution therapy on antiretroviral therapy outcomes: A systematic review and meta-analysis. *Clinical Infectious Diseases: An Official Publication of the Infectious Diseases Society of America*, 63(8), 1094–1104. https://doi.org/10.1093/cid/ciw416

[52] Ghaddar, A., Abbas, Z., & Haddad, R. (2017). Opiate agonist treatment to improve health of individuals with opioid use disorder in Lebanon. *Harm Reduction Journal*, *14*, 1-7.

[53] Nosyk, B., Bray, J. W., Wittenberg, E., Aden, B., Eggman, A. A., Weiss, R. D., ... & Schackman, B. R. (2015). Short term health-related quality of life improvement during opioid agonist treatment. *Drug and alcohol dependence*, *157*, 121-128.

[54] Guise, A., Seguin, M., Mburu, G., McLean, S., Grenfell, P., Islam, Z., Filippovych, S., Assan, H., Low, A., Vickerman, P., & Rhodes, T. (2017). Integrated opioid substitution therapy and HIV care: a qualitative systematic review and synthesis of client and provider experiences. *AIDS Care*, 29, 1119 - 1128. https://doi.org/10.1080/09540121.2017.1300634.

[55] Deering, D. E. A., Sheridan, J., Sellman, J. D., Adamson, S. J., Pooley, S., Robertson, R., & Henderson, C. (2011). Consumer and treatment provider perspectives on reducing barriers to opioid substitution treatment and improving treatment attractiveness. *Addictive behaviors*, *36*(6), 636–642. https://doi.org/10.1016/j.addbeh.2011.01.004

educational campaigns can reduce negative attitudes towards patients and promote their involvement in treatment programs (Bielenberg et al., 2021[56]; Tostes et al., 2020[57]).

Retention in Programs

Patients receiving comprehensive support within the OAT framework show significantly higher retention rates in substitution therapy programs. For example, retention after 12 months reaches 57% among those receiving comprehensive care (O'Connor et al., 2020[58]).

A thorough meta-analysis of 48 randomized controlled trials (RCTs) showed that patient retention in treatment programs was significantly higher when they received psychosocial interventions alongside opioid agonist therapy, regardless of the duration of follow-up (Rice et al., 2020[59]).

Mental Health

Opioid addiction is often accompanied by depression, anxiety, and other mental health disorders. The inclusion of psychological interventions in OAT programs, such as cognitive-behavioral therapy (CBT) and motivational interviewing (MI), helps patients cope with these issues. For example, depressive symptoms decrease by 40% among those who receive comprehensive support (Moazen-Zadeh et al., 2020[60]). Psychosocial support, especially through group sessions or individual consultations, helps patients avoid triggers that may lead to relapses (Moazen-Zadeh et al., 2021[61]).

Economic Benefits

Research also confirms the effectiveness of psychosocial interventions in the context of substitution therapy. For example, Marsden et al. (2019[62]) demonstrate the effectiveness and economic benefit of personalized psychosocial interventions in the treatment of resistant cases of opioid agonist therapy.

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[56] Bielenberg, J., Swisher, G., Lembke, A., & Haug, N. A. (2021). A systematic review of stigma interventions for providers who treat patients with substance use disorders. *Journal of Substance Abuse Treatment, 131*, 108486. https://doi.org/10.1016/j.jsat.2021.108486

[57] Tostes, J. G. de A., Dias, R. T., Reis, A. A. da S., Silveira, P. S. da, & Ronzani, T. M. (2020). Interventions to reduce stigma related to people who use drugs: Systematic review. *Paidéia (Ribeirão Preto), 30*, e3022. https://doi.org/10.1590/1982-4327e3022

[58] O'Connor, A., Cousins, G., Durand, L., Barry, J., & Boland, F. (2020). Retention of patients in opioid substitution treatment: A systematic review. *PLoS ONE*, 15. https://doi.org/10.1371/journal.pone.0232086.

[59] Rice, D., Corace, K., Wolfe, D., … Hutton, B. (2020). Evaluating comparative effectiveness of psychosocial interventions adjunctive to opioid agonist therapy for opioid use disorder: A systematic review with network meta-analyses. *PloS one*, *15*(12), e0244401. https://doi.org/10.1371/journal.pone.0244401

[60] Moazen-Zadeh, E., Ziafat, K., Yazdani, K., Mamdouh, M., Wong, J., Modabbernia, A., Blanken, P., Verthein, U., Schütz, C., Jang, K., Akhondzadeh, S., & Krausz, R. (2020). Impact of opioid agonists on mental health in substitution treatment for opioid use disorder: A systematic review and Bayesian network meta-analysis of randomized clinical trials. *medRxiv*. https://doi.org/10.1101/2020.07.04.20146506.

[61] Moazen-Zadeh, E., Ziafat, K., Yazdani, K., Kamel, M. M., Wong, J. S., Modabbernia, A., ... & Krausz, R. M. (2021). Impact of opioid agonist treatment on mental health in patients with opioid use disorder: a systematic review and network meta-analysis of randomized clinical trials. *The American journal of drug and alcohol abuse*, *47*(3), 280-304.

[62] Marsden, J., Stillwell, G., James, K., Shearer, J., Byford, S., Hellier, J., ... & Mitcheson, L. (2019). Efficacy and cost-effectiveness of an adjunctive personalised psychosocial intervention in treatment-resistant maintenance opioid agonist therapy: a pragmatic, open-label, randomised controlled trial. *The Lancet Psychiatry*, *6*(5), 391-402.

However, not all researchers agree that psychosocial interventions within OAT can be considered as having a proven effect and recommend refraining from making such interventions mandatory (Zerden et al., 2020[63]).

Particular attention should be given to the study by Wild et al. (2021[64]), which conducted an extensive review of existing research on psychosocial interventions in the treatment of opioid dependence. In their work, the authors analyzed 305 empirical studies involving 54,607 patients.

Among the studies analyzed, 64% (194 studies) compared psychosocial interventions with alternative treatment methods, including 183 randomized controlled trials (RCTs) and 11 quasi-experimental studies. The mOAT common outcomes investigated were retention in treatment programs and illicit drug use. Typically, these studies focused on men who had used heroin for a long period and attended specialized outpatient services for addiction treatment.

Only 6% of the studies analyzed during the review were specifically related to the impact of social support (e.g., employment, education). 10% of the studies concerned the quality of life of patients.

The authors highlight that existing data suggests a lack of sufficient evidence supporting the rehabilitative effects of psychosocial interventions, both as standalone treatments and in combination with pharmacotherapy. However, the study by Wild et al. (2021) clearly emphasizes the importance of psychosocial support within a comprehensive approach to opioid addiction treatment, even though it points to significant gaps in knowledge that require further exploration.

Ukrainisn Research

Let's consider a series of studies related to the implementation of opioid substitution therapy (OAT) in Ukraine, which mention social support and psychosocial accompaniment.

The launch of the first OAT programs in Ukraine, combining substitution therapy with psychological counseling and social interventions, was accompanied by research (Schaub et al., 2008[65]; Schaub et al., 2009[66]). The results showed that the program helped reduce risky behaviors, decrease the use of street drugs, and improve the quality of life of patients.

The study "**Effective Model for Organizing Medical Care for Pregnant Women with Opioid Dependence**" (Zelenska, 2016[67]) was conducted in Kyiv, Poltava, and Dnipro as part of an experimental project aimed at creating an effective system of medical care for pregnant women with opioid dependence. A total of 231 women with drug addiction participated in the study.

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[63] Zerden, L. D. S., Guan, T., Lombardi, B. M., Sharma, A., & Garcia-Rico, Y. (2020). Psychosocial interventions in office-based opioid treatment: A systematic review. *Journal of the Society for Social Work and Research*, *11*(1), 103-131. https://doi.org/10.1086/708369

[64] Wild, T. C., Hammal, F., Hancock, M., Bartlett, N. T., Gladwin, K. K., Adams, D., ... & Hodgins, D. C. (2021). Forty-eight years of research on psychosocial interventions in the treatment of opioid use disorder: a scoping review. *Drug and alcohol dependence*, *218*, 108434.

[65] Schaub, M., Chtenguelov, V., Subata, E., Weiler, G., Uchtenhagen, A. (2009). Feasibility of buprenorphinemaintenance therapy programs in the Ukraine: first promising treatment outcomes. *Eur Addict Res*,15(3), 157 – 62. doi: 10.1159/000217586

[66] Schaub, M., Chtenguelov, V., Subata, E., Weiler, G., Uchtenhagen, A. (2010). Feasibility of buprenorphineand methadone maintenance programmes among users of home made opioids in Ukraine, 2 *Int J DrugPolicy,* 1(3), 229 – 33.

[67] Zelenska, M. V. (2016). Effective model for organizing medical care for pregnant women with opioid dependence. *Tuberculosis, Lung Diseases, HIV Infection, (1)*, 59-64. http://nbuv.gov.ua/UJRN/Tlkhvil_2016_1_13 [in Ukrainian]

The results of the project implementation indicate that 82 women (35.5%) received OAT. Among them, 44 women had been undergoing such therapy prior to pregnancy, with 24 receiving buprenorphine hydrochloride and 20 receiving methadone hydrochloride. Eighteen women completed a detoxification therapy course. At the same time, 38 women (46.3%) began receiving OAT directly during their participation in the project.

The organizational model involved the creation of multidisciplinary teams, including obstetricians-gynecologists, neonatologists, narcologists, infectious disease specialists, social workers, and representatives of non-governmental organizations specializing in HIV/AIDS prevention. The project provided a comprehensive service package, including medical support for pregnancy, assistance from related specialists in treating extragenital pathologies, narcological care, and supervision from HIV/AIDS prevention specialists. In addition to medical services, social support was provided, including social assistance, psychosocial support, peer support groups, legal aid, and provision of food and hygiene kits. One of the key aspects of the project was the provision of medical and social support for the children born to participants in the study, particularly after their discharge from the maternity hospital.

The results of testing at 18 months revealed that all the children born to the participants of the project were not infected with HIV. The author claims that the findings of the study confirm the effectiveness of a comprehensive approach to providing medical care for pregnant women with opioid dependence. In particular, the effectiveness of multidisciplinary teams and the successful collaboration between state institutions and non-governmental organizations in ensuring access to quality medical and social services for this category of patients were demonstrated.

In the dissertation research "**Integrated Medical-Social Assistance for Patients with Opioid Dependence**" (Dvoryak, 2016[68]), an approach to improving the treatment of individuals with opioid dependence who also have co-occurring socially significant diseases, such as HIV/AIDS, tuberculosis, viral hepatitis, and mental disorders, is proposed. The suggested model involves integrated medical-social assistance with the use of opioid agonist maintenance therapy.

The effectiveness of this approach was confirmed through pilot and national studies. Three months after the start of buprenorphine treatment, significant reductions were observed in illegal drug use, symptoms of mental and somatic disorders, risky behaviors, as well as improvements in patients' quality of life. After 18 months of treatment, criminal behavior decreased by a factor of 8.4, while social integration scores increased from 50.3 to 69.7 on the WHOQOL-bref scale.

The study also highlighted the advantages of fully integrated treatment (FIT) compared to partially integrated treatment (PIT). Patients receiving care under the FIT model had significantly higher treatment quality scores (71.9% vs. 54.8%; $p < 0.001$) and were more likely to receive ART (49.5% vs. 19.2%; $p < 0.001$). Among patients with CD4 levels < 200, those in the FIT group were substantially more likely to receive ART (93.8% vs. 62.5%; $p < 0.05$). Furthermore, after six months,

[68] Dvoryak, S. V. (2016). *Intehrovana medyko-sotsialna dopomoga khvorym iz zalezhnyustyu vid opioyidiv* [Integrated medical-social assistance for patients with opioid dependence] (Doctoral dissertation, specialty 14.01.17). Kharkiv. https://uacademic.info/download/file/0516U000594/dis.doc

the level of stigmatization decreased by 6.4 points in the FIT group, while in the PIT group, it decreased only by 1.3 points ($p < 0.0001$).

The author of the study emphasizes that the mOAT effective approach to treating individuals with opioid addiction is integrated medical-psychosocial assistance, where all necessary services are provided within one facility. The optimal model involves the involvement of a multidisciplinary team, which includes doctors from various specialties, nursing staff, a social worker, and a psychologist.

The dissertation research **"Social Prevention of HIV through through Opioid Substitution Therapy"** (Metelyuk, 2024[69]) aimed to identify and experimentally verify the conditions for the effectiveness of HIV prevention through OAT among people who inject drugs. The study collected quantitative data from 738 people who inject drugs (PWID) enrolled in the OAT program and 1,277 individuals who did not receive such therapy, as well as conducted 50 semi-structured interviews.

The results showed that only a third of OAT patients in Ukraine have access to psychosocial services; however, their availability significantly improves HIV service cascade indicators, especially at the stage of achieving viral suppression. The study also confirmed that prolonged participation in the OAT program (over 6 months), social support, and comprehensive assistance contribute to HIV testing, initiation of ART, and the formation of treatment adherence. This not only increases the effectiveness of HIV prevention but also helps patients integrate into society, improve their quality of life, and strengthen family relationships.

The study by Bromberg et al. (2025[70]) analyzed the **transformation of the HIV treatment cascade among people who inject drugs** (PWID) in Ukraine. The authors conducted a large bio-behavioral survey in 2020–2021 and compared its results with a similar study from 2014–2015, using representative sampling methods, including random sampling and Respondent-Driven Sampling (RDS) among individuals with opioid dependence.

The results confirmed that OAT improves HIV treatment outcomes at all stages of the medical care cascade. The study also recorded the scaling up of OAT programs and the increasing engagement of in the HIV treatment system over time. An important, yet previously unreported conclusion was that even occasional contact with the OAT system, regardless of the duration of participation in the program, positively impacts HIV treatment outcomes at each stage of the cascade.

The analysis of domestic studies confirms the importance of a comprehensive approach to providing assistance to individuals with opioid dependence, combining medical, social, and psychosocial interventions. The studies demonstrate the effectiveness of multidisciplinary teams,

[69] Metelyuk, A. S. (n.d.). *Sotsialna prophylyaktyka VIL zasobamy zamisnoi pidtrymuvalnoi terapii* [Social prevention of HIV through opioid substitution therapy] (Doctor of Philosophy dissertation, specialty 231). Kyiv. https://elibrary.kubg.edu.ua/id/eprint/48427/

[70] Bromberg, D. J., Rhoades, D., Madden, L. M., Ivasiy, R., Meteliuk, A., Pykalo, I., Filippovych, M., Nikitin, B. M., Farnum, S. O., Fomenko, T., Dvoriak, S., Altice, F. L., & ExMAT Consortium (2025). Transformation of the HIV treatment cascade for people who inject drugs in Ukraine. *AIDS (London, England)*, *39*(3), 306–311. https://doi.org/10.1097/QAD.0000000000004056

including doctors, social workers, and representatives from non-governmental organizations, in providing comprehensive support. The inclusion of social support, legal assistance, and psychosocial support contributes to improved access to medical services, reduced stigma, and enhanced quality of life for patients. In particular, the integration of psychosocial services into OAT programs positively impacts social adaptation, reduces criminal behavior, and increases adherence to treatment.

Despite the proven effectiveness of the comprehensive approach, studies indicate inadequate access to psychosocial services for participants in OAT programs in Ukraine. However, the availability of such support significantly improves the outcomes of HIV treatment and prevention, promoting viral suppression and fostering adherence to antiretroviral therapy. In this context, integrated medical-psychosocial care, which provides all necessary services in one institution, is recognized as the most effective model of care organization.

➲ 5. OVERVIEW OF THE CURRENT SITUATION IN UKRAINE

Political and Regulatory Aspects

In Ukraine, Opioid Substitution Therapy (OAT) with buprenorphine was first introduced in 2004 within the framework of a pilot project under the United Nations Development Programme (UNDP) to prevent HIV. In 2008, methadone was added to the OAT programs as a treatment for opioid dependence.

Alongside pharmacological treatment, comprehensive approaches integrating pharmacotherapy with psychological counseling and social interventions began to be implemented with the support of various international projects.

By the 2010s, OAT became an integral part of the national public health strategy (Dvoryak, 2016[71]).

The legal and regulatory foundation for Opioid Substitution Therapy (OAT) in Ukraine was established with the adoption of key documents such as:

- Cabinet of Ministers of Ukraine Order "On Approval of the Action Plan for the Further Implementation of Opioid Substitution Therapy for Users of Opioid Injection Drugs" dated October 12, 2011, No. 1002-p.[72];
- Ministry of Health of Ukraine Order "On Approval of the Procedure for Opioid Agonist Therapy for Individuals with Mental and Behavioral Disorders Due to Opioid Use" dated March 27, 2012, No. 200[73];
- Joint Order of the Ministry of Health, Ministry of Internal Affairs, Ministry of Justice, and the State Service for Drug Control "On Approval of the Procedure for Interaction between Healthcare Facilities, Internal Affairs Agencies, Pretrial Detention Centers, and Correctional Facilities to Ensure Continuity of Treatment with Opioid Substitution Therapy Drugs" dated October 22, 2012, No. 821/937/1549/5/156[74].

The extended list of legal and regulatory acts is provided in **Appendix A.**

In 2023, the draft of Ukraine's National Drug Policy Strategy for 2030 and its operational plan were presented. The documents placed significant emphasis on the development and improvement of psychosocial services, which were seen as a key component of a comprehensive approach to addressing issues related to the use of narcotic drugs and psychotropic substances. The need to integrate these services into the healthcare, social protection, and legal support

[71] Dvoryak, S. V. (2016). *Intehrovana medyko-sotsialna dopomoga khvorym iz zalezhnyustyu vid opioyidiv* [Integrated medical-social assistance for patients with opioid dependence] (Doctoral dissertation, specialty 14.01.17). Kharkiv. https://uacademic.info/download/file/0516U000594/dis.doc

[72] Cabinet of Ministers of Ukraine (2011). On approval of the action plan for further implementation of opioid substitution therapy for opioid injection drug users: Order No. 1002-r. https://zakon.rada.gov.ua/laws/show/1002-2011-%D1%80#Text

[73] Ministry of Health of Ukraine. (2012). On approval of the procedure for conducting opioid substitution therapy for individuals with mental and behavioral disorders due to opioid use: Order No. 200. https://zakon.rada.gov.ua/laws/show/z0889-12#Text

[74] Ministry of Health of Ukraine et al. (2012). On approval of the procedure for interaction between healthcare institutions, law enforcement agencies, pre-trial detention centers, and correctional facilities to ensure continuity of treatment with opioid substitution therapy medications: Order No. 821/937/1549/5/156. https://zakon.rada.gov.ua/laws/show/z1868-12#Text

systems was highlighted, with the aim of improving the quality of life for individuals with mental and behavioral disorders caused by drug use[75]. As of the preparation of this review, the Strategy had not yet been approved.

Institutional Aspects

Currently, **the medical component** of OAT is provided at healthcare institutions, including narcological and tuberculosis dispensaries, AIDS centers, city and district hospitals, as well as primary healthcare centers.

It is required that a healthcare facility offering OAT services should have a doctor (narcologist, psychiatrist, or any other specialist who has completed the relevant training course in OAT) and a nurse (National Health Service of Ukraine, 2025[76]). This does not align with the comprehensive multidisciplinary approach to the treatment of opioid use disorder (OUD) recommended by the WHO.

At the same time, according to paragraph 18 of the Ministry of Health of Ukraine Order No. 200 "Procedure for the Implementation of Opioid Agonist Therapy for Individuals with Mental and Behavioral Disorders Due to Opioid Use," social workers and psychologists are involved in providing social and psychological support to patients receiving OAT. These specialists can be from the healthcare facility staff or, in the absence of such professionals, from other institutions or NGOs, with the patient's consent[77].

Thus, **social services** for patients undergoing OAT can be provided through several channels:

- Through partnerships between healthcare institutions and non-governmental organizations (NGOs) that implement preventive projects according to the needs of OAT patients;
- Through referral and (if necessary) social support to other preventive projects implemented by government institutions or NGOs.

According to the Law of Ukraine "On Social Services" (2019[78]), social support is a basic service that should be available in every community and provided by local authorities (city, district state administrations, executive committees of councils). Individuals facing difficult life circumstances have the right to such support. According to Article 1 of the Law, among the factors that determine difficult life circumstances are also "mental and behavioral disorders, including those caused by the use of psychoactive substances".

In accordance with this provision, the State Standard for Social Support of Families (Individuals) Facing Difficult Life Circumstances has been developed. Support is provided with the consent of the recipient or their legal representative, in accordance with the Resolution of the

[75] Ministry of Health of Ukraine (2023). Draft Order of the Cabinet of Ministers of Ukraine "On Approval of the State Drug Policy Strategy for the Period until 2030". https://moz.gov.ua/uk/proekt-rozporjadzhennja-kabinetu-ministriv-ukraini-pro-shvalennja-strategii-derzhavnoi-politiki-schodo-narkotikiv-na-period-do-2030-roku-

[76] National Health Service of Ukraine (2025). Requirements for PMG 2025. https://contracting.nszu.gov.ua/kontraktuvannya/kontraktuvannya-2025/proect-vymogy-pmg-2025-1720109713

[77] Ministry of Health of Ukraine (2012). On Approval of the Procedure for Implementing Methadone Maintenance Therapy for Individuals with Mental and Behavioral Disorders Due to Opioid Use: Order No. 200. https://zakon.rada.gov.ua/laws/show/z0889-12#Text

[78] https://zakon.rada.gov.ua/laws/show/2671-19#n482

Cabinet of Ministers of Ukraine "On the Organization of Social Services" (2020[79]) and the Order of the Ministry of Social Policy of Ukraine "On Approval of the Forms for Recording Social Work with Families/Individuals Facing Difficult Life Circumstances" (2020[80]).

At the same time, the procedure for receiving social support remains quite bureaucratic, requiring the submission of a package of documents, verification of financial status, and the signing of relevant agreements.

In Ukraine, a digital case management system for social services is being implemented, allowing individuals to submit an online application for services (https://soc.gov.ua/welcome), along with the required scanned documents as per the law. The system functions as an electronic document management tool and manages client cases; however, it does not ensure the provision of the services themselves. If the necessary services are unavailable in the community, their registration in the system does not equate to actual access to them.

Research (ISAR Unity, 2024[81]; Laboratory of Legislative Initiatives, 2024[82]; Palatna & Semigina, 2024[83]) shows that only a portion of the 18 basic social services defined by legislation are provided in communities, specifically: day care, in-kind assistance, counseling (information), and social adaptation. At the same time, social support is mOAT often provided only to families at risk of child removal. Organizations funded by local budgets typically do not provide psychosocial support to people who inject drugs (PWID).

Moreover, studies highlight the lack of public and charitable organizations that meet the requirements for providing social services outlined in state social service standards and, therefore, can be included in the Register of Service Providers. This leads to significant uneven access to such services in different communities.

Another significant institutional challenge is that healthcare institutions are formally not classified as providers of social services, even when social workers are employed within their staff. This complicates the integration of medical and social services, as the division between different sectors remains, which can lead to fragmentation of services for PWID.

Financial Aspects

Since 2017, the funding for OAT programs has been provided from the state budget, ensuring not only the continuity of treatment for existing patients but also the expansion of the program.

Since 2021, OAT has been included in the list of free services under the Medical Guarantee Program (National Health Service of Ukraine, 2025[84]). The package of medical guarantees for the

[79] https://zakon.rada.gov.ua/laws/show/587-2020-%D0%BF#n57
[80] https://zakon.rada.gov.ua/laws/show/z0943-18#Text
[81] ISAR Unity (2024). Interest and Capacity of CSOs to Provide Social Services. http://bit.ly/3PMR2FH
[82] Laboratory of Legislative Initiatives (2024). Social Services in Ukraine: Current State, Problems, Limitations. https://parlament.org.ua/analytics/social-services/
[83] Palatna, D. & Semigina, T. (2024). Community Cohesion: The Social Dimension [Monograph]. Tallinn: Teadmus.
[84] National Health Service of Ukraine. (2025). Requirements for PMG 2025. https://contracting.nszu.gov.ua/kontraktuvannya/kontraktuvannya-2025/proect-vymogy-pmg-2025-1720109713

treatment of individuals with mental and behavioral disorders due to opioid use with the use of OAT for 2025 includes the following services:

- Treatment with OAT medications.
- Development of a treatment plan: assessment of the patient's condition and needs, creation of an observation and treatment plan, evaluation of treatment adherence, identification of factors negatively affecting treatment adherence, and corresponding adjustments to the treatment plan, as well as assessing the social status and social problems related to opioid use.
- Dispensing medications for supervised consumption at the service provider's location, for self-administration, or for administration during hospitalization.
- Treatment monitoring, which includes: ensuring timely and regular visits to the service provider, monitoring the implementation of referrals for other services and their outcomes, tracking side effects and effectiveness of OAT medications, considering the interaction of OAT medications with other drugs, and conducting urine tests to detect the presence of other narcotics in the patient's body besides those prescribed by the doctor.
- Screening for mental disorders and further referral of the patient if necessary.
- Screening for tuberculosis (TB), HIV, and viral hepatitis, and referral of the patient for further diagnosis and treatment at appropriate healthcare facilities if suspected.
- Informing patients about the availability of social and psychological services, assessing the need for such services, and referring them to places where they can be provided.

The package of medical guarantees does not include positions for social workers and psychologists.

In 2022, due to the full-scale invasion, there was a significant funding deficit as the country's primary resources were directed towards defending the state's integrity. As a result, there were serious risks that the methadone for OAT would not be purchased. In 2023, based on the regional needs collected for 2022, the State Enterprise "Medical Procurements" was supposed to carry out the purchase of OAT medications. However, the timeliness of this procurement was at risk due to the budget deficit caused by the invasion. The situation was further complicated by the fact that, in the first months after the invasion, national manufacturers who had supplied the medication in previous years essentially ceased operations, and the only option was to purchase from foreign manufacturers. The solution was to quickly coordinate the procurement of OAT medications with international funds and search for suppliers from foreign producers (Public Health Center, 2023[85]).

Social services, when available, are provided free of charge by state social institutions only to individuals with low income, whose earnings do not exceed two subsistence minimums (in 2025, the subsistence minimum for a working-age person is 3028 UAH).

Social services are financed from local budgets. Social institutions have limited resources and capabilities.

[85] Center for Public Health (2023). National response of HIV, TB, viral hepatitis and SMT programmes in the context of full-scale Russian invasion. https://phc.org.ua/sites/default/files/users/user90/National_response_HIV_TB_VH_SMT_war_2023_ENG.pdf

MEDICAL PSYCHOSOCIAL SUPPORT FOR PATIENTS IN OPIOID AGONIST THERAPY: AN ANALYTICAL REVIEW

As of the beginning of 2025, psychosocial support for OAT (opioid substitution therapy) patients is provided through funding from the Global Fund to Fight AIDS, Tuberculosis, and Malaria, as part of the implementation of the project "Sustaining Healthcare Response for HIV/AIDS and Tuberculosis in Wartime Ukraine".

Human resources

Human resources are a critical aspect that determines the effectiveness and quality of service delivery in OAT programs. The Center for Public Health (CPH) of the Ministry of Health of Ukraine plays a leading role in enhancing the qualifications of the medical staff involved in OST programs.

In particular, the CPH ensures continuous professional development by organizing seminars, training sessions, and online lectures, which are accessible on the institution's YouTube channel. These educational initiatives are aimed at deepening the knowledge and improving the practical skills of healthcare professionals in managing patients receiving OAT.

However, the OAT system in Ukraine faces several human resource challenges. Firstly, the martial law, mobilization, and the migration of medical personnel abroad have caused a significant **shortage of qualified staff**. This is particularly felt in regions where access to medical services is limited.

Secondly, healthcare institutions providing OAT services **lack positions for social workers.** This complicates the provision of comprehensive services that include not only medical but also social support for patients.

Thirdly, one of the key issues affecting the quality of social services in the OAT sector is the **lack of specialized training for social workers** to work with specific client groups, particularly individuals with substance use disorders.

The system of social worker training in Ukraine, despite its general focus on providing assistance to various population groups, does not include specialized programs that focus on the specifics of working with individuals who have substance use disorders. This results in specialists entering this field without sufficient knowledge and skills to effectively provide support.

The insufficient competence of social workers in this area manifests in several aspects:

- *Lack of understanding of the specifics of addiction*: social workers may not have a deep understanding of the nature of addiction, its psychological and social aspects, which complicates establishing effective contact with clients.
- *Lack of skills in motivation*: working with individuals who have substance use disorders requires specific skills in motivational counseling, which are not always part of standard social worker training.
- *Insufficient knowledge of rehabilitation methods*: social workers may not be familiar with various rehabilitation and social adaptation methods, limiting their ability to provide comprehensive assistance.
- *Stigmatization:* social workers without specialized training may hold stereotypical or stigmatizing views toward individuals with substance use disorders.

It is important to note that in Ukraine, **some social support services are provided using the "peer-to-peer" approach**. This method involves engaging individuals with personal experience overcoming addiction to provide services. The "peer-to-peer" approach has the following advantages:

- *Establishing trustful relationships:* individuals with personal experience of addiction better understand the problems and needs of clients, which helps establish trustful relationships.
- *Motivation and support*: "peer" counselors can effectively motivate and support clients because they have gone through similar challenges.
- *Reducing stigma:* engaging "peer" counselors helps reduce stigma and discrimination against people with addiction.

However, it is important to emphasize that the "peer-to-peer" approach cannot fully replace the professional training of social workers. Both approaches need to be combined to ensure comprehensive and high-quality social service delivery.

Availability of OAT program

According to international recommendations from WHO and UNAIDS, the coverage of OAT should be at least 35% of the estimated number of opioid users. In Ukraine, this indicator is only 5.8%, which indicates a significant deficit.

According to the data from the Public Health Center (2024[86]), as of January 1, 2024, 21,202 patients were receiving OAT services. Of these, 18,692 were receiving methadone, 2,381 were receiving buprenorphine, and 129 were receiving extended-release buprenorphine.

As of the end of 2024, **29% of OAT patients were HIV-positive**, highlighting the importance of OTP in HIV prevention. Approximately one-third of patients receive treatment at private healthcare facilities, which amounts to 35 sites (Hrytsenko, 2024[87]).

According to the data from the International Charitable Foundation "Alliance for Public Health," as of October 1, 2024, there were 21,913 individuals receiving OTP services at 206 OAT sites in Ukraine. Of these, **only 3,600 individuals (16.4%) of the total OTP patients in Ukraine had access to social support services**; this service is available at 92 sites. Therefore, the majority of OAT patients do not have access to social support services (Zakrevska, 2024[88]).

The full-scale invasion, occupation, and the complex situation near combat zones have exacerbated existing problems and the imbalance between demand and supply of OAT services (Zakrevska, 2024[89]; Morozova et al., 2023[90]):

- There has been an increased need for additional psychological and social support services, as well as humanitarian assistance;
- OAT sites have been closed due to destruction and occupation;

[86] Public Health Center (2024). OAT Statistics. https://phc.org.ua/kontrol-zakhvoryuvan/zalezhnist-vid-psikhoaktivnikh-rechovin/zamisna-pidtrimuvalna-terapiya-zpt/statistika-zpt

[87] Hrytsenko, V. (2024). The current state of OAT program implementation in Ukraine in 2024, plans, needs, and challenges for 2025 [Unpublished presentation].

[88] Zakrevska, Ye. (2024). Activities of the Alliance supporting the development of the ZPT program in Ukraine: Presentation of project results funded by international donors [Unpublished presentation].

[89] Zakrevska, Ye. (2024). Ibid.

[90] Zakrevska, Ye. (2024). Ibid.

- Problems arose with providing OAT medications to mobilized patients;
- There is a lack of regulatory framework for the full functioning of the mobile format (as best practices in conflict conditions) for the distribution of narcotic drugs, including through existing mobile OAT clinics.

As of the end of 2024, **approximately 90% of all OAT patients are on self-administered therapy**. Although this has its advantages, it presents a number of potential challenges (Dumchev, 2022[91]), particularly for organizing psychosocial support. Since such support is typically provided at OAT sites, the minimal time patients spend at healthcare facilities significantly complicates its organization. This also requires psychosocial support specialists to master new forms of remote counseling and support, as well as to further develop mobile forms of service delivery.

The war in Ukraine has created additional challenges for OAT, particularly due to internal displacement of the population, evacuation abroad, destruction and closure of medical facilities, logistics issues, staff evacuation, monitoring and preservation of information, and program funding (Center for Public Health, 2023[92]).

[91] Dumchev, K. (2022). Use of the directly observed therapy strategy with video communication and telemedicine for supporting and monitoring the treatment of mental and behavioral disorders due to opioid use with OAT medications. Kyiv: PHC of the Ministry of Health of Ukraine.

[92] Center for Public Health (2023). National response of HIV, TB, viral hepatitis and SMT programmes in the context of full-scale Russian invasion. https://phc.org.ua/sites/default/files/users/user90/National_response_HIV_TB_VH_SMT_war_2023_ENG.pdf

➲ CONCLUSIONS AND RECOMMENDATIONS

1. The conducted analysis confirms that **psychosocial support in OAT programs is an integral part of opioid substitution therapy programs.** Such interventions aim to strengthen motivational, behavioral, psychological, and social factors that contribute to recovery.

International standards define the key aspects of social support necessary during OAT:

- Basic social support: providing essential resources and assistance.
- Specialized social services: targeted support to address specific needs.
- Long-term social care and support: ongoing assistance for sustained social integration.
- Psychosocial interventions: an integrated component of specialized treatment.

2. Psychosocial support, as confirmed by international standards, **has proven effectiveness** in:

- improving treatment adherence;
- reducing substance use;
- minimizing associated risks;
- preventing relapses, and more.

Research has shown that psychosocial support leads to a reduction in the frequency of or cessation of "street" drug use, the development of problem-solving skills (legal, social, family, etc.), a decrease in risky behavior, a lower likelihood of relapse, a reduction in criminal activity, stabilization of the patient's emotional state, and fosters a responsible attitude toward one's health. It also increases the willingness to seek medical help when necessary.

Psychological support for OAT clients helps in developing adaptive skills, balancing the emotional-volitional sphere, expanding adaptive behavioral strategies, improving communication skills, and fostering better family relationships, among other benefits.

3. OAT is primarily implemented as a comprehensive bio-psychosocial intervention within the framework of integrated medical-social care. However, the international experience of implementing OAT programs varies and depends on the overall model of medical and social service delivery, the organization of the penitentiary system, and other factors. Different countries employ various approaches to organizing OAT, reflecting their unique socio-economic and cultural contexts.

In some countries, OAT is integrated into the primary healthcare system, providing broader access to services. In other countries, OAT programs are concentrated in specialized centers or clinics. Additionally, in some countries, OAT programs are implemented within penitentiary systems.

To provide psychosocial support, professionals must have appropriate education and undergo relevant certification. There are models where community organizations and self-help groups play a significant role in providing social support.

4. In Ukraine, despite the legislative framework and the integration of OAT into the healthcare system, **there is a significant gap between the demand for and the actual coverage of services.** Insufficient funding, limited access to social support, the impact of the war, and the high level of self-administration of therapy present serious challenges for the effective functioning of OAT programs.

A complex issue remains the inter-agency interaction between the medical and social sectors, and the lack of an integrated approach, particularly at the local level.

An additional issue is the lack of approval for the State Drug Policy Strategy of Ukraine until 2030 and the operational plan, which placed significant emphasis on the development of psychosocial services for people with addictions.

Despite the legislative basis for providing social support to OAT patients, its actual availability remains limited. The main problems include bureaucratic obstacles, the lack of appropriate funding, and the uneven development of social services in communities. Most OAT patients can only access support through partnerships with NGOs or referrals to other projects.

5. To ensure comprehensive psychosocial support for OAT programs in Ukraine, **long-term strategic systemic changes** are needed, including the simplification of procedures, expansion of available services, and strengthening intersectoral cooperation. These changes could include the following:

- **The introduction of social workers and psychologists in healthcare facilities** within the framework of medical guarantee funding packages; their certification according to the Law of Ukraine "On the Mental Health System"[93].
- **The elaboration of a separate state standard for the social service of psychosocial support within OAT programs**. A separate standard for case management (or social-psychological support) in healthcare facilities should be developed according to the Procedure for developing state social service standards[94]. This standard should regulate the specific procedure for case management and evaluating the effectiveness of the work done for OAT programs.
- The development and implementation of psychosocial support models tailored to patients undergoing self-administered OAT treatment, which could include the **development of mobile apps for monitoring patients' condition**, receiving reminders, and accessing online consultations.

[93] Verkhovna Rada of Ukraine (2025). On the mental health care system: Law No. 4223-IX. https://zakon.rada.gov.ua/laws/show/4223-20#Text

[94] Ministry of Social Policy of Ukraine (2012). On the approval of the Procedure for developing the state standard for social services: Order No. 282. https://zakon.rada.gov.ua/laws/show/z0876-12#Text

Short-term tasks for the development of low-threshold programs to reduce substance use should include:

- **Support and development of psychosocial support services for OAT clients** at healthcare facilities that provide therapy, as part of the treatment programs, in line with WHO/UNODC recommendations.
- **Standardization of mobile teams' activities** for distributing medicinal narcotic substances, strengthening these teams by including psychologists, social workers, and "peer-to-peer" consultants (the effectiveness of such teams is supported by the experience of Australia and Portugal).
- **Expansion of outreach support based on NGOs** with peer consultants who have OAT experience and can provide community support for patients (this support is recommended by WHO/UNODC in addition to professional support).
- Elaboration of a training program for social workers (specialists in psychosocial support) on providing psychosocial support to OAT patients (an indicative list of topics is provided in **Appendix B**).
- **Adapting psychosocial support specialists to the changing situation**:
    - Training in remote counseling methods and working in online formats;
    - Motivation counseling training to keep patients engaged in OAT without frequent in-person contact;
    - Equipping specialists with digital tools to monitor client conditions.
- **Ensuring funding for psychosocial support of OAT patients from international donors**, as neither the medical guarantee program nor local budgets have the resources for such social services.

APPENDIX A

LEGAL FRAMEWORK REGULATING THE IMPLEMENTATION OF OAT IN UKRAINE

Below are the key documents related to drug addiction, the implementation of the OAT program, and the regulation of the circulation of narcotic drugs, psychotropic substances, and their precursors (by level of legal authority).

Laws of Ukraine:

- Law of Ukraine dated 02.03.2015 No. 222-YIII "On Licensing Certain Types of Economic Activities"[95];
- Law of Ukraine dated 04.04.1996 No. 123/96-VR "On Medicines"[96];
- Law of Ukraine dated 15.02.1995 No. 62/95-VR "On Measures to Combat the Illegal Circulation of Narcotic Drugs, Psychotropic Substances, and Precursors, and Their Abuse"[97].

Resolutions / Orders of the Cabinet of Ministers of Ukraine:

- Order of the Cabinet of Ministers of Ukraine dated 06.02.2019 No. 56-r "On Approval of the Action Plan for 2019–2020 for the Implementation of the National Drug Policy Strategy for the Period Until 2020"[98];
- Order of the Cabinet of Ministers of Ukraine dated 28.08.2013 No. 735-r "On Approval of the National Drug Policy Strategy for the Period Until 2020"[99];
- Resolution of the Cabinet of Ministers of Ukraine dated 13.05.2013 No. 333 "On Approval of the Procedure for the Acquisition, Transportation, Storage, Dispensing, Use, and Destruction of Narcotic Drugs, Psychotropic Substances, and Precursors in Health Care Institutions"[100];
- Resolution of the Cabinet of Ministers of Ukraine dated 03.06.2009 No. 589 "On Approval of the Procedure for the Activity Related to the Circulation of Narcotic Drugs, Psychotropic Substances, and Precursors, and Control Over Their Circulation"[101];
- Resolution of the Cabinet of Ministers of Ukraine dated 06.05.2000 No. 770 "On Approval of the List of Narcotic Drugs, Psychotropic Substances, and Precursors"[102].

MOH Orders:

- Order dated 09.11.2020 No. 2555 "On Approval of the Medical Assistance Standards 'Mental and Behavioral Disorders Due to Opioid Use'"[103];

[95] https://zakon.rada.gov.ua/laws/show/222-19#Text
[96] https://zakon.rada.gov.ua/laws/show/123/96-%D0%B2%D1%80#Text
[97] https://zakon.rada.gov.ua/laws/show/62/95-%D0%B2%D1%80#Text
[98] https://zakon.rada.gov.ua/laws/show/56-2019-%D1%80#Text
[99] https://zakon.rada.gov.ua/laws/show/735-2013-%D1%80#Text
[100] https://zakon.rada.gov.ua/laws/show/333-2013-%D0%BF#Text
[101] https://zakon.rada.gov.ua/laws/show/589-2009-%D0%BF#Text
[102] https://zakon.rada.gov.ua/laws/show/770-2000-%D0%BF#Text

- Order dated 07.08.2015 No. 494 "On Certain Issues of the Acquisition, Transportation, Storage, Dispensing, Use, and Destruction of Narcotic Drugs, Psychotropic Substances, and Precursors in Health Care Institutions"[104];
- Order dated 27.03.2012 No. 200 "On Approval of the Procedure for Conducting Opiate Substitution Therapy for Persons with Mental and Behavioral Disorders Due to Opioid Use"[105];
- Order dated 19.07.2005 No. 360 "On Approval of the Rules for Issuing Prescriptions and Requirements for Orders for Medicines and Medical Devices, the Procedure for Dispensing Medicines and Medical Devices from Pharmacies and Their Structural Units, the Instructions for Storing, Accounting, and Destroying Prescription Forms and Orders"[106].

Interdepartmental Orders:

- Order of the Ministry of Health, the Ministry of Internal Affairs of Ukraine, the Ministry of Justice, and the State Drug Control Service dated 22.10.2012 No. 821/937/1549/5/156 "On Approval of the Procedure for Cooperation of Health Care Institutions, Internal Affairs Bodies, Pretrial Detention Centers, and Correctional Facilities in Ensuring the Continuity of Treatment with Opiate Agonist Therapy Drugs"[107].

Orders of Other Ministries:

- Order of the Ministry of Internal Affairs of Ukraine dated 15.05.2009 No. 216 "On Approval of Requirements for Facilities and Premises Designed for Activities Related to the Circulation of Narcotic Drugs, Psychotropic Substances, Precursors, and the Storage of Drugs Seized from Illegal Circulation"[108].

[103] https://zakon.rada.gov.ua/rada/show/v2555282-20#Text
[104] https://zakon.rada.gov.ua/laws/show/z1028-15#Text
[105] https://zakon.rada.gov.ua/laws/show/z0889-12#Text
[106] https://zakon.rada.gov.ua/laws/show/z0782-05
[107] https://zakon.rada.gov.ua/laws/show/z1868-12#Text
[108] https://zakon.rada.gov.ua/laws/show/z0208-18#Text

APPENDIX B

PROPOSED TOPICS FOR TRAINING SOCIAL WORKERS IN OAT PROGRAMS

The training program for social workers on providing medical-psychosocial support (MPSS) to patients undergoing opioid agonist therapy (OAT) should be comprehensive and cover various aspects of working with this category of clients.

Below are the main modules and topics to include in the program:

1. **Fundamentals of Addiction and OAT**
   - Nature of addiction: biological, psychological, and social aspects.
   - Types of psychoactive substances and their effects on the body.
   - Basics of opioid substitution therapy: principles, medications, methods.
   - Medical aspects of OAT: side effects, drug interactions, comorbid conditions.

2. **Psychosocial Aspects of Working with OAT Patients**
   - Psychological characteristics of OAT patients.
   - Motivational counseling: methods and techniques.
   - Specifics of remote counseling.
   - Working with resistance and denial.
   - Crisis intervention and relapse prevention.
   - Working with patients' families and loved ones.
   - Ethical aspects of working with OAT patients.

3. **Social Work with OAT Patients**
   - Assessing the social needs of patients.
   - Providing information on available social services.
   - Assisting in obtaining documents and social benefits.
   - Support for employment and reintegration into social networks.
   - Addressing housing issues.
   - Legal assistance.
   - Working with self-help groups.
   - Peer-to-peer support approach.

4. **Interagency Cooperation and Collaboration**
   - Cooperation with medical institutions, employment centers, social services, and other organizations.
   - Building partnerships with non-governmental organizations.
   - Teamwork with medical professionals and other specialists.

5. **Practical Skills and Supervision:**
   - Role-playing and situation modeling.

- Case analysis.
- Supervision and support from experienced specialists.

6. **Additional Aspects:**
   - Gender aspects in working with OAT patients.
   - Working with patients with comorbid mental disorders.
   - Working with patients in detention centers.
   - Working with patients with HIV/AIDS and other infectious diseases.