

# CHAPTER 4. HUMAN RESOURCES

## 4.1 The health workforce

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### Introduction

Substance use disorders are complex phenomena. They have multiple causes and consequences that co-occur with other chronic diseases and touch on many areas of life. Prevention and treatment of substance use disorders are therefore not simple tasks and require the consideration of multiple components in the treatment process, the participation of several disciplines, and the inclusion of a variety of resources – including those offered by the health workforce and other institutionalized groups such as NGOs.

Despite the availability of cost-effective prevention and treatment approaches, the treatment gap for substance use disorders remains considerable (WHO, 2005; Wang et al., 2007). Not by coincidence, many of the people in need are in the poorest and most vulnerable sectors of society. Many other impeding factors influence the treatment gap – factors that need to be addressed by the health workforce and national authorities – such as the denial of substance use disorders, structural barriers (such as lack of services and trained personnel) and personal barriers among patients and their families (such as stigma and lack of trust in the treatment outcome).

All of these factors hinder people from seeking treatment.

The treatment gap for substance use disorders can be closed only with the integration of services into the mainstream of treatment of chronic disorders, and with the participation of multiple sectors of society.

### Health workforce: availability and role of health professionals, NGOs, and self-help groups in treating people with substance use disorders

NGOs are essential partners in closing the intervention gap by preventing harmful use of alcohol and drugs, aggravation of dependency syndromes and subsequent health and social consequences for the patient. In general, the involvement of NGOs is more salient in prevention and rehabilitation, and less in treatment; it is also more salient in the area of drug use disorders as compared to alcohol use disorders. NGOs are present in all regions of the world and in countries at all levels of development, but they are more prominent in countries with higher income levels.

Civil society plays a key role in the self-help movement – especially Alcoholics Anonymous, Narcotics Anonymous and, more recently, Cocaine Anonymous which is most prominent in the Americas (UNODC, 2010).

Persons with substance use disorders may use drugs despite being faced with devastating consequences. Research evidence shows that effective treatment is available but also indicates that long-lasting recovery from substance use disorders may occur only after several episodes of treatment have been received over many years. It is well documented

that self-help groups have an important impact on the maintenance of abstinence after treatment (Kelly et al., 2006; Kelly, Magill & Stout, 2009). Self-help groups have a number of advantages: they provide free support, are easily accessible, and the individual can self-regulate his or her involvement according to their perceived needs. Although it has been shown that the combination of treatment by health professionals and involvement in self-help groups leads to the best treatment outcome, self-help groups and other alternative treatments on their own have also helped many persons to recover from addiction and dependence (Gutiérrez et al., 2009).

The treatment gap places a high social and financial burden on the family. Persons may live for many years with family members who, without treatment, frequently escalate to increasing levels of dependence. The family system is important because it constitutes a significant context in which the substance use problem first becomes evident. Families may serve as a risk factor per se that precedes the manifestation of the substance use problem as other family members may provide negative role modeling, facilitating the use of psychoactive substances. In some cases the social context of the family may serve to maintain the substance use problem, but on the other hand the family system may also facilitate help-seeking, treatment and recovery. Although problems often arise as a result of cohabiting with persons who have problems with psychoactive substance use, treatment for families and their involvement in self-help groups is not common. Actions should be taken to improve the options for families to help themselves while helping the family member who has a substance use problem.

### The role of non-professionally trained staff in treating people with substance use disorders

Since 12-step programmes consider that helping others facilitates recovery, assisting others who suffer from the same substance use disorder is seen by many health professionals as an important component of the recovery process. Evidence shows that helping other patients increases the likelihood of 12-step involvement after treatment, and that the time patients with alcohol use disorders spend in helping other patients is associated with a higher rate of abstinence and less binge drinking. Therefore, former addicts or those who are in the process of recovery have an important role to play in providing formal care to other patients. Religious groups and religion-oriented NGOs constitute another important group in providing care for people with substance use disorders (Kelly, Magill & Stout, 2009). Where no other treatment is available, traditional healers – who are more frequently present in low-income countries – may also provide formal care for people with substance use disorders.

### The role of primary health care professionals in treating people with substance use disorders

Integrating the treatment of substance use disorders and other mental disorders into the general health system will minimize the treatment gap. In a new conceptualization of the treatment system, primary care workers (including medical practitioners, nurses, social workers and other health personnel) would have a major role in detecting persons with substance use disorders in the early disease stages, while psychiatrists, addictologists or narcologists would be involved in the treatment of more severe cases. Combining enrolment in self-help groups and ensuring continued participation in such groups beyond treatment would be encouraged to expedite recovery and to prevent relapse. Networking between primary and specialized care is encouraged in order to reduce the costs of treatment by early detection of relapse and by ensuring prompt referral to a more specialized level of care when symptoms intensify.

Currently, specialists still play the most important role in all regions of the world in treating patients with both alcohol and drug use problems. This shows the need to re-conceptualize the health care system and to train other health professionals and also non-institutionalized groups of people – such as former addicts or those in recovery – to become more involved in providing care and assistance to persons with substance use disorders.

### Needs of health professionals to provide effective treatment

In order to provide comprehensive care and treatment for people with substance use disorders, and also to influence the quality of life of the patient, it is indispensable to increase the variety of health professionals working in the area of substance use disorders, thus utilizing their different skills and knowledge to maximize the treatment outcome.

There is a need for more psychiatrists in the treatment system in order to treat severe cases, especially those patients who have a substance use disorder which co-occurs with other psychiatric disorders. An increase in specialists is particularly needed in developing countries that have historically had a shortage of psychiatrists – which is exacerbated by a “brain-drain” from developing to industrialized countries (Katschnig, 2010). Helpful steps to increase the enrolment of medical doctors in psychiatry and addiction medicine include efforts to reduce the social stigma against people with substance use disorders and their treatment providers, expanding insurance coverage, and disseminating evidence on the effectiveness of medical treatment. Efforts are also needed to increase the acceptance of addiction medicine as a medical specialty or subspecialty (Soyka & Gorelick, 2008).

Ensuring a high level of quality in treatment delivery has a positive influence on patient satisfaction. Only half the countries around the world have criteria for standards of care. Among high-income countries, the proportion achieves a modest 64%, whereas in low-income countries only one fourth of countries have quality-of-care criteria. Systems of clinical supervision for health care professionals are present in half of the medical professions with the lowest rates being found in developing countries.

### Towards closing the gap

The challenge remains to close the prevention and treatment gap. Effective treatment is available but success is more likely with continuous care provided by various kinds of health professionals and other groups, when treatment is available and delivered even in times of relapse, and when help and assistance are guaranteed. Such assistance is also needed with regard to the social and occupational life which may be disrupted as a result of the substance use disorder. This can only be achieved through the integration of various health professionals and civil society in the treatment system, and with psychiatrists, general practitioners, psychologists, social workers, nurses, former addicts, self-help groups and other NGOs working together to achieve a common goal. Continuous education to further the advances of science and to reduce stigma will be essential.

## 4.2 Health professionals

(Figures 4.1–4.2)

### Background

- Nominated focal points were asked about the professional background of health care staff treating persons with alcohol and drug use disorders in their countries.
- Countries applied a ranking to the involvement of different groups of health professionals in treating persons with alcohol and drug use disorders. The graphs in this section show the relative importance in countries of the three leading groups of health professionals treating persons with alcohol and drug use disorders.

### Salient findings

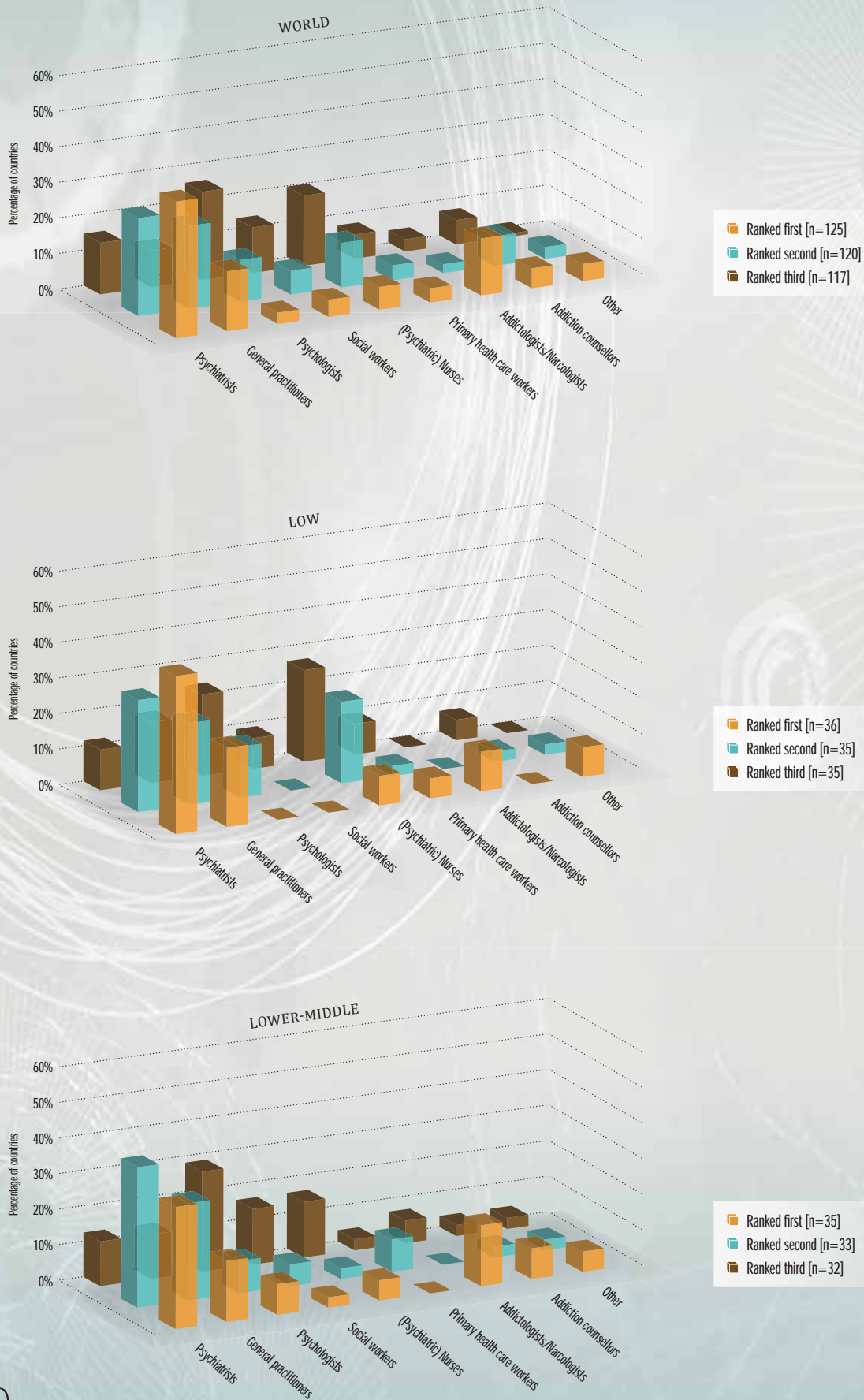
- Among the various groups of health professionals (i.e. health professionals who are most often involved in treating alcohol and drug use disorders), the majority of countries reported psychiatrists, general practitioners and addictologists/narcologists to be the most important health professionals for the treatment of alcohol and drug use disorders.
- Specifically, psychiatrists were reported to be the health professionals most involved in treating alcohol and drug use disorders in approximately 35% of countries in the survey. General practitioners and addictologists/narcologists were reported to be the health professionals most involved in treating alcohol and drug use disorders in approximately 10% of countries.
- The proportion of countries reporting psychiatrists as the health professionals most involved in the provision of treatment for alcohol and drug use disorders seems to be highest in low-income countries (approximately 45% for the treatment of alcohol use disorders, and approximately 55% for the treatment of drug use disorders), and lowest in high-income countries (approximately 25% for the treatment of alcohol use disorders, and approximately 10% for the treatment of drug use disorders).
- Among countries in the high-income group there seems to be no clearly predominant group of health professionals that is treating persons with alcohol and drug use disorders. This is in contrast to countries in the other income groups. For example, over 50% of surveyed countries in the low-income group reported that psychiatrists would be the health professionals most involved in the treatment of drug use disorders.
- Traditional healers were reported by a number of countries as the group of health professionals most involved in treating substance use disorders. Traditional healers are included under the category “other”.

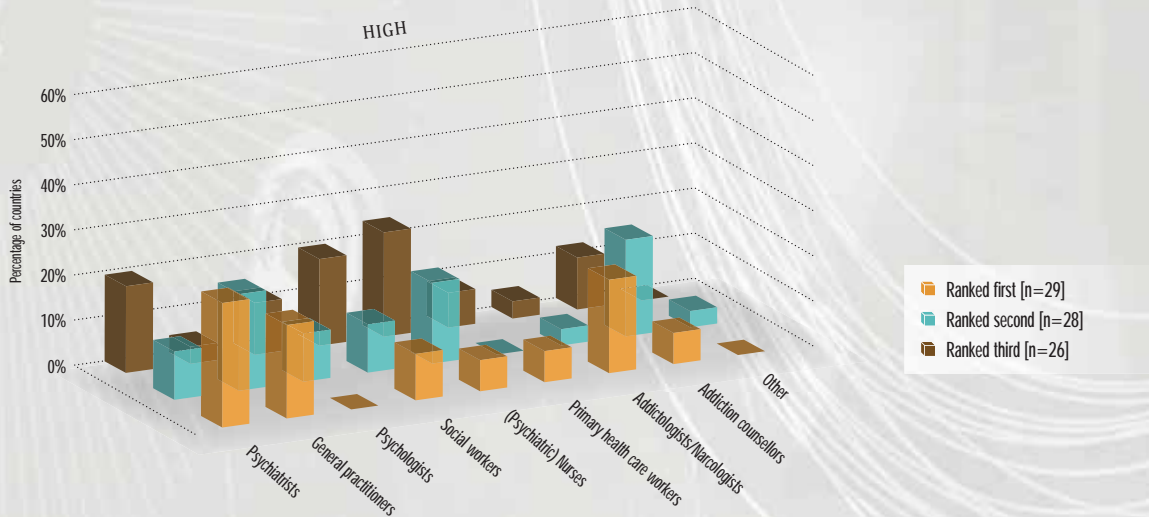
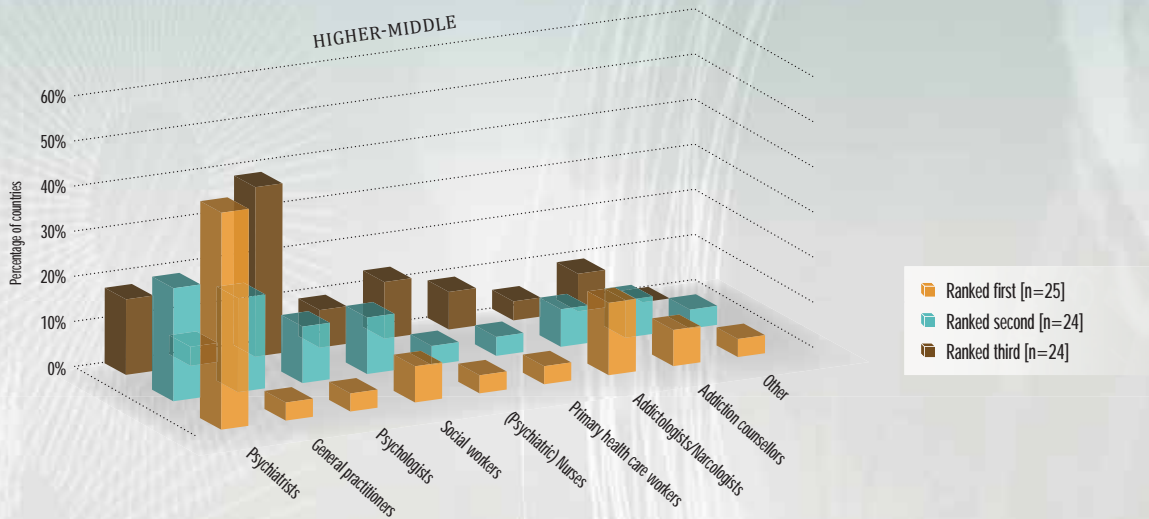
### Notes and comments

- A variety of health professionals seem to be responsible for the management of alcohol and drug use disorders in different countries.
- The data here imply a predominance of “top heavy” systems in treating substance use disorders, with many countries identifying specialist medical practitioners (psychiatrists or addiction specialists) as the health professionals most often involved in treating alcohol and drug use disorders. These data should be interpreted with some caution, as it is difficult to gather data on the number of different classes of professionals working in a treatment system, particularly in relation to primary care.
- General practitioners were often identified as an important group for the treating of substance use disorders. This suggests that more effective use of primary care can be considered as one method of reducing the treatment gap in countries that are not currently using primary care practitioners for that purpose.
- Availability of trained counsellors, psychologists, social workers and nurses, as well as their increasing engagement in the prevention and treatment of substance use disorders, could improve access to prevention and treatment services and facilitate a multidisciplinary approach to the management of substance use disorders.

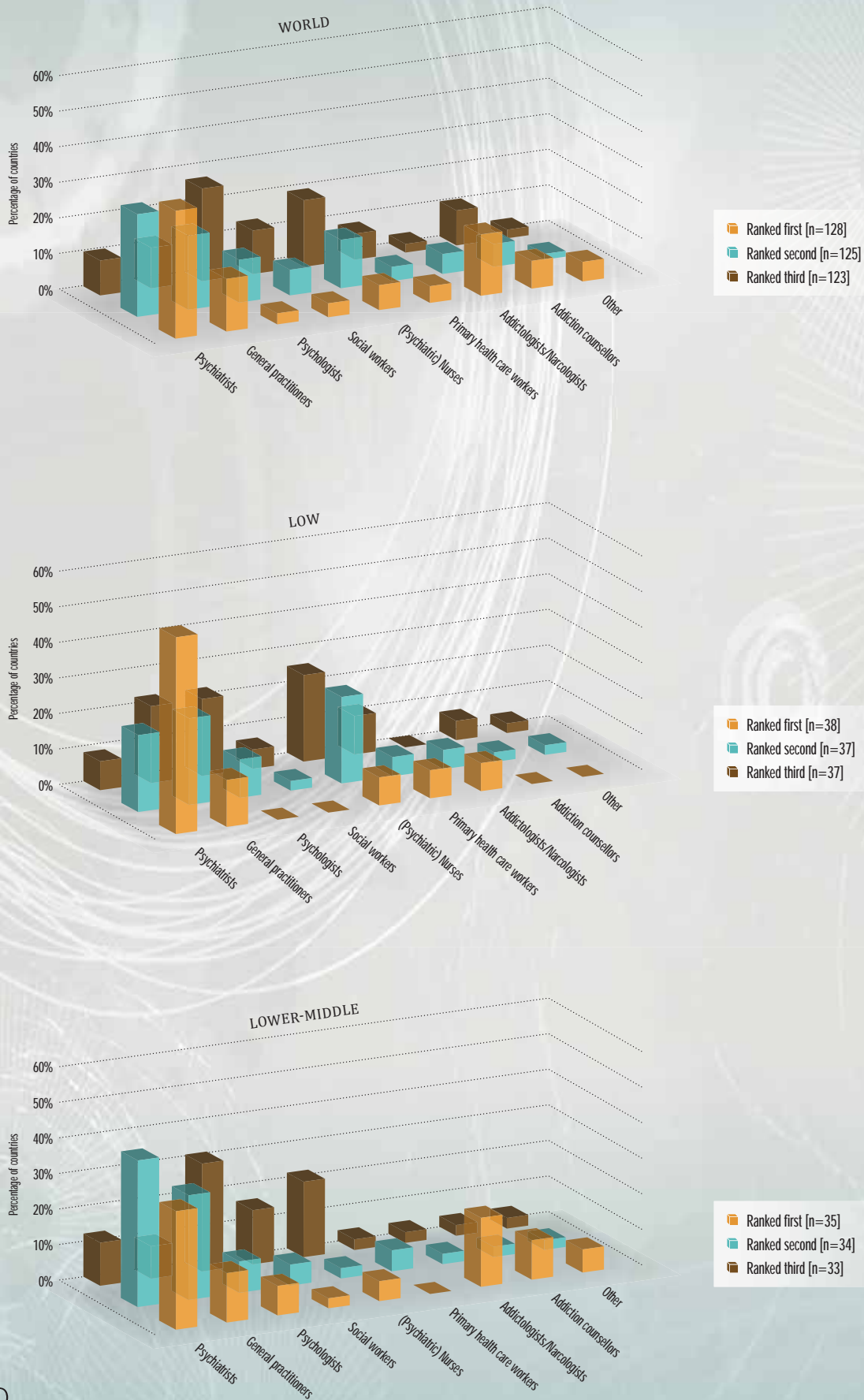


**FIGURE 4.1**  
PROFESSIONAL BACKGROUND OF HEALTH CARE STAFF MOST INVOLVED IN TREATING PERSONS WITH ALCOHOL USE DISORDERS,  
BY INCOME GROUP, 2008

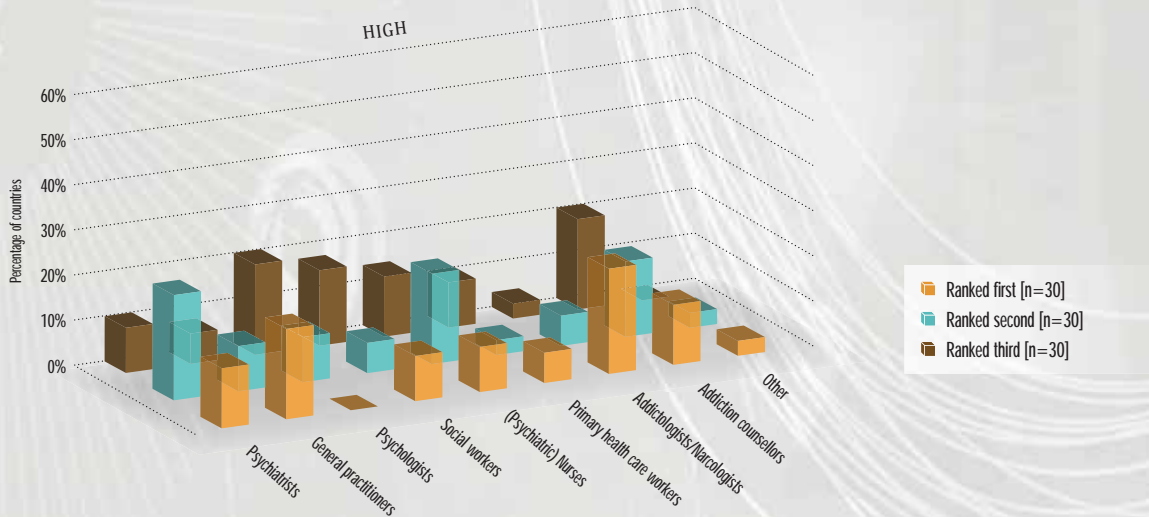
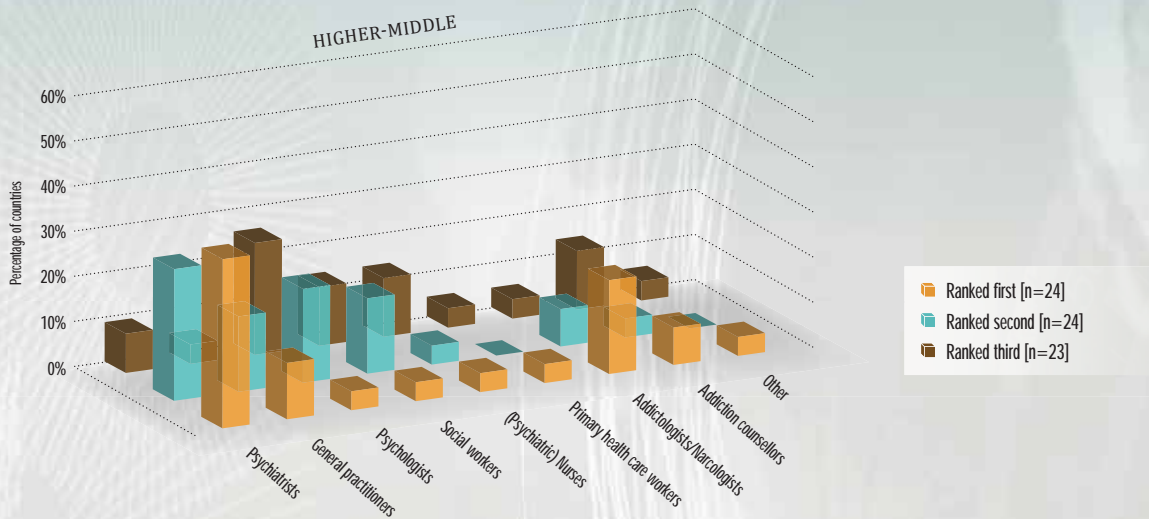




**FIGURE 4.2**  
**PROFESSIONAL BACKGROUND OF HEALTH CARE STAFF MOST INVOLVED IN TREATING PERSONS WITH DRUG USE DISORDERS, BY INCOME GROUP, 2008**







## 4.3 Standards of care and supervision for health professionals

(Figures 4.3–4.6)

### Background

- Nominated focal points were asked about the presence in their countries of national standards of care required for health professionals working with persons who have substance use disorders.
- Clinical supervision has positive effects on the performance of health care staff. Focal points were asked whether a system of clinical supervision of health care staff working with persons who have substance use disorders exists in their countries.

### Salient findings

#### Standards of care for health professionals

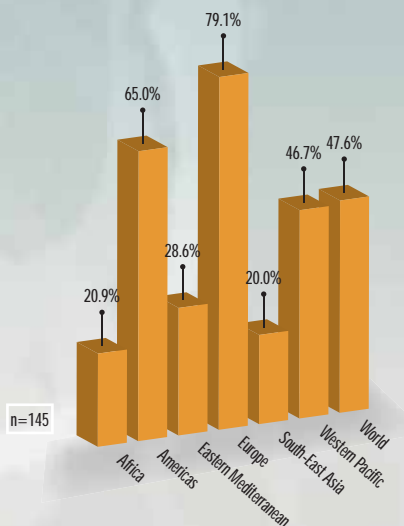
- Approximately half of the countries in the survey (47.6%) reported having national standards of care for health professionals working with persons having substance use disorders.
- Europe (79.1%) and the Americas (65%) were among the regions reporting the highest proportions of countries with national standards of care for health professionals working with substance use disorders. The lowest proportions of countries with standards of care were reported in the South-East Asian (20.0%), African (20.9%) and Eastern Mediterranean (28.6%) regions.
- There is some variation according to country income as to the presence of standards of care for health professionals working with substance use disorders. However, there is no marked difference in the proportion of standards of care reported by countries in the higher middle-income (65.5%) and high-income (63.6%) groups.

#### Clinical supervision of health care staff

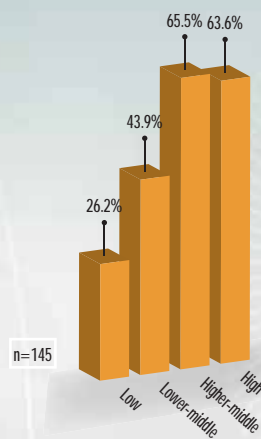
- Approximately half of the countries in the survey reported clinical supervision of health care staff treating substance use disorders. Clinical supervision for nurses was reported to be most common among countries in the survey (57.1%), followed by clinical supervision of doctors (52.5%), social workers (44.4%) and psychologists (43.5%).
- Across the regions, Eastern Mediterranean and Europe reported having the highest proportions of countries with clinical supervision of doctors, psychologists, nurses and social workers.
- There is no clear effect of the level of country income on the presence of clinical supervision of health care staff across different income groups of countries. Low-income countries reported, for example, a higher proportion of clinical supervision for doctors (57.1%) and nurses (66.7%) compared to countries in the lower middle-income (44.7% and 47.4% respectively) and higher middle-income (39.3% and 46.4% respectively) groups.

### Notes and comments

- Standards of care for health professionals working with persons who have substance use disorders, and clinical supervision of health care staff appear to be absent in many countries. The impact of this on the quality of care provided is not clear.
- The significant proportion of countries with systems of clinical supervision, even of medical staff, indicate that clinical supervision is a model that can be implemented in diverse settings, although estimates of the impact of this were not possible through this survey.

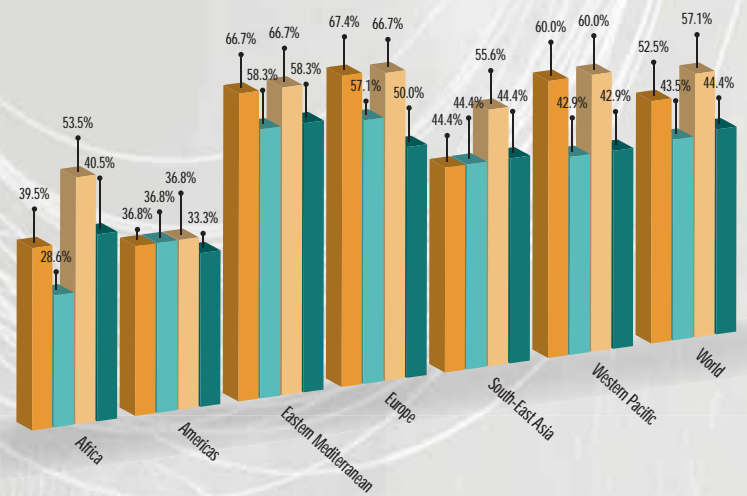


**FIGURE 4.3**  
PROPORTION OF COUNTRIES WITH NATIONAL STANDARDS OF CARE FOR HEALTH PROFESSIONALS TREATING SUBSTANCE USE DISORDERS, BY REGION, 2008

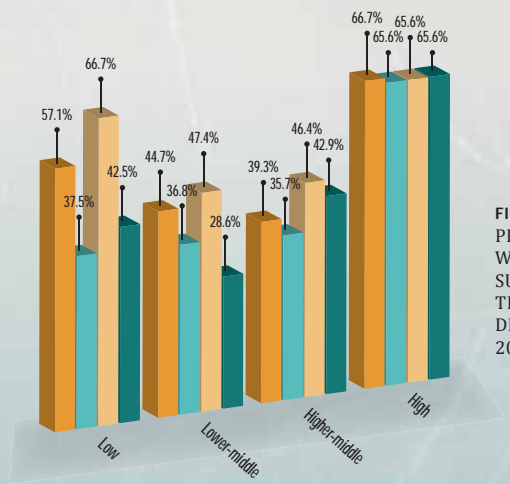


**FIGURE 4.4**  
PROPORTION OF COUNTRIES WITH NATIONAL STANDARDS OF CARE FOR HEALTH PROFESSIONALS TREATING SUBSTANCE USE DISORDERS, BY INCOME GROUP, 2008

- Doctors [n=141]
- Psychologists [n=138]
- Nurses [n=140]
- Social workers [n=135]



**FIGURE 4.5**  
PROPORTION OF COUNTRIES WITH A SYSTEM OF CLINICAL SUPERVISION OF HEALTH STAFF TREATING SUBSTANCE USE DISORDERS, BY REGION, 2008



**FIGURE 4.6**  
PROPORTION OF COUNTRIES WITH A SYSTEM OF CLINICAL SUPERVISION OF HEALTH STAFF TREATING SUBSTANCE USE DISORDERS, BY INCOME GROUP, 2008

## 4.4 Nongovernmental organizations and self-help groups for substance use disorders

(Figures 4.7–4.14)

### Background

- Focal points were asked about the presence in their countries of nongovernmental organizations (NGOs) providing treatment, rehabilitation or prevention of alcohol and drug use disorders.
- Focal points were asked about the presence of various self-help groups (Alcoholics Anonymous, Al-Anon/Alateen, Narcotics Anonymous and Cocaine Anonymous) in their countries.
- Focal points were further asked to indicate the presence of people without formal training working in the treatment of substance use disorders, such as people with a history of substance dependence (sometimes referred to as “ex-addicts” or “recovering addicts”), traditional healers, and religious groups.
- WHO guidelines suggest that treatment staff should attempt to use what effective self-help groups are available by referring patients to self-help groups when appropriate.

### Salient findings

#### Nongovernmental organizations for substance use disorders

- A high proportion of countries in the survey reported having NGOs focusing on alcohol and drug prevention (74.8% for alcohol and 81.6% for drug prevention). Approximately 70% of surveyed countries reported the presence of NGOs focusing on rehabilitation of persons with alcohol and drug use disorders. NGOs involved in treatment of alcohol or drug use disorders were reported from 54.5% and 59.9% of countries respectively.
- The Eastern Mediterranean and South-East Asia regions reported a higher proportion of countries with NGOs focusing on drug use disorders than on alcohol use disorders.
- There is some variation in the presence of NGOs according to country income level. NGOs for the treatment, rehabilitation and prevention of alcohol and drug use disorders seem to be more often present in high-income countries than in low-income countries.

#### Self-help groups for substance use disorders

- Alcoholics Anonymous was reported by the majority of countries (71.1%). The Americas, Europe and Western Pacific were the regions with the highest proportion of countries reporting the presence of Alcoholics Anonymous and Al-Anon/Alateen.
- Narcotics Anonymous was reported by approximately half of the countries in the survey (56.7%). The Americas, Europe and the Western Pacific were the regions reporting the highest proportion of countries with Narcotics Anonymous.



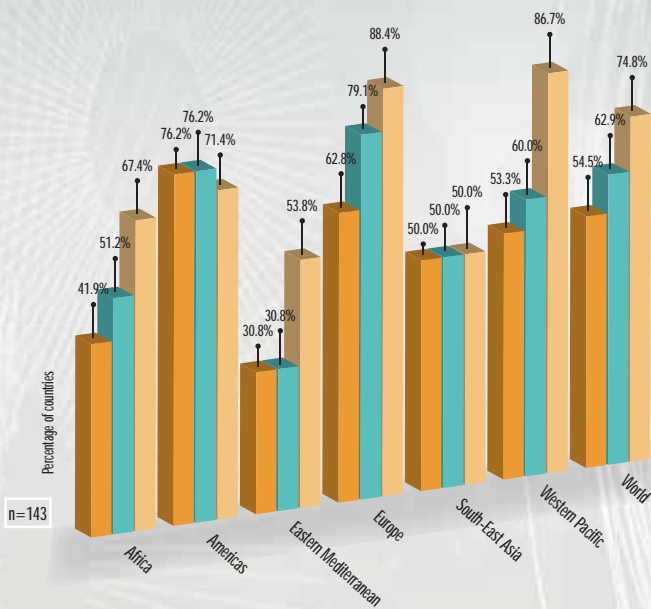
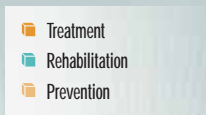
- The presence of Cocaine Anonymous was reported by 11.5% of countries in the survey. The Americas reported the highest proportion of countries with Cocaine Anonymous.
- Besides Cocaine Anonymous, which seems to be most often present in countries in the higher middle-income group, there is a strong effect of country income level on the presence of Alcoholics Anonymous, Al-Anon/Alateen and Narcotics Anonymous in different income groups of countries.

### Other groups providing formal care for substance use disorders

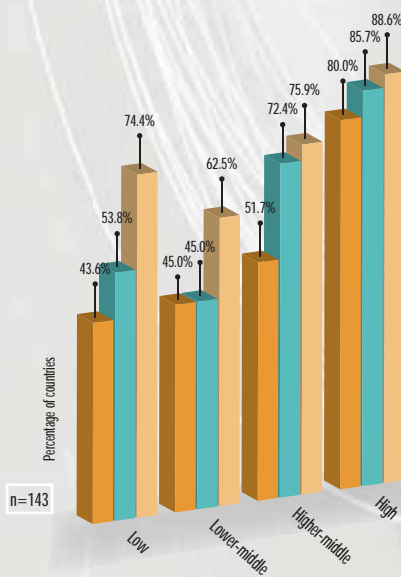
- “Ex-addicts” or “recovering addicts” were reported to provide formal care for persons with substance use disorders in 59.9% of countries in the survey.
- Traditional healers providing care for persons with substance use disorders were reported by 31.3% of countries. The Americas and South-East Asia were the regions reporting the highest proportions of countries with traditional healers.
- Religious groups or NGOs based on religious groups were reported by 67.4% of countries, and were reported to be most common among countries in the Americas and South-East Asia.
- “Ex-addicts” or “recovering addicts” providing care for persons with substance use disorders seem to be most often present in high-income countries (75.0%). The highest proportion of traditional healers was reported from low-income countries (44.7%). Religious groups or NGOs based on religious groups are reported most commonly among countries in the higher middle-income group (79.3%).

### Notes and Comments

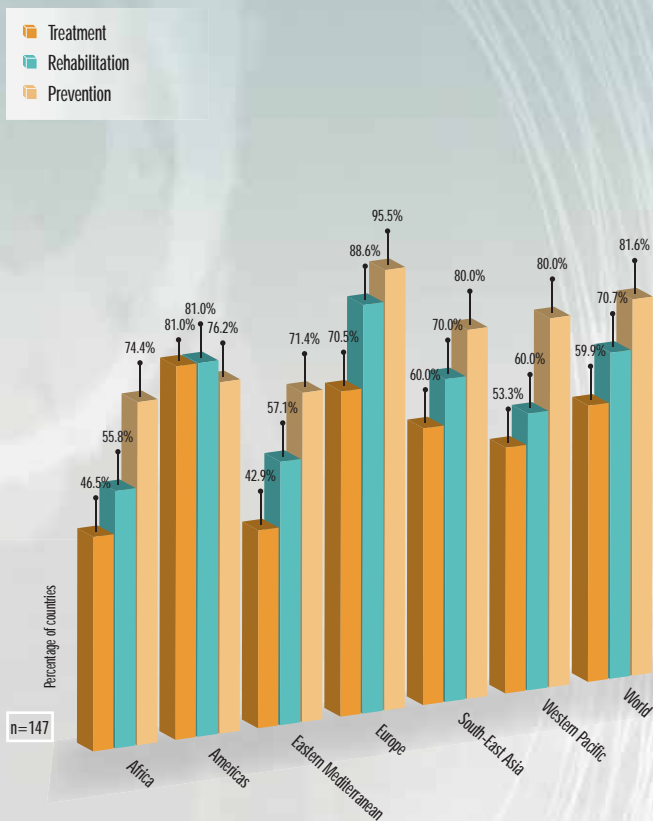
- The widespread dissemination of NGOs and self-help groups throughout the world demonstrates that they have made significant contributions to prevention, treatment and rehabilitation systems. Countries wishing to expand the coverage of services may wish to consider the role that can be played by both NGOs and self-help groups. As both NGOs and self-help groups may be beyond the direct supervision of the Ministry of Health, they present particular challenges to policy-makers who seek to include them in the broader system of care.



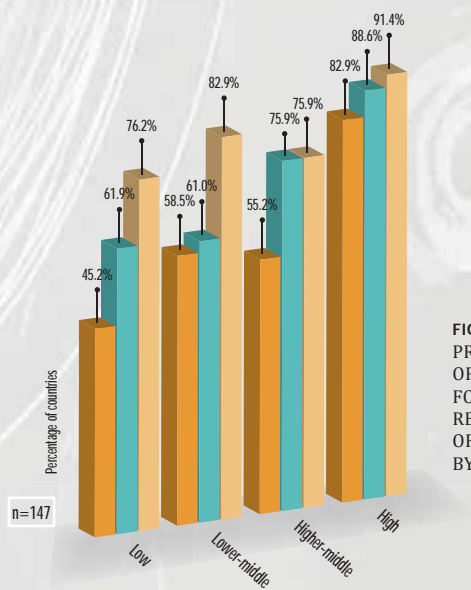
**FIGURE 4.7**  
 PRESENCE OF NONGOVERNMENTAL ORGANIZATIONS IN COUNTRIES FOCUSING ON TREATMENT, REHABILITATION AND PREVENTION OF ALCOHOL USE DISORDERS, BY REGION, 2008



**FIGURE 4.8**  
 PRESENCE OF NONGOVERNMENTAL ORGANIZATIONS IN COUNTRIES FOCUSING ON TREATMENT, REHABILITATION AND PREVENTION OF ALCOHOL USE DISORDERS, BY INCOME GROUP, 2008

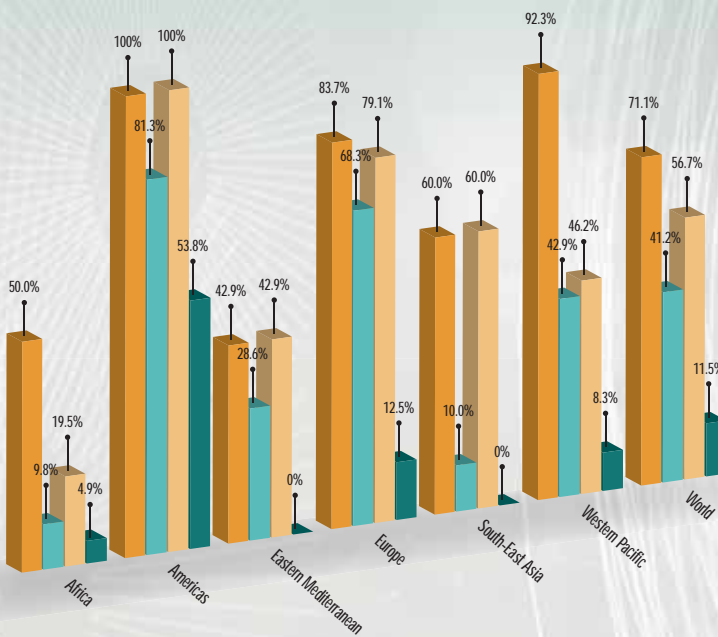


**FIGURE 4.9**  
PRESENCE OF NONGOVERNMENTAL ORGANIZATIONS IN COUNTRIES FOCUSING ON TREATMENT, REHABILITATION AND PREVENTION OF DRUG USE DISORDERS, BY REGION, 2008

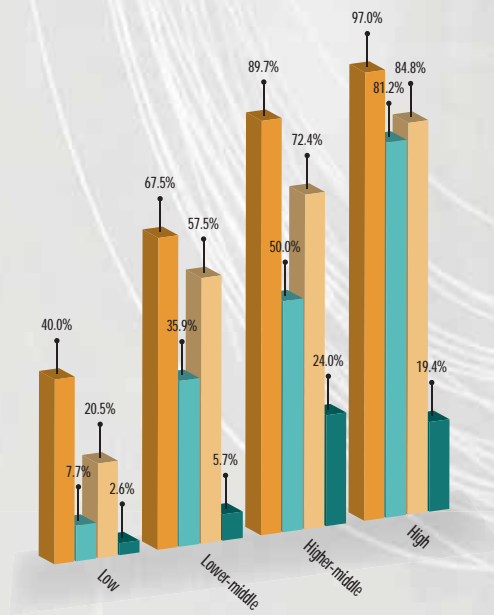


**FIGURE 4.10**  
PRESENCE OF NONGOVERNMENTAL ORGANIZATIONS IN COUNTRIES FOCUSING ON TREATMENT, REHABILITATION AND PREVENTION OF DRUG USE DISORDERS, BY INCOME GROUP, 2008

- Alcoholics Anonymous [n=142]
- Al-Anon/Alateen [n=136]
- Narcotics Anonymous [n=141]
- Cocaine Anonymous [n=130]

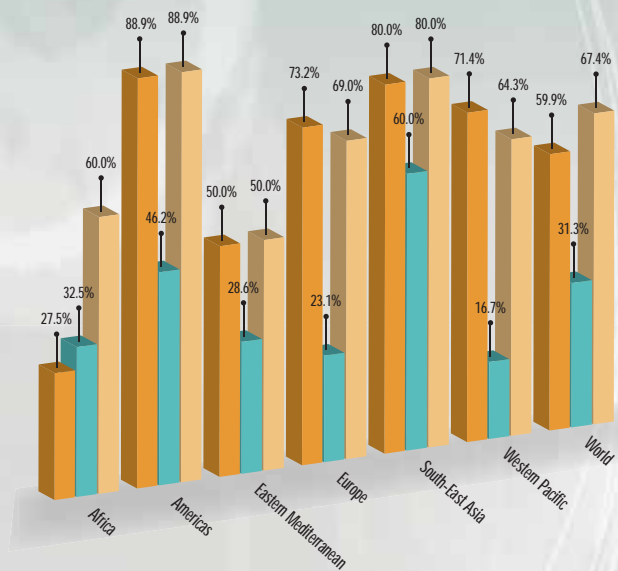


**FIGURE 4.11**  
PROPORTION OF COUNTRIES WITH SELF-HELP GROUPS FOR SUBSTANCE USE DISORDERS, BY REGION, 2008

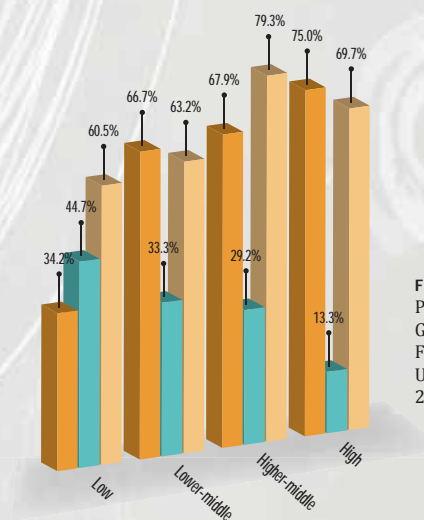


**FIGURE 4.12**  
PROPORTION OF COUNTRIES WITH SELF-HELP GROUPS FOR SUBSTANCE USE DISORDERS, BY INCOME GROUP, 2008

- Ex-addicts or recovering addicts [n=137]
- Traditional healers [n=128]
- Religious groups/NGOs based on religious groups [n=138]



**FIGURE 4.13**  
PROPORTION OF COUNTRIES WITH GROUPS PROVIDING FORMAL CARE FOR PERSONS WITH SUBSTANCE USE DISORDERS, BY REGION, 2008



**FIGURE 4.14**  
PROPORTION OF COUNTRIES WITH GROUPS PROVIDING FORMAL CARE FOR PERSONS WITH SUBSTANCE USE DISORDERS, BY INCOME GROUP, 2008