

The Health Ministry's Department for the Treatment of Substance Abuse's Policy Regarding:
Treating Opiate Addicts with Medication for an Extended Period of Time
(using agonist or partial agonist drugs, e.g. methadone, buprenorphine)

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This document does not exclude or minimize orders and/or requirements, and/or restrictions that appear in the Institutions for Drug Users (Supervision and Treatment) Act of 1993, and its ordinances, and the Department for the Treatment of Substance Abuse's regulations, which are updated periodically .

This policy paper does not oblige the Ministry of Health to provide treatment and/or services which it is not authorized to provide, and are anyways excluded from the Ministry's budget, despite the importance of such treatments or services.

1 Key points in the policy for treating opiate addicts with medication for an extended period of time.

Relying on the most up-to-date research and medical information from both Israel and abroad, and in line with the findings of professional organizations worldwide such as the American Psychiatric Association (APA), the National Institute for Health and Clinical Excellence (NICE) in England, and the Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States, the Ministry of Health had declared that:

- 1.1 Extended treatment with agonists (e.g. methadone) or partial agonists (e.g. buprenorphine, drugs such as Subutex and Suboxone), is an effective and safe way to treat opiate addicts who are interested in stopping using opiates, and greatly reduces the direct and indirect harms of addiction.
- 1.2 Patients who are treated with medication over an extended period of time have higher retention rates than patients receiving other forms of treatment.
- 1.3 The efficiency of the treatment is measured as controlling drug use until the patient stops using it entirely, reducing the risk of catching or spreading infectious diseases via needles, and reducing crime associated with the use of street drugs.
- 1.4 The combination of psychosocial therapy, rehabilitation, and medication has been proven to greatly improve the likelihood of ceasing use and achieving total abstinence from opiates and other street drugs. The integrative approach significantly helps the patient function in the many aspects of their lives: work, family, society, and helps the patient and their family recover from the addiction.
- 1.5 This form of treatment can take many years, and some patients will use agonists for the rest of their lives.
- 1.6 Each patient will have a systematic, differential, multiphase treatment plan, which will outline the type and dosage of medication and intensity of the psychosocial therapy. This plan will be tailored to each patient individually, according to their condition.

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- 1.7 The multidisciplinary staff (including medical and psychological professionals) and patient will work together to determine the content and duration of each stage of treatment.
- 1.8 A doctor will determine the drug type (methadone/buprenorphine/Suboxone) and the dosage according to clinical examinations, lab results, and varying factors such as personal history of addiction, the severity of addiction, motivation for any specific treatment, and the risks and benefits of each treatment. This must be done together with the patient, and account for indications and contraindications to specific drugs.
- 1.9 The integrative approach is not limited to medical treatment and psychosocial therapy, but must also guide the patient towards minimizing damages and promoting their health.
- 1.10 In Israel, it is recommended to treat opiate addicts over an extended period with personal, oral doses of methadone hydrochloride or buprenorphine.
- 1.11 Opiate addicts may be treated with methadone or buprenorphine only in clinics or government centers, either private or public, which have a medical or combined license according to the Institutions for Drug Users (Supervision and Treatment) Act of 1993 and its ordinances. These centers must meet the Act's standards and abide by its regulations, and be accessible via public transportation and accommodate handicapped patients.
- 1.12 Mobile units will tour the eastern and upper Galilee, the western and upper Galilee, and the Negev and Eilat in order to treat addicts who live far from treatment centers. The Department for the Treatment of Substance Abuse will determine where treatment will take place.
- 1.13 It is crucial that immediate care institutions (i.e. clinics and mental health centers) and hospitals, both general and psychiatric, foster reciprocal, cooperative relationships.
- 1.14 Research into drug and alcohol use, addiction, and new treatment methods should increase. Medical researchers, including neuroscientists and biologists, and social scientists should be encouraged to engage with this field.

2 Introduction

2.1 Opiate addiction: the disease and its damages

Addiction to opiates (heroin, morphine, methadone, OxyContin, fentanyl, and their derivatives) is a significant physiological disease, which negatively affect the addict, their family and community, and the public's health. Addiction is frequently associated with the abuse of other psychoactive substances (polydrug abuse), which may make treatment challenging, and must be addressed as well.

2.1.1 Defining addiction

2.1.1.1 Addiction is a chronic disease of the brain that results from drug use, which causes changes, some reversible and some irreversible, in the brain's neuroplasticity and nerves. This disease is evident at the molecular and nerve levels.

2.1.1.2 The disease is manifested as recurring outbreaks with psychosocial aspects. These are typically associated with an obsessive-compulsive search for drugs, alcohol, or other psychoactive substance, which are used despite their negative impact.

2.1.2 Diagnosing symptoms of dependency (addiction)

2.1.2.1 In Israel, patients are diagnosed by a doctor using the international classification of diseases (ICD-10).

2.1.2.2 A diagnosis of addiction may be considered definite only if the patient has demonstrated or experienced three or more of the following conditions within the past year.

2.1.2.2.1 A strong desire or obsessive urge to use the substance.

2.1.2.2.2 Difficulty controlling behavior relating the substance, such as using, not using, and the amount used.

2.1.2.2.3 Physiological signs of withdrawal when less or no substance is

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used. This may be evidence of withdrawal symptoms typically associated with that psychoactive substance, or easing or eliminating the symptoms of withdrawal by using the substance (or a similar substance).

2.1.2.2.4 Developing tolerance; the user requires more of the psychoactive substance to attain a state previously reached with less of the substance (opiate users often take doses that would debilitate or kill less tolerant users).

2.1.2.2.5 Serious neglect of other activities and enjoyable experiences due to the use of the psychoactive substance, the time spent finding and using it, or the time needed to recover from its effects.

2.1.2.2.6 Consistent use despite clear evidence of damage, including: liver damage due to alcohol abuse, periods of depressions due to “heavy” use, or impaired cognitive function. It must be determined that the user was aware of the damage and its extent, or that the user should be expected to know about the damage.

2.1.3 **Diagnosing the use of a harmful substance (abuse)**

Definition: a pattern of using a psychoactive substance that harms one's health. Damages may be physical (e.g hepatitis from shared needles) or psychological (e.g. minor depression from heavy drinking).

2.1.4 **Damages from addiction and abuse**

2.1.4.1 A increased risk of death and physical/psychological morbidity due to an overdose, infectious disease spread via needles (hepatitis B and C, HIV), improper nutrition and an unhealthy lifestyle (dental diseases, loss of teeth), suicidal tendencies, falls, accidents, injuries from violence, and more.

2.1.4.2 A heightened risk of spreading infectious diseases.

2.1.4.3 Criminal behavior (theft, robbery) to fund the substance.

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- 2.1.4.4 Engaging in prostitution to fund the substance.
- 2.1.4.5 Inadequate engagement with society/family, unemployment and a lack of productivity, living in the streets, violence, breaking up the familial unit, persuading family members to use drugs.

2.2 Medical treatment of opiate addicts

The extended treatment of opiate addicts with medication is based on administering an agonist or partial agonist drug, either methadone hydrochloride or buprenorphine.

2.3 Psychosocial therapy

The integration of psychosocial therapy, rehabilitation, and medical treatment has been proven to significantly improve the likelihood of stopping substance abuse and attaining total abstinence. This holds true for opiates, alcohol, and other street drugs. This integrative approach significantly increases the patient's ability to function in different capacities in their life: work, family, and society, and enables the patient and their family to recover from the addiction.

3 The target population and treatment goals

3.1 The target population

- 3.1.1 This treatment is suitable for opiate addicts who have expressed interest in stopping their use of street drugs.

3.2 Treatment goals

3.2.1 Short- and medium-term goals

- 3.2.1.1 Reducing the use of opiates to the point of cessation.
- 3.2.1.2 Reducing the use of street drugs and other psychoactive substances to the point of cessation
- 3.2.1.3 Participating in individual and group psychosocial therapy sessions.

3.2.2 Long term goals

3.2.2.1 Stabilization through treatment with medication and re-integrating into society.

4 Qualifying for treatment (intake committee and criteria)

4.1 **Intake committee** - Each center will have a multidisciplinary intake committee, which will have at least two members including a doctor, social worker, clinical psychologist, or clinical criminologist.

4.2 Intake criteria

4.2.1 Over the age of 18

4.2.2 Opiate users for at least a year (determined by a urine test, anemnesis, family and community testimonials, etc).

4.2.3 At least two failed attempts at withdrawal, or incompatibility with withdrawal programs for medical or psychosocial reasons.

4.2.4 A good prognosis of ability and basic willingness to meet the requirements of the center and treatment plan.

4.2.5 Completion of all medical examinations, as required by the doctor.

4.2.6 No contraindication to participating in a treatment program with medication.

4.2.7 Patients who do not meet these criteria may petition the Department for the Treatment of Substance Abuse and seek admission to the program.

4.3 Immediate intake criteria (circumventing the wait list)

Patients will undergo immediate intake in the following cases:

4.3.1 The patient is a carrier, or is sick with, HIV.

4.3.2 Pregnant women.

4.3.3 An addict waiting to be admitted to an in-patient treatment center, pending Department approval.

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4.3.4 A patient receiving methadone or buprenorphine treatments at another institution, whether a hospital, detention center, jail, or other clinic.

4.3.5 Extenuating medical and/or psychosocial circumstances, pending approval by the Ministry of Health's Department for the Treatment of Substance Abuse.

4.4 Managing the wait list

4.4.1 Each center must have a computerized wait list.

4.4.2 The wait list must be transferred to the Department for the Treatment of Substance Abuse on a monthly basis.

4.5 Computerized intake

4.5.1 The intake process must be comprehensive and should be documented in the computer system, as approved by the Department for the Treatment of Substance Abuse.

5 Guidelines for medical treatment and psychosocial therapy

5.1 Tenets of treatment

5.1.1 Under staff guidance with the assistance of medication, the patient must cease using any drugs not prescribed by a doctor.

5.1.2 Random urine samples will be collected to test for street drugs or drugs not prescribed by a doctor. These tests must adhere to the ordinance for collecting and sending urine samples on behalf of the Unit for Treating Drug Users (no. 40.007).

5.1.3 Treatment centers will randomly conduct tests to detect alcohol consumption, using machines approved by the Department.

5.1.4 Patients must cooperate with the treatment plan, which is devised with them and on their behalf. This plan addresses medical, psychosocial, familial, and employment problems the patient may be experiencing.

5.1.5 Addicts showing signs of physical or psychological morbidity must be

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under the supervision of a family doctor or specialist.

5.1.6 The duration of treatment will be determined according to medical indications and psychosocial considerations.

5.1.7 The treatment center will provide patients with the appropriate care during each of the four stages of treatment. Activities will have appropriate hours, intensity, and content.

5.1.8 The patient will participate in developing their treatment plan, in accordance with this policy and the Department's regulations and guidelines.

5.1.9 Patients receiving treatment with medication over an extended period of time are eligible for services offered by the Ministry of Social Affairs and Social Services (e.g. community therapy). The treatment center's staff must maintain contact with all other professionals serving the patient.

5.2 Stages of treatment

5.2.1 Acute- For patients beginning treatment. This extensive and intensive stage aims to minimize the use of opiates until the patient stops using them entirely, and to minimize the use of street drugs and other psychoactive substances. At the same time, the patient undergoes treatment to stabilize their medical, psychological, social, and familial situations, and addresses legal or other problems relating to addiction.

5.2.2 Stabilization- When the patient's dosage has been stabilized, they are refraining from street drugs, and are cooperating with the treatment plan and treatment center's rules. This stage integrates treatment with medication, medical counseling, and psychosocial therapy. The patient visits the treatment center less frequently, according to their needs and condition. There are many psychosocial problems that typically accompany addiction, and some patients may remain in this stage for a long time, perhaps their entire lives.

5.2.3 Advanced stabilization- The patient becomes a partner in developing a treatment plan tailored to their needs and according to available opportunities,

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in order to help them reintegrate into society.

5.2.4 Ending treatment and transitioning to full rehabilitation- Patients who constantly abstain from harmful use of street drugs and have reached a steady psychosocial state for a duration of time. At this point, it becomes possible to taper off the medication until the patient is entirely drug-free. This must be accompanied by psychosocial therapy, in line with the Ministry of Social Affairs and Social Service's full withdrawal program, and requires constant medical oversight.

It must be noted that addiction is a chronic disease with recurring outbreaks; regression to previous stages is entirely possible.

5.3 **Continuous care**

5.3.1 Addicts being treated with agonist drugs elsewhere (e.g. prison, hospital, another clinic) must be admitted immediately, in order to guarantee continuous care.

5.3.2 Any caregiver (doctor, nurse, therapist) who leaves their job at the treatment center must transfer their patients to another caregiver, and review each case together. This ensures continuous care and protects the patient from harm.

5.3.3 The treatment center's staff will share necessary information and advise the staff of general/psychiatric hospitals, jails, and other prison programs on how to treat patients under their auspices, according to the Patient's Rights Act of 1996.

5.3.4 Treatment with medication is not an ends, but rather a means for treating and rehabilitating patients under the guidance of a multidisciplinary staff.

5.4 Medical treatment

5.4.1 Intake examinations

5.4.1.1 Before being admitted, addicts must undergo anemnesis, submit a urine sample to detect drugs, and have a chest x-ray and EKG performed.

5.4.1.2 The medical staff will determine whether to require additional examinations before admitting the addict.

5.4.1.3 After the treatment with medication has begun, the patient must give a blood sample to detect infectious diseases: hepatitis B and C, HIV.

5.4.2 Medical evaluation

5.4.2.1 After the treatment with medication has begun and the dosage has been stabilized, the doctor must perform a comprehensive medical evaluation of the patient's physical and psychological condition. This must be done at least every two weeks.

5.4.2.2 The evaluation may be complemented with additional lab work: a basic urine test, a HIT pregnancy test for women, a bio-chemical analysis of a blood sample including: urea, chloride, creatinine, sodium, potassium, glucose, and liver function: total and direct bilirubin levels, GGT, AST, and ALT at least every six months.

5.4.3 Dispensing methadone

5.4.3.1 The treatment center will provide personal doses of methadone for drinking under medical supervision, every day except the Sabbath and holidays.

5.4.3.2 In certain cases, such as illness or a psychosocial condition that prevent the patient from reaching the treatment center, the doctor may provide a dose to the patient's home.

5.4.3.3 If a patient is admitted to a general or psychiatric hospital, the center must notify the hospital about the patient's dosage.

5.4.4 Dosage

5.4.4.1 Assumption: Dosage is one of the main factors in determining the patient's physical and mental condition and affecting how the patient functions, especially their ability to refrain from using street drugs. Thus, it is crucial to determine the dosage according to the patient's condition, and adjust it according to his medical and psychosocial indication throughout the course of treatment.

5.4.4.2 The doctor will determine the dose based on his professional judgment and the patient's condition. The doctor must consult with the multidisciplinary staff and consider the patient's psychosocial condition and the degree of cooperation with the treatment center's plan.

5.4.4.3 The average dose of methadone hydrochloride is between 60-120 mg.

5.4.4.4 It is recommended to start with 20-40 mg of methadone, and gradually increase the dosage until it plateaus. It may be increased only after a medical examination and if the patient's condition allows. The doctor must consider drug synergy and potentially negative effects, especially with medications for depression or tuberculosis.

5.4.4.5 Doses greater than 120 mg require the approval of Dr. Paula Rosca (director of the Department for the Treatment of Substance Abuse) and Dr. Anatoli Margolis (deputy director of the Department for the Treatment of Substance Abuse), who have been authorized by the head of the Ministry of Health in accordance with the Dangerous Drugs Act.

5.4.4.6 Doses greater than 150 mg require extra precautions, including checking the level of methadone in the patient's blood, an EKG test to rule out a long QT, which may indicate risk to the heart.

5.4.4.7 Under extenuating circumstances, and according to the patient's indication, the dose may be divided and administered at two occasions

during the day.

5.4.5 **Dispensing buprenorphine**

5.4.5.1 The average dose of buprenorphine is 12 mg. The initial dose is 2 mg, which may be administered only after the patient shows objective symptoms of withdrawal.

5.4.5.2 The buprenorphine dose may be increased only after a comprehensive doctor's examination and according to the patient's condition.

5.4.5.3 Treatment must adhere to the ordinance for treating with buprenorphine (Subutex) in authorized institutions (no. 40.008) & appendix 8.1 – protocol for treating with Subutex.

5.4.5.4 Suboxone is recommended for patients who receive their medication at home or from a pharmacy with a prescription, in order to minimize abuse of the medication.

5.4.5.5 If the patient at the treatment center is admitted to a general or psychiatric hospital, the center must alert the hospital about the patient's dosage.

5.5 **Psychosocial therapy**

5.5.1 Staff members will be assigned patients and serve as their case managers. This staff member will be responsible for integrating and coordinating all aspects of the treatment plan, even those parts they will not directly administer.

5.5.2 Psychosocial therapy is built on a personal relationship and fostering trust between the patient and caregiver. The therapy must be multi-focal and address topics such as the use of harmful substances, trauma, familial problems, and more.

5.5.3 The staff at each treatment center will be comprised of professionals including: social workers (including clinical psychologists and clinical

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criminologists) and a rehabilitation specialist. Additionally, an effort will be made to hire professionals from different cultural backgrounds, to reflect the diversity of patients.

5.5.4 Each patient's personal treatment plan will include goals and mid-range targets. The plan will be reviewed and updated at least every three months, according to the patient's needs and condition.

5.5.5 The initial treatment plan will take effect immediately upon intake to the center.

5.5.6 The intensity of the psychosocial therapy will be adjusted to meet the patient's needs and according to their condition.

5.5.6.1 The acute stage - the patient and case manager will meet at least once a week, and the patient will participate in group sessions at least three times a week.

5.5.6.2 The stabilization stage - the patient and case manager will meet at least once every two weeks, and the patient will participate in group sessions at least once a week. Participation in self-help group meetings (MA, NA) is of great importance.

5.5.6.3 Advanced stabilization stage - the patient and case manager will meet as deemed necessary, but no less than once a month. The patient will participate in group sessions at least once a month or as needed. Participation in self-help group meetings (MA, NA) is of great importance.

5.5.6.4 Ending treatment and transitioning to full rehabilitation - the patient and case manager will meet at least once a week, as needed. Participation in self-help group meetings (MA, NA) is of great importance.

5.5.6.5 In times of distress, the patient is eligible for additional sessions, as needed.

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5.5.7 The treatment plan will be updated once every three months or as needed, in consultation with the doctor.

5.5.8 Working patients whose doses have been stabilized will receive a psychosocial therapy plan that accommodates their work schedule.

5.5.9 Psychosocial therapy helps patients minimize and cease the use of street drugs. Interventions should be adapted according to the severity of use, type of substances used, and polydrug abuse.

5.5.10 Psychosocial interventions can take many forms: individual, group, familial, or educational sessions, including a wide range of methods such as cognitive behavioral therapy (CBT), contingency treatment (CT), dialectical behavioral therapy (DBT), consulting on social problems, minimizing damages, motivational approaches (such as motivational interviewing, or MI), guidance (advancing and educating for a healthy lifestyle), adjustment groups, twelve step groups, support groups for coping with longing and relapse prevention, psycho-educational interventions, and more.

5.5.11 Caregiver qualifications

5.5.11.1 Each treatment center is obliged to offer psychosocial therapy, and thus must employ experienced, qualified professionals.

5.5.11.2 Representative caregivers from each treatment center must participate in periodic continuing education, professional development, and designated courses at the Ministry of Health's Department for the Treatment of Substance Abuse.

5.6 Medical guidelines for detoxification using methadone/buprenorphine

5.6.1 Gradual detoxification using methadone/buprenorphine is possible. As a rule, doses are reduced according to the patient's condition, the doctor's professional judgment, and medical indications.

6 Treating patients with extenuating circumstances

6.1 Pregnant women and neonates

The number of women using opiates has increased significantly in recent years, and most users are of procreative age. Although pregnancy may be an excellent motivator to stop using drugs, both mother and fetus may experience significant medical complications during the withdrawal process. Instead, it is recommended to choose extended treatment with methadone. Addict women tend to neglect their physical health, and often seek gynecological care only late in their pregnancy. This increases the health risks to the mother and fetus.

Pregnant patients must be treated as follows:

- 6.1.1 Refer to a gynecologist as quickly as possible for evaluation and requisite tests.
- 6.1.2 Refer to a well-baby clinic (*tipat chalav*) for routine prenatal care.
- 6.1.3 Place under close medical supervision, and adjust the methadone dosage as the pregnancy advances.
- 6.1.4 The patient's societal, familial, and social situation must be evaluated for potential risk, and an appropriate solutions must be found to meet her special needs (e.g. protected housing).
- 6.1.5 Encourage the patient to register to give birth at a hospital, and note the hospital name in her file.
- 6.1.6 The patient should be prepared that upon arrival to the hospital she must clearly state that she is being treated at a methadone center, and inform the hospital about her dosage and how to communicate with the center's staff. This will ensure continuous care for the mother and prevent withdrawal syndrome for the neonate.
- 6.1.7 The center's staff should advise the hospital on how to treat the mother and neonate with medication, as to prevent withdrawal syndrome.

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- 6.1.8 An uncooperative mother places herself at risk and may cause the neonate to suffer from withdrawal syndrome, which qualifies it as a minor who requires help. According to the Youth (Care and Supervision) Act of 1960, the the welfare authorities must be notified.
- 6.1.9 After the mother returns to the treatment center, sessions must be held frequently (at least twice a week), and include medical examinations to track her condition and ensure that the neonate is receiving appropriate care. If not, the welfare authorities must be notified immediately.
- 6.1.10 If there is reason to fear that the mother is experiencing postpartum psychological distress, she should be directed to a mental health clinic for an evaluation, therapy, and parental counseling.
- 6.1.11 If the mother is a carrier of infectious diseases such as hepatitis B, C or HIV, she should be referred to a specialist.
- 6.1.12 Methadone is not a contraindication for nursing, but the mother's dose should be reduced to the lowest level possible.

6.2 Pregnancy test

Female opiate addicts are often be unaware of their pregnancy because menstruation frequently ceases with addiction. Thus, any woman seeking treatment who is of reproductive age must be encouraged to take a H.I.T test to detect pregnancy.

6.3 Aborting the pregnancy

- 6.3.1 If a pregnant patient wishes to abort the pregnancy, she should be accompanied through the process. With her consent, the treatment center must inform the hospital that she is being treated with methadone/ buprenorphine and notify them of her dosage.
- 6.3.2 Following the abortion of a pregnancy, whether intentional or accidental, the woman's physical and mental condition must be monitored, and her dose adjusted accordingly.

6.4 Psychological dual diagnosis

6.4.1 Patients being treated with medication over an extended period of time often suffer from psychological dual diagnosis. The combination of mental illness and addiction increases the severity of addiction, worsens the patient's prognosis for therapy, and increases the likelihood of remission into street drug use, recurring psychiatric hospitalizations, and suicidal tendencies.

6.4.2 Following intake, the doctor must carry out a comprehensive evaluation of the patient's mental health. If the patient is determined to suffer from mental illness, the doctor must refer the patient to a mental health station, while maintaining contact and coordinating continuous care.

6.4.3 If the patient is diagnosed as suffering from a mental illness and the treatment center's staff includes a psychiatrist, this doctor may continue providing mental care at the treatment center.

6.5 Extensive use of street drugs and medication (Polydrug abuse)

6.5.1 Methadone patients frequently use other street drugs, especially benzodiazepine drugs. It is crucial to encourage the patient to stop using street drugs, while staging interventions that include treatment with medication and psychosocial therapy.

6.5.2 If previous attempts to stop using street drugs have failed:

6.5.2.1 A psychiatric evaluation should be carried out, to rule out any undetected psychological disturbances.

6.5.2.2 The patient may be referred to an in-patient program to stabilize their methadone dosage, pending written approval from the Department for the Treatment of Substance Abuse.

7 Patient rights and limits of treatment

7.1 Preface

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7.1.1 As a whole, drug users present many ongoing therapeutic challenges.

Most addicts need an adjustment period of six months or longer, during which their use of street drugs is gradually reduced by the center's treatment. This treatment must be consistent, stable, and steadfast. At the same time, the therapist must treat the patient fairly, with respect, and honor their rights as citizens and patients (according to the Patient's Rights Act of 1996).

7.1.2 Evidence from Israel and abroad shows that therapeutic frameworks for treating drug abuse, specifically centers that treat with medication over an extended period of time, often have no choice but to apply sanctions to ensure proper and professional care.

7.1.3 As a rule, an effort should be made to develop a system of therapeutic and financial incentives (benefits).

7.2 Patient rights

7.2.1 The patient's rights will be listed in the treatment contract, along with the patient's obligations. By admitting a patient for treatment, the staff is committing itself to providing appropriate care.

7.2.2 The patients' rights are determined and protected by the Patient's Rights Act of 1996, including the protection of personal information according to the laws, ordinances and regulations relating to the Department for the Treatment of Substance Abuse.

7.2.3 The patient has the right to medical treatment of methadone/ buprenorphine according to the rules and regulations of the Department for the Treatment of Substance Abuse.

7.2.4 The patient will receive a hard copy of the treatment contract, with oral explanations as necessary.

7.2.5 In accordance with the Patient's Rights Act of 1996, the patient will receive necessary information and explanations as required by the doctor, regarding their medical/psychological condition, medication administered,

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including replacement drugs and doses, the influence of such medications, and known potential side effects or complications.

7.2.6 The staff will address patient inquiries within a reasonable about of time from when they were received. The treatment center will also establish a reasonable way for the patient to contact the center's director, according to regulation 40.010, Addressing Complaints and Public Comments at the Department for the Treatment of Substance Abuse.

7.2.7 The patient may contact the regional director in writing, or contact the Department for the Treatment of Substance Abuse via supervisors.

7.3 Limits of treatment (rules)

7.3.1 Obligations

7.3.1.1 The rules, which are identical in all treatment centers, are part and parcel of the contract signed by the patient.

7.3.1.2 The patient will provide a urine sample when requested to do so by the medical staff for the purpose of detecting drugs.

7.3.1.3 The patient will adhere to the schedule for receiving medication according to their condition, and according to the guidelines and regulations of the Department for the Treatment of Substance Abuse.

7.3.1.4 The patient will follow staff instructions regarding all aspects of the treatment center.

7.3.2 Prohibitions

7.3.2.1 Violence- whether physical, threats, directed at patients or staff, causing damage to property or equipment that belongs to the center or individuals.

7.3.2.1.1 Sanctions - The treatment center's management may decide to immediately distance a physically violent patient for a period of up to 3 months, while referring the patient to an in-patient withdrawal program.

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Treatment may be terminated without approval of the staff doctor, and the police should be notified.

7.3.2.1.2 In case of heightened risk, the treatment center may explore the possibility of continuing treatment only if the patient visits the clinic with a family member or another responsible adult, with approval from the center's director.

7.3.2.2 Weapons- cold weapons and firearms are absolutely prohibited and may not be brought into the treatment center.

7.3.2.3 Bringing drugs or other medication into the treatment center.

7.3.2.4 Extended use of street drugs- Consistent evidence that the patient is using opiates and street drugs, including alcohol and non-prescription medications, can be interpreted as an ongoing lack of cooperation or the lack of potential to stop using street drugs and/or other medication. If this continues for three years, the center may seek permission to terminate treatment if the following steps have been taken: therapeutic interventions, including checking the methadone level in the patient's plasma, increasing the intensity of therapy, warnings, and patient transfer. **Patients using street drugs or other medication may not be denied methadone/ buprenorphine, unless it will put them further at risk.**

7.3.3 **Placing therapeutic restrictions (sanctions)**

7.3.3.1 Restrictions (sanctions) - these must start easy, but may gradually grow harsher. At the same time, the patient should undergo additional therapy.

7.3.3.2 Written warning - this must be delivered by a staff member.

7.3.3.3 Canceling benefits - such as eliminating or reducing doses of medication sent home.

7.3.3.4 Patient transfer - transitioning the patient to another center for

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define period of time, pending approval by the doctor and after coordinating with the receiving institution.

7.3.3.5 Distancing - denying the patient all treatment and services. The patient's dose must be gradually reduced over the course of at least 21 days. Distancing the patient requires the doctor's approval. An alternative solution is to refer the patient to an in-patient withdrawal program. Distancing the patient is an extreme measure and thus must be used sparingly. The duration will be determined by the treatment center's management, and must not exceed three months. A patient who returns after being distanced must repeat the intake process.

7.3.4 **Benefits (incentives)**

7.3.4.1 Providing doses for home use, thus reducing the number of days the patient must visit the treatment center.

7.3.4.2 Reducing the participation requirements for patients who test clean for street drugs for three consecutive months.

8 Providing doses of methadone//buprenorphine for trips abroad.

8.1 Stable patients who wish to travel abroad are eligible for bottles of methadone. As a rule, up to 21 personal doses can be approved. For longer trips, the patient should be referred to a medical institution at their destination that provides methadone/ buprenorphine treatment. The patient should be given a letter written in English and signed by a doctor stating that they are in treatment and noting the daily dosage. The letter should include the name of the drug, its form, concentration, and active ingredient. If the destination country does not offer methadone/ buprenorphine treatment, the therapist may petition the Department for the Treatment of Substance Abuse to dispense additional doses for the duration of the patient's trip.

9 Accepting tourist patients for limited durations of time

9.1 International treaties and Israeli law allow travelers to enter Israel with up to

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31 daily doses of methadone/buprenorphine, as long as the Ministry of Health's regional pharmacist has issued their approval. Tourists entering Israel must have an official letter from authorities in their home country (the official institution where they receive treatment), which identifies them by name and passport number and allows them to exit their home country with methadone/buprenorphine for their personal use, according to doctor's orders.

- 9.2 A tourist may be accepted for treatment at the center for extended treatment with medication if they have a letter from the authorities in their home country, as outlined above.

10 Obligation to report

According to the Sanitation Act of 1961 and the director's circular 35/09, the doctors are obliged to report:

- 10.1 To notify the Institute for Road Safety regarding driving. According to the Gun Laws Firearms Act of 1949 and director's circular 35/92, the Ministry of Health's Department of Information and Evaluation must be notified if the patient has firearms and poses a potential or real threat.
- 10.2 According to director's circular 23/98 and the Ministry of Health's mental health regulations, "documenting and reporting incidents of violence and abuse during psychiatric treatment," any anomalous incidents must be reported.
- 10.3 According to the Public Health Act of 1940, section 12, there is a duty to report any infectious diseases such as tuberculosis, hepatitis B and C, or HIV.

11 Oversight

- 11.1 Supervisors from the Ministry of Health's Department for Treatment of Substance Abuse will oversee the treatment centers, according to the Institutions for Drug Users (Supervision and Treatment) Act of 1993 and its ordinances.
- 11.2 Each center must be licensed before being allowed to operate, according to the Institutions for Drug Users (Supervision and Treatment) Act of 1993 and its ordinances, and meet the criteria noted there.

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- 11.3 According to the Institutions for Drug Users (Supervision and Treatment) Act of 1993 and its ordinances, supervisors may visit any treatment center without notice and must be given access to all information, including patient names, files, and other information pertaining to treatment.
- 11.4 Supervisors are responsible for handling patient complaints. The center's director and staff must fully cooperate with the supervisor and deliver whatever information they need to fully explore and resolve each complaint.
- 11.5 The center's up-to-date license must be displayed in a visible location, alongside the regional supervisor's name and telephone and fax numbers where they can be reached.
- 11.6 The treatment center's director must immediately notify the supervisor of anomalous incidents such as: physical violence, medical or drug-related complications, or death. A written report of the incident must be delivered within 24 hours.

Appendix A

Staff

- 1 **Director** - responsible for the daily operation of the treatment center and establishing the center's policies and rules. Runs general staff meetings, guides other staff members, and develops new and unique projects for treating drug addicts at the treatment center. The director may be a psychiatric doctor, a doctor trained as an addiction specialist, a social worker, clinical criminologist, or a clinical psychologist as stated in the Institutions for Drug Users (Supervision and Treatment) Act of 1993 and its ordinances.

Role and responsibilities

- 1.1 Developing the center's treatment plan and getting it approved by the Department for the Treatment of Substance Abuse in accordance with the Institutions for Drug Users (Supervision and Treatment) Act of 1993 and its ordinances.
- 1.2 Emphasizing oversight laws, regulations, and guidelines of the Department for the Treatment of Substance Abuse in the treatment center's work.
- 1.3 Listing, documenting, and reporting as required by law, regulations, policies, and guidance of the Department for the Treatment of Substance Abuse.
- 1.4 Responsible for implementing the Patients Rights act of 1996 and other laws that relate to the treatment of drug addicts.
- 1.5 Obtaining an adequate supply of medication from an authorized pharmacist.
- 1.6 Licensing the treatment center prior to opening, in accordance with the Institutions for Drug Users (Supervision and Treatment) Act of 1993 and its ordinances. Manage the treatment center properly, with the appropriate level of services.
- 1.7 Regularly reporting to the Department for the Treatment of Substance Abuse and its supervisors, and providing information upon request.

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- 1.8 Hiring qualified professionals to work at the treatment center.
 - 1.9 Offering professional development and training for the staff according to the Department for the Treatment of Substance Abuse guidelines, while developing yearly professional training plans (to be approved by the Department supervisors), and fostering a constructive workplace.
 - 1.10 Determining a work plan for each employee, addressing both professional and administrative aspects of their job.
 - 1.11 Holding staff meeting on a regular basis.
 - 1.12 Representing the treatment center to outside organizations, as required by the Department for the Treatment of Substance Abuse.
- 2 **Psychosocial therapist** - a social worker, clinical psychologist, or clinical criminologist. Every staff must include an employee with rehabilitation experience, who will oversee this aspect of the center's work and coordinate with all authorities to ensure patients receive proper care.

Role and responsibilities

- 2.1 Establishing and managing treatment plans
- 2.2 Conducting psycho-therapeutic sessions for individuals, groups, families, etc.
- 2.3 Opening and managing psychosocial cases.
- 2.4 Maintaining communication with relevant professional organizations outside the treatment center, including: the Ministry of Social Affairs and Social Services, the National Insurance Institute (*Bituach Leumi*) and others as needed.
- 2.5 Case management, coordination, and cooperation with relevant authorities and entities.
- 2.6 Participating in patient intake, staff meetings, offering guidance and trainings as needed.
- 2.7 Conducting periodic evaluations and updating the treatment plans of patients under their care.

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- 2.8 Referring patients to community therapy after successfully completing the treatment center's program.
- 3 **Nurse/Medic** - subordinate to the doctor and updates them regularly.

Role and responsibilities

- 3.1 Providing professional nursing services as needed
- 3.2 Managing the area where the medication is dispensed and administering medication on a regular basis and according to schedule.
- 3.3 Assisting and carrying out doctor orders as needed.
- 3.4 Maintaining communication with the pharmacist.
- 3.5 Running programs at the treatment center that promote health.
- 3.6 Participating in staff meetings and other committees as needed, such as the intake committee and evaluation committee.
- 3.7 Collecting urine samples from patients according to the ordinance for collecting and sending urine samples on behalf of the Unit for Treating Drug Users (no. 40.007).
- 3.8 Instructing patients about personal hygiene, with an emphasis on infectious diseases and how to prevent spreading them.
- 4 **Doctor** – a psychiatric doctor or a doctor trained as an addiction specialist (one doctor at each center will be appointed as head doctor)

Role and responsibilities

- 4.1 Conducting a medical evaluation during patient intake.
- 4.2 Determining each patient's dosage of medication according to their condition and his professional judgment.
- 4.3 Advising medical organizations outside of the treatment center.
- 4.4 Maintaining communication with clinics for infectious diseases, mental health clinics, and others, as dictated by patient needs.

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- 4.5 Coordinating between hospital departments when patients are admitted.
- 4.6 Responsible for patients' physical and psychological health, and referring them for laboratory examinations as needed, according to their condition.
- 4.7 Opening and managing each patient's medical file, in accordance with the Patients Rights Act of 1996.
- 4.8 Providing medical and nursing guidance for the staff.
- 4.9 Providing medical oversight of each patient during their treatment period.
- 4.10 Examining each patient at least once a month.