Вивчення соціальних практик

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TEN YEARS OF THE OPIOID AGONIST THERAPY IMPLEMENTATION EXPERIENCE IN UKRAINE. WHAT FURTHER? (Second part)

ДЕСЯТИРІЧНИЙ ДОСВІД ЗАСТОСУВАННЯ ЛІКУВАННЯ АГОНІСТАМИ ОПІОЇДІВ В УКРАЇНІ. ЩО ДАЛІ? (Частина друга)

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Abstract

By this article, the authors complete the presentation of the ten-year history of the introduction of opioid agonist therapy (OAT) in Ukraine. The authors differentiate four stages of introduction of this treatment in the country, and first two of them are described in the previous paper. Two subsequent stages – "Stagnation" and "Awareness of the main problems" are characterized now. The authors highlighted organizational barriers to OAT in Ukraine with an accent on administrative, medical and psychological issues. The analysis is completed with general conclusions about the proven effectiveness of OAT, the significance of the socio-psychological component of the program. The necessity for introduction of specialized professional training of social workers for work in OAT programs is specified.

Анотація

Цією статтею автори завершують презентацію десятирічної історії впровадження в Україні підтримувальної терапії агоністами опіоїдів (ПТАО). Аналіз матеріалів низки закордонних і вітчизняних публікацій дозволив перейти до розкриття двох наступних етапів – періодів стагнації та усвідомлення основних проблем. Визначено найголовніші бар'єри впровадження методу (опір органів виконавчої влади та частини професійної спільноти, упереджене ставлення з боку широкого загалу й окремих клієнтів, консервативна позиція представників мас-медіа, застаріла антинаркотична політика, невдалий менеджмент, недостатній рівень професійної підготовки фахівців). Висвітлено рганізаційні перешкоди лікування агоністами опіоїдів на українських сайтах, складнощі застосування адекватних доз препаратів та психологічні аспекти проведення ПТАО.

Матеріал завершено загальними висновками щодо доведеної ефективності методу; потреби в його ширшій імплементації; значущості соціально-психологічної компоненти програм, що має бути реалізована психологами, соціальними працівниками й зосереджена, насамперед, на подолання зовнішньої та внутрішньої стигматизації осіб з опіоїдною залежністю та їхню соціальну реабілітацію. Окреслено потребу в запровадженні спеціалізованої професійної підготовки соціальних працівників для роботи в програмах лікування агоністами опіоїдів.

Ключові слова:
drug use, treatment of opioid dependence, social work, methadone, buprenorphine, change of attitude towards treatment.

Key words:
вживання наркотиків, лікування опіоїдної залежності, соціальна робота, метадон, бупренорфін, ставлення до наркотичної залежності.

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Foreword

In the first part of the paper (Dvoriak, Karagodina, Chtenguelov & Pykalo, 2018) using the method of publications review we divided all period of opioid agonist therapy (OAT) provision in Ukraine in 4 stages. We have described first two of them ("Dating and Hopes"; "Sturm und Drang"[1]) in previous paper. Now we would like using the same method to review the following third and fourth stages ("Stagnation"; "Awareness of the main problems"). We mostly will focus on the issues linked with social work and place of social workers in the process we are calling "psychosocial support".

1 Storm and Stress

Key findings (continuation)

From stagnation to awareness of the main problems

We should mention shortly the peculiarities of both phases. The period between 2010 and 2013 ("Stagnation" stage) can be characterized by increasing pressure from the side of enforcement bodies, diminishing activities of clinicians and researchers, lack of political support from the Ministry of Health. There was the only resource for financing OAT and its advocacy – Global Fund to Fight AIDS, Tuberculosis and Malaria and NGOs sponsored by the Fund. Number of patients in OAT programs increased very slowly at this period, and there were suspicions, even expectations, that OAT could be wrapped up and stopped completely. These expectations grounded on the general political trends in our country after election of Victor Yanukovich as the President of Ukraine and skewing of the Ukrainian drug policy toward the Russia's one. It is a well-known fact that OAT is prohibited by law in Russian Federation (World Health Organization, 2008).

The period from 2014 up to now (2018), we have called the stage of "Awareness of the main problems". When the phase of technical provision and primary advocacy ended and most obvious obstacles (the resistance of enforcement bodies and lack of knowledge in the professional community) were surmounted, it became clear that there are a lot of barriers, determined by deep-seated reasons on the way of OAT scaling up and achieving coverage 35-40% of estimated number of people with opioid addiction (PWOA).

The list of problems and barriers turned out to be quite long: multitude of myths and misconceptions about OAT as amid patients as well as among professionals; conservative perception of OAT by media and general population; old, rigid drug policy; resistance of professional (narcological) community to accept scientific data opposed to habitual patterns and stereotypes and finally the post-Soviet health care system. that doesn't match to modern public health challenges like HIV/AIDS epidemic. It is important to note that from our perspective, a big part of these problems can be coped with, but changes depend very much from people who are responsible for psychosocial support of patients in OAT programs. Social workers' activity could eliminate many misconceptions and wrong believes determining poor outcomes of OAT and negative attitude to the treatment in the society.

In the study by Makarenko I. et al., a sample of 1179 PWID with opioid use disorder not currently on OAT from five regions of Ukraine was assessed using multivariable logistic regression for independent factors related to willingness to initiate OAT, stratified by their past OAT experience (Makarenko et al., 2016). The findings seriously challenged the opinions of many practical narcologists: there is a point of view that majority of opioid dependent patients already covered by OAT and there is no sense to increase number of slots for this treatment. In the study 421 (36%) PWID were willing to initiate OAT. If we extrapolate this data on estimated number of people with opioid addiction we will get 40-60 thousands of slots for OAT (Makarenko et al., 2016).

It was identified that despite its effectiveness, OAT is markedly inadequately scaled-to-need in Ukraine due to three types of barriers: individual, programmatic (institutional), and structural (Bojko M. J., 2016). Among them moral biases and prejudices (Bojko, Dvoriak & Altice, 2013) and persistent criminalization of using any drugs including methadone and harassment of PWIDs by police (Kutsa et al., 2016).

For the purpose of this article that is oriented mostly on social workers and psychologists we can offer a reductive classification. It would be more distinct if we consider all set of barriers in terms of administrative, medical and psychological issues. Talking about administrative ones, we are meaning all issues connected with legislation (drug policy), health infrastructure, financing of treatment, supply of medication, police harassment, etc. Concerning medical issues, we are mentioning type and quality of medicines, dosage, regimes of drugs administration, therapeutic setting, presence or absence of the integrated approach, professional training of medical doctors and nurses, and other related to medical

activity issues. Psychosocial issues in our understanding are factors that influence attitude to the disease and treatment process; perception by patients of the roles of medical and non-medical staff and perception of patients by staff members; all kinds of stigma and any type of discrimination of people who inject drugs (PWID); relationships between personnel and patients, emotional atmosphere in treatment centers; vision of long-term perspective by treatment program participants; expectations of treatment outcomes and readiness to take responsibility for recovery, and other similar issues that can be modified by psychological interventions.

It was shown in our studies that some factors such as awareness of addiction; acceptance of OAT; optimism about recovery and intention to recover play important role in achievement of treatment effectiveness. Especially it is crucial for patients who are in prison or just after release (Polonsky et al., 2016).

In this part of our paper, we will concentrate much attention on psychosocial issues how they were reflected in the available publications. It is essential to keep in mind that although the ultimate goal of OAT is improvement of quality of life (SAMHSA, 2018), the retention in OAT program is among the most effective indicators associated with long-term positive outcomes. Desirable outcomes often include: reducing of injecting use and drug use in general, adherence to antiretroviral therapy (ART) for HIV treatment and anti-mycobacterial therapy for tuberculosis (TB), social life improvement, etc. (Morozova, Dvoryak & Altice, 2013; Wickersham, Marcus, Kamarulzaman, Zahari & Altice, 2013). Therefore, we formulate the basic principle of OAT: 'the longer is the better', and hence, we can suggest that all efforts should be applied to retain patients in OAT as long as possible.

Indirect confirmation of the priority of retention in OAT programs can be the fact of dramatic consequences of the therapy cessation in Crimea after its annexation by Russian Federation. According to the UN special envoy Prof. Michel Kazatchkine between 80 and 100 people who relied on opioid substitution treatment have died since May 2014, when new authorities in Crimea suddenly closed all 11 OAT programs with total number of patients ~800. It means roughly 10% mortality rate among OAT participants during that period of time (Hurley, 2015; Filippovich, 2015).

In our further discourse, we will evaluate OAT programs from following position: whether they help to make easier access and improve retention of patients in OAT or not, because there are no doubts that agonist treatment is effective and the only question remains - how people can get it and retain within.

Administrative issues

The first article we cited in this section is "The Future of Opioid Agonist Therapies in Ukraine: A Qualitative Assessment of Multilevel Barriers and Ways Forward to Promote Retention in Treatment" (Bojko et al., 2016). To investigate barriers for OAT and in order to gain a deeper understanding of the various factors that influence OAT entry and retention in Ukraine, researchers have recruited three specific categories of PWID with diagnosis of "opioid use disorder moderate and severe" according to DSM-V or "Mental and behavioral disorders due to opioids use, dependence syndrome" according to ICD-10. The groups were: (1) Patients on OAT - 86 men and women currently receiving OAT; (2) Formerly on OAT – 34 men and women who had previously been on OAT; and (3) Never on OAT - 43 men and women eligible for OAT but have never started it.

The main barrier from point of view of the respondents was Daily Observed Therapy. All patients started OAT had to visit treatment center every day to get the medicine. Even those PWID who had never received OAT claimed that the biggest obstacle keeping them from enrolling in OAT program was their fear of be tied to the OAT site and not being able to find employment or to move from the clinic for time more than 24 hours.

The next barrier was a policy that make it difficult to issue prescriptions or to transport methadone to other facilities. According to Ukrainian legislation, any dose of methadone must be transported only under strict security control and with special escort of police or other special armed service.

There is another barrier to retention that is not set by the law or written rules but is broadly used in practice of OAT. It is medication dispensing. Because the personnel are afraid of persecution by the police for not controlling the methadone or buprenorphine diversion from treatment sites, nurses are enforced to dispense tablets before delivery to patients. Therefore, many patients experience serious discomfort and prefer to stop treatment. It is noteworthy that according to the Ministry of Health regulations all medicines must be delivered in the producer's pack units. It means that pills must be given as pills, not solution. However, personnel prefer to follow the police recommendation rather than medical rules (Bojko et al., 2016).

Another research studied the barriers and factors influenced the retention in OAT. The authors analyzed the data exported from an electronic Simple Treatment Monitoring Application (STMA), developed by the authors for the purposes of routine clinical data management and reporting. The database was designed to routinely track OAT patients, including patient drug use history, treatment admission and discharge dates, medication prescription and dosage, and a wide variety of clinical and laboratory assessments and psychosocial services provided (Dumchev et al., 2017).

This study showed that OAT as a strategy to prevent HIV transmission and to improve engagement into and adherence to ART, should remain a priority for the Ukrainian National HIV Program. There was a definite progress in this area. During ten years (2004-2015), satisfactory short-term retention that improved over time was observed. However, from the other hand long-term retention was not so satisfactory. Overall, index of 12-month retention at all sites after admission was 65.8%, slowly declining to 39.6% after 60 months. Results of this study confirm the importance of adequate dosage, which remains suboptimal for many patients, very limited practice of take-home doses. If we look more generally - addiction treatment specialists in Ukraine have not fully adopted evidence-based treatment strategies for using OAT due to the legacy of Soviet-style narcology that promotes negative attitudes toward PWID and OAT and mostly was oriented on an abstinence achievement as the goal of drug treatment. Though using of low doses of OAT medications can be considered as a medical issue (see the next section) we suggest that it is directly associated with administrative cluster of problems because is mostly determined by old-fashion understanding of the addiction, rather as a bad behavior than a biological disorder.

Also, it is to note that out of date legislation and existing policies, mandating complicated diagnostic procedure for confirmation of opioid addiction (Verkhovna Rada of Ukraine, 1997), and inpatient treatment for patients diagnosed with TB, and absence of OAT in TB treatment facilities affect entering to and dropout from OAT programs. This finding calls for wider integration of OAT and revision of TB treatment guidelines (Dumchev et al., 2017).

Interesting results were obtained from a study that used so called Nominal Group Technique (NGT), a key ingredient of the Network Improvement Addiction Treatment (NIATx) toolkit. Three trained coaches in collaboration with 18 OAT clinicians and administrators directed the Group to identify barriers to increase OAT capacity at the "oblast" level, find solutions, and prioritize local change projects. Clinicians were able to identify the top three barriers: (1) Strict regulations and inflexible policies dictating distribution and dispensing of OAT; (2) No systematic approach to assessing OAT needs on regional or local level; and (3) Limited funding and financing mechanisms combined with a lack of local/regional control over funding for OAT treatment services (Madden et al., 2017).

Regarding financial issues that also can be considered as administrative factors, there are data in a special study about willingness to pay for OAT (Makarenko et al., 2017). It was showed that many patients with opioid use disorders are enough motivated to pay for treatment to avoid undesired additional circumstances connected to free-of-charge treatment. First, they want to protect themselves from uncertainty whether

the program will continue or stop. In addition, they hope that in a paid program attitude of personnel will be more humanistic and tolerant. Willingness to pay was mostly determined among people with relatively high income, who live in big cities and have strong family and social support. In addition, it was found that patients of buprenorphine programs were more interested to participate in paid programs than patients of methadone programs. The conclusion was done that it is time to implement and develop self-pay and co-payment programs in the country.

In our country OAT is partly regulated by the Law on Drug Turnover (Verkhovna Rada of Ukraine,1999). Because of this a facet between legal and illegal turnover sometimes is not clear the police suggest it is important to control every aspect of drug use including methadone and buprenorphine distribution in medical institutions. The drug policy is a part of administrative problems in provision of OAT.

There were as minimum four publications about interference of police in drug treatment process. One of them regarded physical and sexual violence. In 2014-2015, the researchers conducted in five Ukrainian cities a cross-sectional study of 1613 PWID who were currently, previously and never on OAT, using a combination of respondent-driven sampling, as well as random sampling. They analyzed correlates of police violence by multiple factors, including by gender, and their effects on duration of OAT retention. Self-reported physical and sexual violence by police were the two primary outcomes, while retention on OAT was used as a secondary outcome (Kutsa et al., 2016).

The authors suggest that law enforcement practices may indirectly discourage PWID from engaging in OAT. It is highlighted that law enforcement raids on OAT treatment sites with attempts to seize medical records and other private information data about patients PWID have negative effect on medical personnel. Consequently, many hospitals refuse to establish OAT treatment programs due to the frequent reports about police investigations and harassment of clinicians. The police threatened medical staff to dissuade them from providing OAT or to force doctors to provide care only to certain patients. As a result, lack of trust between patients and doctors may develop if patients perceive that their clinicians are in promise with the police (Kutsa et al., 2016).

M. Golovanevskaya, L. Vlasenko and R. Saucie (2012) stressed:

> *"Further complicating the treatment experience is the overtly hostile attitude of law enforcement toward substitution treatment programs in Ukraine. It is not uncommon for the police to enter the clinics demanding to see (and make copies of) the patients' medical records, including their personal information. Similarly, patients often fall prey to the police (who wait near clinics to make arrest quotas and extort bribes) when entering or leaving the premises of the OST clinic – and as a result, are taken to the police station to be fingerprinted, questioned and sometimes held in detention for extended periods of time in the state of opiate withdrawal" (Golovanevskaya, Vlasenko & Saucier, 2012, p. 516).*

It is necessary to state, that confrontation of drug users with harsh drug policy have ambivalent effect. The study of Mazhnaya et al., revealed the fact that fear of the police and arrests facilitated OAT entry and simultaneously contributed to avoiding OAT because system-level requirements identify OAT clients as targets for police harassment (Mazhnaya et al., 2016). OAT represents an evidence-based option to "break the cycle"; however, authors suggest that law enforcement practices still thwarted OAT capacity to improve individual and public health.

Most clearly expressed administratively and politically determined barriers exist in penitentiary health system. Strong resistance to provide OAT in prisons having the biggest proportion of PWID and opioid addicts was explained using data of a study by Polonsky et al. Authors mentioned that in Ukraine, ideological prejudices, biases, and persisting negative attitudes toward OST restrict its adoption and expansion in Criminal Justice system (CJS), despite the evidence supporting its introduction. By elucidating existing attitudes among

CJS personnel, understanding better the relationships between drug addiction, OST attitudes and accurate knowledge will help direct subsequent interventions to address the barriers to implementing evidence-based HIV prevention treatments. Future strategies should include designing effective interventions for CJS personnel that incorporate identifiability and accurate information. In the absences of such interventions with prison personnel, staff may collectively undermine introduction of evidence-based treatments on ideological rather than informed principles. (Polonsky et al., 2015).

S. Alistar, D. Owens and M. Brandeau (2011) mentioned once more the paradoxical situation with provision of OAT in Ukraine: in one of the most frequently cited articles the authors regarded cost-effectiveness of treatment of HIV-positive PWID. The authors have mathematically modelled three scenarios. First – low density of coverage by OAT and low density by ART; second – high density by methadone and moderate by ART and third – high density of OAT and ART. The best result can be achieved if the third scenario is used, but the best cost effectiveness can be achieved if we increase number of patients on OAT up to 25% of estimated PWID number. It means that realization of the National Program on Fighting AIDS will give us the best ratio of public health expenses and positive influence on HIV-epidemic (Alistar, Owens& Brandeu, 2011).

Medical issues

Talking about medical issues, we have to mention type and quality of medicines, dosage and regimes of drugs administration, therapeutic facilities; comorbid disorders and the integrated approach, training of medical staff, and some other related questions.

The statistical data of the Public Health Center of the Ministry of Health (Tsentr hromads'koho zdorovya Ministerstva okhorony zdorovya Ukrainy, 2018) prove that OAT in Ukraine is scaling-up. During one year (form 1st October 2017 till 1st October 2018) the number of OAT patients increased by more than a thousand. By 1st October 2018, total number was 10777 patients, which is however about 50% of the planned indicator of the Global Fund. Therefore, the barriers still exist and efforts demand to overcome them.

For years, the main concerns of patients were about the next conditions: no take-home medication doses; everyday visits required; no possibility to continue OAT in case of hospitalization or incarceration. Progress was made in introducing the prescription form of distributing OAT medications, creating in-patient conditions at the place of residence for patients who cannot attend the facility every day (currently there is limited possibility of take-home OAT medicines). The use of the liquid form of methadone in OAT is implemented as a pilot project. Some medication used in OAT are now produced in Ukraine. A study is conducted in Ukraine on the possibilities of OAT in the State penitentiary system (Polonsky et al., 2015).

The Ukrainian Public Health Center data indicate that by 1st October 2018 3104 patients had take-home OAT medications (comparing to 1798 patients a year ago) (Tsentr hromads'koho zdorovya Ministerstva okhorony zdorovya Ukrainy, 2018). At the same time average doses of substitution medications decreased, especially for liquid methadone – from 93.8 to 57.0 mg during past year. Adequate dosage (80-120 mg/day) is also an important element for retention in treatment.

Recently SAMHSA-Ukraine created a project "Review of clinical guidelines and treatment protocols for mental and behavioral disorders due to psychoactive substance use: (Legislation and Policy Analysis Project)". Its main recommendations were to implement the AGREE technique for effective treatment for mental and behavioral disorders due to psychoactive substance use in Ukraine. For the treatment of disorders due to opioids use the Australian guidelines has already been chosen for translation to Ukrainian for possible approval for the country use. One more recommendation is to run a review and develop guides for psychosocial interventions (Deloitte, 2018).

Psychosocial issues

Problems due to psychological and social barriers were described in details in two papers. The study pudlished in 2017 provided resuts of the exploration of causes and risk factors to drop off the OAT programs. The authors have analyzed data from 25 focus groups conducted in five Ukrainian cities in 2013 with 199 participants who had currently, previously, or never been on OAT (Rozanova et al., 2017). Authors used a method of constant comparison and symbolic interactionism as well as stigma theory. They were focused on definite psychosocial constructs: the "Discharge", "Withdrawal", "Societal Norms", "Relapse", "Abstinence", "Stigma", "Disadvantages", "Dependence", "Attitudes", "Way out", "Abstinence", "Fear", and "Life" codes. Specific attention was paid to PWID's perceiving of OAT and themselves, what they tell about reducing the dose or getting off OAT, and what intrinsic and extrinsic individual, cultural, and structural factors their comments suggest.

All reasons to drop off OAT programs were classified in three clusters:

1. Withdrawing from OAT as resistance to external social control

In OAT programs, patients should visit treatment centers every day to get the dose of methadone or buprenorphine (currently there is a possibility for stable patients after 6 months of successful treatment to get the medications hope and visit the clinic no more than once a week, but when the paper was prepared this possibility was absent). They also were subjects to strict control by staff to avoid diversion of medications. In general, in most cases personnel demonstrated non-friendly attitude to patients. Moreover, the OAT patients could be stopped by the police on their way to the treatment site. All these factors create feeling of lack of autonomy, dependence from external influence and provoke a wish to quit the program. In the conscience of many patients the dominant idea to be personally responsible for their own life. Their mentality cannot accept idea of permanent support from medications and other persons. One of the tasks of psychological support is to help patients get over this stage of treatment on site and achieve next phase when they will have right to use home dose regime (take medicines once in a week). Also, counselors should work with psychological problems and resistance to treatment, to understand deeper problems underlying readiness to stop treatment and return to previous life style.

2. Withdrawing from OAT to recover a 'wounded identity'

To fully understand why patients could be tempted to resist social control in the OAT programs by discontinuing treatment, it is essential to examine how the patients believe others perceive them. The participants described societal views towards drug addicts in general in the most negative and inferior terms. Many patients were experiencing so called auto-stigmatization. They believe that participation in methadone treatment is a kind of "mark" that they achieved the bottom and completely lost control of own life. The OAT patients perceived themselves placed in the social hierarchy not above but below those who injected street drugs (from the side of both OAT providers and peers). Their lower status stemmed from perception that drug users came to OAT program when they became too sick and too broken to pursue street drugs use.

This compromised their health status in the eyes of peers was also supported by attitudes of providers who, as participants suggested, treated OAT patients as if they would die soon anyway, and thus had low usefulness for good treatment and respect. The participants described how the OAT sites were demarcated from the rest of the medical facility as ghetto spaces for "sub-humans" as opposed to spaces for "normal humans" where other patients who were not on OAT (including probable drug addicts) could freely go, and where OAT clients stay was forbidden.

The role of social worker is to increase self-esteem of patients and ensure their self-efficacy.

3. Discontinuing OAT as a quest for "normal life"

For majority of PWID there is a specific understanding of recovery centered on the folk concept of a "normal person". When doctors or other staff members communicate with the patients they hear many

times that a motive for coming to the treatment is "I'd like to be a normal person". It means to be independent from drugs and (the best result) to use them under own control without medical and social problems. The participants referred to peer role models who lived "normal lives" having discontinued OAT. Usually medical staff also support this idea and ensure patients that they have to strive to "become normal people". It means that during the therapeutic process patients cannot accept themselves as "normal" and only stopping treatment will give them a chance.

Findings suggest that for the patients discontinued therapy for reasons other than their health, the reasons were their relationships with the providers, ways in which therapy undermined (or supported) their sense of identity, and their conceptions of a normal life. Exploring and comparing patients' and providers' conceptions of recovery is indispensable for developing new measurement tools for assessing recovery in patients and also for designing interventions with both patients and providers aimed at correcting myths, prejudice, and stereotypes about OAT (Rozanova et al., 2017).

Though the participants appreciated risks of overdose, relapse or re-incarceration after discontinuing OAT, and feared more painful withdrawal than after discontinuing street opioids, they also perceived the risks of being administratively dismissed from the program. The participants suggested that patients on OAT wished to be an exception (i.e. recovering and living a 'normal life' without any treatment) not the rule (i.e. admitting one has a chronic disease and get treatment indefinitely and thus enduring all the associated concerns).

Very beneficial observations were made by J. Carroll in her paper. She studied the perception of OAT by medical doctors and patients. It was found that

> *"Ukrainian physicians who work in OAT programs frequently reference desire as the most significant factor in determining the success or failure of treatment. They refer to a desire to be treated, desire to get better, desire to live. The moralized imperative to possess this desire to get better is, in many ways, a reflection of how addiction and the addicted psyche is constructed and understood in the Ukrainian context" (Carroll, 2016, p. 198).*

The author also stipulates that there are the specific concepts of "normal person" and "normal life" which do not match with life style of OAT patient. Doctors try to encourage patients to keep the path that will ultimately lead them to desirable goal: to become a "normal person" and live by "normal life".

One of the important therapeutic targets for social workers is to help a patient to accept his/her identity as a regular person, to reject a folk idea about "normal life" and shift his/her focus on diminishing the problems. Show a person that quality of life is the best criteria for evaluation of himself, support patient's self-efficacy and independency from ignoramus opinions. Another important point stressed in the article is "anti-materialistic" position of medical staff. They hardly understand that "desire" and craving are typical brain functions and depend from level of neurohormones and neurotransmitters like dopamine, serotonin, endogenic opioids, etc. In practical work, medical staff are guided mostly by psychological constructs than by biological indicators. The main role of OAT is to change the brain functioning:

> *"Thus, in the international ideal, OAT serves as a disciplinary technology for limiting and controlling desires and, by extension, controlling behaviors linked to those desires" (Carroll, 2016, p. 206).*

Therefore, our efforts have to be directed on the right dosage of OAT medications and pharmacotherapy of comorbid mental disorders, which play important role in general clinical presentation of opioid addiction rather than attempts to change behavior itself. Psychosocial support is important but it has to be aimed at enhancing medical interventions.

Conclusions

During last decade, OAT was the most studied drug treatment program. There is no other treatment method under so huge attention of researchers. Main conclusion of the majority of publications is Ukrainian context of OAT implementation has some specific features, but in general effectiveness of the program completely confirmed in terms of decreasing of opioid use, reduction of risk behavior and increasing of adherence to ART and TB treatment.

Studies have shown and it was reflected in more than dozens of peer-reviewed articles that despite its effectiveness, OAT is markedly inadequately scaled-to-need in Ukraine. There are some objective barriers on the way of dissemination of the method and part of them – particularly individual ones – can be overcome by special activities of social workers and psychologists. External as well as internal stigma of PWID remain among biggest barriers to scaling up of the OAT in the country. It is critical to change the attitude of society, especially service providers, to opioid dependence, promoting the brain disease model of addiction. There are problems of OAT implementation, particularly low dosage of medications (methadone and buprenorphine) and not sufficient level of retention in the program. Strategies to optimize OAT dynamics are crucial for Ukraine.

In general, there is a reason suggesting that psychological issues and social work as part of OAT program were evaluated much less than medical and administrative issues. In reviewed articles, this facet of treatment was obviously understudied. Future researches should address psychosocial support in OAT programs and intervention like health education to reduce ongoing drug use during the treatment, especially for those with severe drug dependence, alcohol use problems and lack of family support. There is a necessity to expand special training on psychosocial support for social workers of OAT programs.

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