



Beyond fragmentation: building a consensus framework for integrated care in addictions and mental health

Más allá de la fragmentación: construcción de un marco consensuado de atención integrada en adicciones y salud mental

Marisa Dorado García¹, Amparo Sanchez Mañez², Carmen Cortell Cortell³, Isabel Lopez Escamilla⁴,
Teresa Orengo Caus⁵ & Elena Puche Pinazo⁶

Conselleria de Sanidad. Generalitat Valenciana. Spain

1. UCA Guillem de Castro; 2. UCA Paterna-La Coma; 3. UCA San Isidro; 4. UCA Requena; 5. UCA Padre Porta; 6. UCA Sagunto; 7. UCA San Vicente del Raspeig; 8. UCA Torrevieja; 9. Subdirectorate of Public Health; 10. UCA Alcoy; 11. UCA Castellón-San Agustín.

Working Group: Francisco Camarena Soler⁷, José Antonio García Gómez⁸, Ana Belén Muñoz Llacer⁵, Beatriz Navarro Cubells⁹, Francisco Pascual Pastor¹⁰, Marta Penalva Segovia⁴, Carmen Sala Añón¹¹, Raúl Sierra Serrano⁵, Raquel Valdés Torres⁴.

Received: 04/09/2025 · Accepted: 10/12/2025

Cómo citar este artículo/citation: Dorado García, M., Sanchez Mañez, A., Cortell Cortell, C., Lopez Escamilla, I., Orengo Caus, T. & Puche Pinazo, E. (2025). Beyond fragmentation: building a consensus framework for integrated care in addictions and mental health. *Revista Española de Drogodependencias*, 50(4), 204-224. <https://doi.org/10.54108/10128>

Abstract

Healthcare service portfolios, unlike benefit catalogs, are fundamental organizational tools in the functioning of the health system. However, addiction healthcare has historically lacked a clearly defined service portfolio, which has led to significant inequalities in the availability of care among the different health departments, both at the regional and national levels. This study analyzes the current situation of the Addictive Behavior Units (UCA) in the Valencian Community, based on a multidisciplinary expert panel, with the aim of identifying the available healthcare services, assessing emerging needs, and proposing strategies for standardization and improvement.

Keywords

Addiction Behavior Unit, healthcare services, addiction care.

— Correspondence:

Marisa Dorado

Email: dorado.marisa9@gmail.com



Resumen

Las carteras de servicios sanitarios, a diferencia de los catálogos de prestaciones, constituyen herramientas organizativas fundamentales en el funcionamiento del sistema de salud. Sin embargo, la atención sanitaria a las adicciones ha carecido históricamente de una cartera de servicios claramente definida, lo que ha generado desigualdades significativas en la oferta asistencial entre los distintos departamentos de salud, diferencias asistenciales que se extienden también a nivel nacional. En este estudio, se analiza la situación actual de las Unidades de Conductas Adictivas (UCA) de la Comunitat Valenciana, a partir de un panel de expertos multidisciplinar, con el objetivo de identificar los servicios asistenciales disponibles, evaluar las necesidades emergentes y proponer estrategias de normalización y mejora.

Palabras clave

Unidad de Conductas Adictivas, prestaciones, atención adicciones.

I. INTRODUCTION

Health benefit catalogues and service portfolios are established through legislative procedures and serve different functions: while catalogues define citizens' rights, service portfolios operate as organizational tools for healthcare services.

The service portfolio can be defined as the set of techniques, technologies, and procedures—understood as methods, activities, and resources based on knowledge and scientific evidence—through which healthcare benefits are delivered (Ministry of Health and Social Policy, 2009). These portfolios are dynamic instruments, subject to modification in accordance with scientific and technological advances, and largely determine the quality of healthcare.

In the field of addictions, the historical absence of a clearly established service

portfolio has led to significant variability in care across the health departments of the different autonomous communities. This situation has left the application of current regulations to professional interpretation, resulting in disparities in access and quality of care.

In the case of the Valencian Community, Legislative Decree 1/2003 establishes the guiding principles for the care of individuals with addictive disorders, recognizing their right to comprehensive healthcare and guaranteeing their inclusion in the public health system:

“Persons dependent on drugs or suffering from other addictive disorders, in their capacity as patients, enjoy all the rights recognized in current legislation for users of health and social services in the Valencian Community.” (*Legislative Decree 1/2003, Title 2, Chapter 2, Article 10*)



“Medical and healthcare services for persons dependent on drugs or with other addictive disorders shall be provided by the Addictive Behavior Units (UCAs), whose organization and operation shall be determined by regulation. These units shall be integrated into the Valencian Health Service, fully normalized within its structure and coordinated with the other healthcare resources of the corresponding Health Area.” (*Legislative Decree 1/2003, Title 2, Chapter 2, Article 11*).

Over time, healthcare professionals—physicians, psychologists, and nurses—working in UCAs have adapted their clinical practice to scientific advances, changes in consumption patterns, the emergence of new substances, and the diversification of patient profiles.

This work presents a comprehensive evaluation of the current care capacities of the UCAs in the Valencian Community, developed by a group of professionals with extensive experience in addiction treatment, fully integrated into the public health system, and supported by scientific evidence.

2. METHODOLOGY

The expert panel technique was employed as a qualitative tool for the collection and analysis of knowledge, combining both scientific evidence and accumulated clinical experience, with the aim of identifying the real care capacities of the UCAs and formulating sustainable improvement proposals.

2.1. Panel selection criteria

The panel was composed of 15 professionals, distributed as follows:

- a. 14 specialists (physicians, psychologists, nurses, and social workers) from 10 UCA across the three provinces of the Valencian Community.
- b. 1 professional linked to the field of Public Health.

Inclusion criteria:

- Minimum of 20 years’ experience in the field of addictions.
- Ability to work collaboratively, critical thinking skills, active listening, and willingness for reflective analysis.

2.2. Work development

Throughout 2022 and 2023, eight sessions were held—both in-person and online. A reproducible work plan was established, allowing for the extraction of consensus-based conclusions and recommendations.

Each care area was discussed around the following themes:

- Existing and necessary care activities.
- Emerging factors and associated levels of controversy.
- Existence and feasibility of alternative solutions.
- Degree of available scientific evidence.
- Identification of clinical and organizational uncertainties.

2.3. Classification of care services

Six major groups were identified, encompassing the different areas of UCA care activity:



GROUP 1. Care for substance and non-substance addictions

Evaluation, diagnosis, and treatment of substance use disorders and non-substance-related addictive behaviors.

GROUP 2. Care for specific populations

Interventions aimed at minors, the elderly, women, migrants, LGTBIQ+ individuals, and other vulnerable groups.

GROUP 3. Updating and standardization of opioid agonist treatments

Protocolization and evaluation of the use of methadone, buprenorphine, and other substitution treatments.

GROUP 4. Comprehensive patient care services

Coordination with Primary Care, mental health, social services, and other care units for an integrated and multidisciplinary approach.

GROUP 5. Prevention, health promotion, and community care

Activities focused on health education, family intervention, consumption prevention, and community well-being promotion.

GROUP 6. Knowledge dissemination and transfer

Ongoing training, applied research, and dissemination of best care practices.

For diagnostic classification, the criteria established in the *DSM-5* by the American Psychiatric Association (APA, 2013) were applied, covering both substance use disorders and behavioral addictions (e.g., pathological gambling).

3. RESULTS

Based on the work of the expert panel, minimum evidence-based standards of care have been identified and applied to the design of the proposed care services. These standards provide a common reference for all Addictive Behavior Units (UCA) in the Valencian Community, contributing to the homogenization of care quality in addiction treatment.

3.1. Scientific basis

Table I presents the main reference documents used to define care activities, classified by type of document, level of evidence, and degree of recommendation, according to the criteria of the National Institute for Health and Care Excellence (NICE, 2015). This compilation demonstrates strong scientific support for most of the proposed interventions, with a predominance of high-level clinical guidelines (I/1a) and systematic reviews (2++/II).

These documents address fundamental aspects such as the pharmacological treatment of substance use disorders, psychosocial interventions, care for vulnerable populations, and comprehensive approaches aimed at improving adherence and continuity of care.

3.2. Quality Criteria in the Proposed Services

The definition of the services included in this proposed portfolio is based on the following principles of healthcare quality:

- **Scientific evidence:** All interventions must be supported by efficacy studies and national or international clinical guidelines (see Table I on evidence).



Table 1. Evidence of care standards in addictions

Document	Reference	Type of Document	Level of Evidence / Grade of Recommendation*
Screening Guide for HCV Infection. Ministry of Health and Consumer Affairs.	Aparicio Azcárraga et al. (2020)	Clinical guideline. 2020	I/1a
Evidence-Based Clinical Guideline on Behavioral Addictions.	Arias & Orio (2023)	Clinical guideline. 2023	I/1a
Addictions Manual for Clinical Psychology Trainees. Socidrogalcohol-PNSD.	Becoña & Cortes (2011)	Clinical guideline. 2011	I/1a
Guideline for the Treatment of Opioid Addiction with Buprenorphine/Naloxone. Socidrogalcohol.	Bobes et al. (2010)	Clinical guideline. 2010	I/1a
Management of Opioid Use Disorders: A National Clinical Practice Guideline.	Bruneau et al. (2018)	Clinical guideline. 2018	I/1a
Interventions for Reducing Self-Stigma in People with Mental Illnesses: A Systematic Review of Randomized Controlled Trials.	Büchter & Messe (2017)	Systematic review. 2017	2++/II
Clinical Practice Guideline: Treating Tobacco Use and Dependence.	Clinical Practice Guideline Treating Tobacco (2008)	Clinical guideline. 2008	I/1a
Psychological Therapies for Pathological and Problem Gambling.	Cowlishaw et al. (2012)	Cochrane Database of Systematic Reviews. 2012	2++/II
Recommendations for Buprenorphine and Methadone Therapy in Opioid Use Disorder.	Dematteis et al. (2017)	European expert consensus. 2017	4/IV
Technical Document on Addressing the Chemsex Phenomenon. National AIDS Plan Secretariat, Ministry of Health.	Soriano et al. (2020)	Clinical guideline. 2020	I/1a
Opioids: Health and Social Responses.	European Monitoring Centre for Drugs and Drug Addiction (EMCDDA 2021)	EMCDDA Miniguide. 2021	2+/II
Polydrug Use: Health and Social Responses.	EMCDDA (2021b)	EMCDDA Miniguide. 2021	2+/II
Stimulants: Health and Social Responses.	EMCDDA (2021c)	EMCDDA Miniguide. 2021	2+/II
Families of People Who Use Drugs: Health and Social Responses.	EMCDDA (2022)	EMCDDA Miniguide. 2022	2+/II
Homelessness and Drugs: Health and Social Responses.	EMCDDA (2022b)	EMCDDA Miniguide. 2022	3/IV
Cannabis: Health and Social Responses.	EMCDDA (2023)	EMCDDA Miniguide. 2023	2+/II
Migrants and Drugs: Health and Social Responses.	EMCDDA (2023b)	EMCDDA Miniguide. 2023	4/IV
Methadone Maintenance Dosing Guideline for Opioid Dependence.	Fareed et al. (2010)	Systematic review. 2010	2++/II
Opioids: Socidrogalcohol Evidence-Based Clinical Guidelines.	Fernández-Miranda (2008)	Clinical guideline. 2008	I/1a

(table continues on next page)



Document	Reference	Type of Document	Level of Evidence / Grade of Recommendation*
<i>Psychosocial Interventions for Cannabis Use Disorders.</i>	Gates et al. (2016)	Cochrane Database of Systematic Reviews. 2016	2++/II
<i>Clinical Practice Guideline for the Treatment of Cocaine Dependence.</i> GENCAT.	Generalitat de Catalunya (2011)	Clinical guideline. 2011	I/la
<i>Addictions Manual for Medical Specialist Trainees.</i> 1st ed.	Ledo et al. (2010)	Clinical guideline. 2010	I/la
<i>Guideline of Recommendations for the Comprehensive Approach to Gender-Based Violence and Substance Abuse in Women.</i>	Martínez-Redondo & ArosteGUI (2023)	Clinical guideline. 2023	I/la
<i>Effectiveness of Group Therapy for Alcoholics.</i>	Monras et al. (2000)	Randomized clinical trial	2++/II
<i>Opioid Dependence Treatment and Guidelines.</i>	Nicholls et al. (2010)	Clinical guideline. 2010	I/la
<i>Principles of Drug Addiction Treatment: A Research-Based Guide.</i>	National Institute on Drug Abuse (NIDA 1999)	Clinical guideline (revised 2018)	I/la
<i>Principles of Drug Addiction Treatment: A Research-Based Guide.</i>	NIDA (2009)	Clinical guideline (revised 2011)	I/la
<i>Treatment Approaches for Drug Addiction.</i>	NIDA (2014)	Clinical guideline. 2014	I/la
<i>Alcoholism. Sociodrogalcohol Clinical Guidelines.</i>	Pascual et al. (2013)	Clinical guideline. 2015	I/la
<i>Addictions Guide for Specialist Training. Sociodrogalcohol.</i>	Pereiro & Fernández-Miranda (2018)	Clinical guideline. 2018	I/la
<i>A Systematic Review of Harm Reduction.</i>	Ritter & Cameron (2005)	Cochrane Database of Systematic Reviews. 2005	2++/II
<i>Pocket Guide: Medication-Assisted Treatment of Opioid Use Disorder.</i>	Substance Abuse and Mental Health Services Administration (SAMHSA 2015)	Clinical guideline. 2015	I/la
<i>Cocaine: Sociodrogalcohol Evidence-Based Clinical Guidelines.</i>	Terán et al. (2008)	Clinical guideline. 2008	I/la
<i>Substance Abuse Treatment and Care for Women.</i>	United Nations Office on Drugs and Crime (UNODC 2004)	Expert panel	4/IV
<i>Guidelines for the Identification and Management of Substance Use and Substance Use Disorders in Pregnancy.</i>	World Health Organization (WHO 2014)	Clinical guideline. 2014	I/la
<i>International Standards for the Treatment of Drug Use Disorders.</i>	UNODC & WHO (2023)	International expert consensus. 2023	4/IV
<i>The Efficacy of Motivational Interviewing for Disordered Gambling: Systematic Review and Meta-Analysis.</i>	Yakovenko et al. (2015)	Systematic review and meta-analysis. 2015	2++/II



- **Clinical relevance:** The proposed actions are considered essential for patient rehabilitation and the improvement of their quality of life.
 - **Patient safety:** Priority is given to interventions that can be carried out in an outpatient setting with a controlled risk profile.
 - **Outcome-oriented approach:** Emphasis is placed on therapeutic impact rather than on the technical procedure itself.
- Detoxification (outpatient or inpatient unit).
 - Rehabilitation (psychological, pharmacological, and social).
 - Nursing interventions (Directly Observed Therapy — DOT, counseling, biological samples).
 - Social intervention (work with support networks and referral to community resources).
 - Evaluation of treatment adherence.

Among the common and cross-cutting actions, the following stand out:

a. Implementation of the Quality Evaluation System for Drug Dependence Care (SECAD)

A treatment demand recording system that enables the monitoring of healthcare quality through structured indicators.

b. Comprehensive clinical assessment

Includes a detailed anamnesis (personal, family, and toxicological history), physical and psychopathological examination, as well as complementary tests. All information is documented in the electronic medical record, allowing for strict traceability and patient follow-up.

Note: Although each service includes a specific anamnesis, emphasis is placed on the need for a broad biopsychosocial assessment that considers emotional, functional, cognitive, and social aspects.

c. Individualized therapeutic plan

This plan must include strategies tailored to the clinical diagnosis, the patient's stage of motivation, and their biopsychosocial context, including:

This comprehensive approach enables the establishment of a solid therapeutic alliance that takes into account the patient's preferences, values, and personal circumstances, thus facilitating their engagement in the process of change and rehabilitation.

3.3. Proposed Services for Each Group

Group 1. Care for Substance and Non-Substance Addictions

A total of 12 specific services have been proposed within this group, aimed at addressing substance use disorders (SUDs) and other behavioral addictions. Most of these services are already being provided in the Addictive Behavior Units (UCAs), although significant variations have been identified among units regarding their implementation, protocols, and available resources (see Table 2). These differences affect:

- The intensity and duration of interventions.
- The existence or absence of standardized protocols.



Table 2. Group 1: Care for Substance and Non-Substance Addictions

SERVICE	DEFINITION	ACTIVITY
<p>a. Care for individuals with opioid use disorder (Bobes et al., 2010) (Bruneau et al., 2018) (Dematteis et al., 2017) (EMCDDA, 2021) (Fareed et al., 2010) (Fernández-Miranda, 2008) (Ledo et al., 2010) (Nicholls et al., 2010) (NIDA, 1999, 2009, 2014) (Pereiro & Fernández-Miranda, 2018) (SAMHSA, 2015) (UNODC & WHO, 2023)</p>	DSM-5	<p>Basic care activities:</p> <ul style="list-style-type: none"> ▪ Clinical assessment according to defined quality standards. ▪ Therapeutic plan (as described in quality standards). ▪ Access to and dispensing of methadone or long-acting buprenorphine (LP) in the UCA under conditions similar to any other public health system treatment (for Group 1a). ▪ Access to aversive treatment (for Group 1b). ▪ Annual ECG to assess QTc interval (for Group 1a). ▪ Toxicological monitoring.
<p>b. Care for individuals with alcohol use disorder (Ledo et al., 2010) (Monras et al., 2000) (Pascual et al. 2013) (Pereiro & Fernández-Miranda, 2018) (UNODC & WHO, 2023)</p>	DSM-5	
<p>c. Care for individuals with sedative, hypnotic, or anxiolytic use disorder (Ledo et al., 2010) (Pereiro & Fernández-Miranda, 2018) (UNODC & WHO, 2023)</p>	DSM-5	
<p>d. Care for individuals with stimulant-related disorders (EMCDDA, 2021c) (Generalitat de Catalunya, 2011) (Ledo et al., 2010) (Pereiro & Fernández-Miranda, 2018) (Terán et al., 2008) (UNODC & WHO, 2023)</p>	DSM-5	
<p>e. Care for individuals with cannabis use disorder (EMCDDA, 2023) (Gates et al., 2016) (Ledo et al., 2010) (Pereiro & Fernández-Miranda, 2018) (UNODC & WHO, 2023)</p>	DSM-5	
<p>f. Care for individuals with tobacco use disorder* (Clinical Practice Guideline: Treating Tobacco Use, 2008)</p>	<p>DSM-5</p> <p><i>Care for tobacco use disorder in the UCAs should be limited to patients who, due to the complexity or severity of their nicotine addiction, have failed multiple treatments in Primary Care.</i></p>	<p>Basic care activities:</p> <p>Clinical assessment:</p> <ul style="list-style-type: none"> ▪ Identify smoking patterns. ▪ Quantify tobacco use. ▪ Assess degree of dependence (Fagerström Test). ▪ Assess motivation to quit (analog scale). ▪ Record previous quit attempts. ▪ Assess smoking habits in the patient's environment. ▪ Conduct complementary tests if indicated. ▪ Provide cessation treatment. ▪ Psychological treatment if indicated. ▪ Medical/pharmacological treatment if indicated.

(table continues on next page)



<p>g. Care for individuals with new psychoactive substance use disorder (Ledo et al., 2010) (Pereiro & Fernández-Miranda, 2018) (UNODC & WHO, 2023)</p>	<p>DSM-5</p>	<p>Basic care activities: (same as Service 1d)</p>
<p>h. Care for individuals with pathological gambling disorder (Arias & Orio, 2023) (Becoña & Cortes, 2011) (Cowlshaw et al., 2012) (Yakovenko et al., 2015)</p>	<p>DSM-5</p>	<p>Basic care activities:</p> <ul style="list-style-type: none"> ▪ Clinical assessment according to defined quality standards. ▪ Therapeutic plan (as described in quality standards). ▪ Assessment for registration in the Gambling Registry (for Group 1h). ▪ Toxicological monitoring if indicated.
<p>i. Care for individuals with gaming disorder (video game use disorder) (Arias & Orio, 2023) (Becoña & Cortes, 2011) (Yakovenko et al., 2015)</p>	<p>ICD-11</p>	
<p>j. Group interventions (NIDA, 1999, 2009, 2014) (Becoña & Cortes, 2011)</p>	<p>Group interventions consist of both psychological group therapy and psychoeducational groups conducted by different professionals.</p>	<p>Group treatment for patients and families, aimed at: Providing information about addiction as a disease. Motivational intervention. Relapse prevention intervention.</p>
<p>k. Family care (NIDA, 1999, 2009, 2014) (EMCDDA, 2022)</p>	<p>Provide information and emotional support.</p>	<ul style="list-style-type: none"> ▪ Informative interventions. ▪ Individual and/or group psychoeducational interventions.
<p>l. Care for women with addiction (NIDA, 1999, 2009, 2014) (UNODC, 2004) (UNODC & WHO, 2023)</p>	<p>Gender-specific care for women to ensure access to UCA services.</p>	<ul style="list-style-type: none"> ▪ Assessment according to defined quality standards. ▪ Therapeutic plan with a gender perspective. ▪ Coordination with various services. ▪ Individual and/or group therapy especially for women with addiction. ▪ When applicable, implementation of the gender-based violence protocol for addicted women.

- The availability of specialized personnel.
- Coordination with other services (mental health, primary care, social services).

Group 2. Care for Specific Populations

This group includes six proposed services (Table 3) aimed at highly vulnerable populations whose care requires the implementation of specific programs, distinct from

general interventions. These populations include, among others, minors, pregnant women, individuals experiencing social distress or lacking support networks, immigrants facing barriers to treatment access, and individuals engaged in chemsex practices.

Care for these groups requires **intersectoral coordination**, effectively integrating the health, social, educational, and/or legal resources involved in each case.



Table 3. Group 2: Care for Specific Populations

SERVICE	DEFINITION	ACTIVITY
<p>a. Care for minors with addictive disorders (NIDA, 1999, 2009, 2014)</p>	<p>Under 18 years old; require specific programs and family involvement.</p>	<p>Basic care activities:</p> <ul style="list-style-type: none"> ▪ Clinical assessment according to the described quality standards. ▪ Individual and/or group psychological treatment. ▪ Individual and/or group psychoeducational intervention with families. ▪ Coordination with child social services when required. ▪ Coordination with Child and Adolescent Mental Health Units (USMIA/USM) when required. ▪ Referral to specific support resources for minors.
<p>b. Care for pregnant and postpartum women with substance use disorders (WHO, 2014)</p>	<p>High-risk pregnancies requiring specific interventions.</p>	<p>Basic care activities:</p> <ul style="list-style-type: none"> ▪ Clinical assessment according to the described quality standards, with a gender-sensitive approach and minimizing stigmatization. ▪ Immediate or priority care. ▪ Coordination with midwives and/or the Obstetrics Department. ▪ Coordination with Social Services and/or the Child Protection Division of the Regional Government when required.
<p>c. Intervention to promote treatment adherence (Becoña & Cortes, 2011)</p>	<p>Adherence is defined as the degree to which a patient's behavior matches the instructions provided by healthcare professionals.</p>	<p>Basic care activities:</p> <ul style="list-style-type: none"> ▪ Identification from the initial assessment of barriers that may affect adherence, considering factors related to: <ul style="list-style-type: none"> ○ <i>The patient:</i> language, culture, education, employment status, etc. ○ <i>The disorder:</i> executive or memory impairments, lack of illness awareness, unrealistic expectations of recovery, etc. ○ <i>The treatment:</i> complexity, adverse effects, patient habits, etc. ○ <i>The care team:</i> accessibility. ▪ Individual tutoring and dispensing of prescribed treatment according to the needs of the patient or family (daily, weekly, biweekly, monthly, etc.). ▪ Family interventions as a support network.
<p>d. Care for addicted patients with severe social distress (EMCDA, 2021b; EMCDA, 2022b; NIDA, 1999, 2009, 2014)</p>	<p>Mismatch between the patient's needs, demands, services, responsibilities, and the expectations of the society in which they live.</p>	<p>Basic care activities:</p> <ul style="list-style-type: none"> ▪ Social assessment, evaluation, and diagnosis of the patient and family. ▪ Process evaluation and updated planning. ▪ Information and guidance on available resources.

(table continues on next page)



SERVICE	DEFINITION	ACTIVITY
<p>e. Care for immigrant patients with substance use disorders (EMCDA, 2023b)</p>	<p>Migration is a risk factor for initiating drug abuse, often by adopting local consumption patterns, which may worsen due to barriers in accessing healthcare services.</p>	<p>Basic care activities:</p> <ul style="list-style-type: none"> ▪ Clinical assessment according to the described quality standards. ▪ Identification of barriers to treatment access (language, culture, etc.). ▪ Therapeutic plan (as described in the quality standards). ▪ Social intervention. ▪ Coordination with specific support resources.
<p>f. Care for individuals engaging in Chemsex (Soriano et al., 2020)</p>	<p>Intervention with individuals who engage in Chemsex and have developed a substance use disorder in this context.</p>	<p>Basic care activities:</p> <ul style="list-style-type: none"> ▪ Clinical assessment according to the described quality standards. ▪ Nursing intervention for harm reduction. ▪ Offer of PrEP (pre-exposure prophylaxis). ▪ Coordination with sexual and reproductive health units (USSR), HIV Information and Prevention Centers (CIPS), or other resources providing specific psychotherapeutic treatment.

Group 3. Updating and Standardizing Opioid Agonist Treatments

This group includes two proposed services related to public health objectives and patient-centered care (Table 4). From a pharmacological perspective, it is essential to update opioid agonist treatments by incorporating all available formulations for the treatment of opioid use disorder, as well as by modernizing methadone formulation and dispensing toward more stable and less stigmatizing presentations.

Group 4. Comprehensive Patient Care

This group includes three proposed services (Table 5). Care for individuals with mental illness and substance and/or alcohol use disorders requires comprehensive management and continuity of care. This entails effective coordination across different health-care levels and services to ensure integrated and consistent care over time.

In cases related to criminal behavior, the Addictive Behavior Units (UCAs) play a key role

in the rehabilitation process through outpatient treatment. This care is conditioned on informed monitoring of the disorder's progression and the patient's therapeutic commitment, thereby promoting recovery and social reintegration.

Group 5. Interventions in Health Prevention and Promotion, Family Care, and Community Care

In this group, eight services have been proposed (Table 6), integrating prevention and health promotion interventions aimed at the early detection of infections, immunization against HBV and influenza, and the micro-elimination of HCV. It also includes the identification of gender-based violence and the reduction of stigma associated with addictive disorders, which are key factors influencing treatment adherence and access.

Finally, community care strategies, group health education, and harm reduction approaches are considered essential pillars to improve both individual and collective health.



Table 4. Group 3: Updating and Standardizing Opioid Agonist Treatments

SERVICE	DEFINITION	ACTIVITY
<p>a. Dispensing of opioid agonist treatment (methadone or buprenorphine) in Addictive Behavior Units (UCA) (Bobes et al., 2010) / (Bruneau et al., 2018) / (Dematteis et al., 2017) / (EMCDA, 2021) / (Fareed et al., 2010) / (Fernández-Miranda, 2008) / (Ledo et al., 2010) / (Nicholls et al., 2010) / (NIDA, 1999, 2009, 2014) / (Pereiro & Fernández-Miranda, 2018) / (SAMHSA, 2015) / (UNODC & WHO, 2023)</p>	<p>Opioid agonist treatment is the treatment of choice for opioid use disorder.</p>	<p>Dispensing of methadone by qualified nursing staff within the UCA.</p> <ul style="list-style-type: none"> ▪ Preference will be given to the use of commercially available formulations. ▪ Nursing staff will provide harm reduction, psychoeducation, and counseling interventions during medication dispensing. ▪ Whenever possible, coordination will be established with the pharmacy department of each healthcare area to ensure methadone distribution through standard channels, avoiding parallel systems outside the normal operation of other pharmaceutical specialties.
<p>b. Administration of long-acting buprenorphine (Bobes et al., 2010) (Bruneau et al., 2018)</p>		<ul style="list-style-type: none"> ▪ Administration by UCA nursing staff, including dose indication, injection site selection, and inspection. ▪ Nursing staff will provide psychoeducation and counseling interventions during medication administration.

Table 5. Group 4: Comprehensive Patient Care

SERVICE	DEFINITION	ACTIVITY
<p>a. Care for psychiatric comorbidity through specific programs and coordination with the Mental Health Service (Ledo et al., 2010) (NIDA, 1999, 2009, 2014) (Pereiro & Fernández-Miranda, 2018) (UNODC & WHO, 2023)</p>	<p>Dual Diagnosis: Individuals who suffer from a mental illness and have a substance use disorder.</p>	<p>Development and implementation of a coordination protocol with the Mental Health Service in each department.</p>
<p>b. Coordination among resources across different levels of care (NIDA, 1999, 2009, 2014)</p>	<p>Care coordination is a priority for healthcare systems, especially in the treatment of substance use disorders, which involve multiple professionals and services.</p>	<p>Coordination with the various levels of the public healthcare network.</p>
<p>c. Coordination with the judicial system: alternative sentencing programs and care for individuals in “third degree” status (NIDA, 1999, 2009, 2014)</p>	<p>Patients referred from different areas of the judicial sector for monitoring compliance with court-ordered measures related to their addiction.</p>	<ul style="list-style-type: none"> ▪ Preparation of clinical and periodic follow-up reports for: Social Reintegration Centers (CIS), Sentencing and Alternative Measures Management Services, Courts, Judicial Chambers, Government Delegations, and Juvenile Social Services. ▪ Court appearances as expert witnesses in cases where required.



Table 6. Group 5: Interventions in Health Prevention and Promotion, Family Care, and Community Care

SERVICE	DEFINITION	ACTIVITY
a. Early detection of infectious and sexually transmitted diseases (NIDA, 1999, 2009, 2014)	The detection of infectious and sexually transmitted diseases requires a thorough clinical history, identifying risk factors and using diagnostic tests to guide the presumptive diagnosis.	Detailed anamnesis at all first visits and follow-up for individuals with risk factors or frequent relapses. Serology tests for HIV, HBV, HCV, and syphilis: <ul style="list-style-type: none"> For all patients attending the UCA for the first time and upon reentry. Once a year for those in follow-up. Every six months for those with risk factors. Treatment and referral of positive cases when applicable.
b. Primary prevention (Hepatitis B and Influenza) (NIDA, 1999, 2009, 2014)	Active artificial immunization against HBV and influenza.	<ul style="list-style-type: none"> Provide information to patients attending the UCA. Facilitate vaccination accessibility and efficient administration. Ensure access to immunization.
c. HCV Microelimination (Aparicio et al., 2020)	The WHO recommends implementing measures to reduce new HCV cases by 90% and HCV-related mortality by 65% by 2030.	<ul style="list-style-type: none"> Prevention and harm reduction information. Serological screening. Routine serology for detecting new infections and reinfections among follow-up patients. Facilitate access to treatment. Directly observed therapy (DOT) when required.
d. Detection of gender-based violence (Martínez-Redondo & Aros-tegui, 2023)	Drug use among women appears to be associated with traumatic life experiences, whether intrafamilial or intimate partner violence, which contribute to the onset and persistence of addiction.	Systematic recording and detection: <ol style="list-style-type: none"> Specific anamnesis for all women. Systematic collection of observations and assessments. Close coordination with other professionals. Address both current and past violence. Implement the following actions: » SIVIO (see protocol). » Referral to the women's support service.
e. Addressing stigma elimination (Büchter & Messe, 2017)	Negative attitudes and stereotypes toward people with substance use and alcohol disorders create barriers to treatment and worsen addiction.	<ul style="list-style-type: none"> Interventions aimed at eliminating self-stigma. Interventions aimed at eliminating institutional stigma. Register detected cases of institutional stigma in SINEA. Interventions aimed at eliminating social stigma through community-based activities.
f. Community care and group health education (NIDA, 1999, 2009, 2014)	A set of planned actions involving the participation of the population, professionals, and institutional representatives, aimed at identifying community health needs and problems.	<ul style="list-style-type: none"> Group health education interventions on nutrition, exercise/physical activity, and emotional well-being. Health asset prescription: map local health assets and create a recommendation network. Promote networking to improve well-being and health promotion efforts.

(table continues on next page)



SERVICE	DEFINITION	ACTIVITY
f. Individual health education (NIDA, 1999, 2009, 2014)		<ul style="list-style-type: none"> ▪ Individual health education interventions on nutrition, exercise/physical activity, and emotional well-being. ▪ Brief nursing advice during all interventions.
g. Harm reduction interventions (Ritter & Cameron, 2005)	Individual and collective strategies aimed at minimizing harm associated with active drug use, without necessarily reducing or eliminating use.	<ul style="list-style-type: none"> ▪ Individual or group psychoeducational interventions to identify and understand the effects and risks of substance use, aimed at cessation, reduction, and/or harm prevention. ▪ Needle exchange programs (NEP). Condom distribution. ▪ Naloxone use education programs.

Group 6. Knowledge Dissemination Interventions

This group includes two proposed services (Table 7). Knowledge dissemination services are part of the teaching activities of Health Departments, especially in University Hospitals. The tutor plays a central role in addiction training, ensuring the acquisition of knowledge, skills, and attitudes. Clinical sessions and other training activities, both clinical and organizational, constitute key tools for professional development, decision-making, and resource optimization.

After defining the basic services for the care of addictive disorders, the expert panel

conducted a qualitative analysis that identified several priority areas for improvement. These include the need to:

- A. Standardize clinical protocols** in the management of major substances (alcohol, cannabis, cocaine, and opioids);
- B. Update pharmacological treatments** in line with the most recent scientific evidence, including the systematic incorporation of buprenorphine/naloxone;
- C. Integrate** structured care for behavioral addictions, such as pathological gambling, in accordance with DSM-5 diagnostic criteria;

Table 7. Group 6: Knowledge Dissemination Interventions

SERVICE	DEFINITION	ACTIVITY
Teaching	Most Health Departments include University Hospitals, making teaching part of the department's formal activities.	Training activities for healthcare professionals on basic concepts of addictions, enabling them to conduct clinical practice aimed at detecting and managing various addictive processes.
Clinical Sessions	Clinical sessions are one of the fundamental tools for continuing education.	<ul style="list-style-type: none"> ▪ Clinical sessions: presentation of clinical cases, critical reading of articles, etc. ▪ Monographic or review sessions. ▪ Sessions on clinical practice guidelines. ▪ Operational sessions: organization and functioning of the UCA.



D. Strengthen gender perspectives alongside differentiated care for groups with higher vulnerability.

4. DISCUSSION

Care services for people with addictive disorders should aim to ensure comprehensive, safe care based on the best available scientific evidence. This principle, aligned with the right to health protection enshrined in Article 10 of Law 10/2014 of the Health Law of the Valencian Community (Comunitat Valenciana, 2014), implies that interventions should be clinically effective, feasible in an outpatient setting, and outcome-focused.

Opioid Agonist Treatment

A priority aspect identified is the need to update services for prescribing and dispensing opioid agonists. The current model has been in place for over three decades, which constitutes a barrier to ensuring rational medication use.

Under current regulations, magistral formulations (MF) and officinal preparations (OP) are considered exceptional medications, intended to meet specific therapeutic needs when there is no commercially available authorized pharmaceutical specialty that fulfills the same therapeutic objective in the same administration route, dose, and dosage form.

Law 6/1998 on Pharmaceutical Regulation in the Valencian Community (Comunitat Valenciana, 1998) establishes in Article 2.8 that “the dispensing of medications must be carried out according to the basic criteria

of rational use established in the Medicines Law” (p.7). This reference to the national framework requires prioritizing the use of authorized medicines (Spain, 2015), as they guarantee quality, safety, and efficacy under the control of the Spanish Agency for Medicines and Health Products (AEMPS).

At the national level, Royal Legislative Decree 1/2015, approving the revised text of the Law on guarantees and rational use of medicines and health products, provides:

- Article 3: Guarantees the dispensing of medicines with appropriate safeguards.
- Article 8: Differentiates between industrially manufactured medicines (specialties) and individualized formulations (MF and OP).
- Articles 42–44: Define and regulate MF, OP, and the National Formulary, emphasizing their preparation for individualized patients in accordance with official standards.

Royal Decree 175/2001 (Spain, 2001), which establishes Good Preparation and Quality Control Standards for magistral formulas and officinal preparations, specifies in its Annex (section 4.1.1.4) that centralized preparation and supply of MF by the Administration will be “exceptional,” particularly in cases of industrial drug shortages.

Consequently, in the Valencian Community, the technical and legal criteria for choosing the type of medication are summarized as follows:

1. General rule: Dispense the authorized pharmaceutical specialty available if it meets the required route, dose, and form.



2. Exception: Resort to MF/OP only when no suitable specialty exists, individual dose adjustments are needed, excipient intolerance occurs, or documented shortages arise.

This prioritization aligns with the principle of rational drug use, optimizing safety, efficacy, and efficiency in pharmaceutical provision. In this context, it is proposed to align methadone treatment updates with the regulatory framework, clinical trials, prescribing quality, and rational drug use.

Care for Psychiatric Comorbidity

Another significant challenge is caring for people with substance use disorders who have psychiatric comorbidities.

The European Union Drug Strategy 2021–2025 highlights the need for integrated care models (European Commission, 2021) for patients with complex needs. Organizations such as UNODC, WHO, and EMCDDA agree that these patients require multidisciplinary, stigma-free care with a gender-sensitive approach (UNODC & WHO, 2023).

Scientific literature (Fernández-Miranda et al., 2020) recognizes that coexisting psychiatric and addictive disorders are the norm rather than the exception. Addiction care networks must face the challenge of managing patients moving between two traditionally separate healthcare systems. It is essential to promote integrated therapeutic plans, ensure rapid access to treatment from any entry point, and achieve real coordination between care networks.

Therefore, the working group proposes (service 4a) implementing an interdepartmental coordination protocol with Mental Health, aimed at:

- Improving detection and assessment of comorbid cases.
- Establishing common referral and consultation criteria.
- Enhancing therapeutic adherence in high-complexity care profiles.
- Ensuring priority assessments and early interventions.
- Facilitating joint therapeutic plans and interdisciplinary clinical sessions.
- Promoting joint actions in care, training, and research.

Care for Women with Substance Use Disorders

The expert group emphasizes the need to develop differentiated, gender-sensitive care for women with substance use disorders (services 11 and 5d). Previous studies have highlighted the relevance of traumatic factors in women with substance use disorders (Fonseca et al., 2021; Santos Goñi et al., 2010; Torrens et al., 2021). Traumatic experiences, including sexual abuse and domestic violence, significantly contribute to the development and maintenance of addiction in women.

Systematic inclusion of gender-sensitive anamnesis is a fundamental tool for providing more effective, equitable care tailored to the specific needs of these patients (Torrens et al., 2021).

In many cases, women do not recognize certain violent actions as such, requiring the implementation of specific detection and intervention strategies. Intersectoral coordination with specialized resources



and the use of the SIVIO system for the detection and response to gender-based violence are priority measures to ensure comprehensive care. Inclusion of these patients in services for women victims of gender-based violence allows addressing the dual vulnerability arising from addiction and victimization, thereby enhancing recovery opportunities.

Role of Nursing in UCAs

The multidisciplinary team in UCAs is a cornerstone of care. Within it, nursing staff play a strategic role in several key services, particularly those in Groups 3 and 5. Nursing interventions range from interpersonal communication and group work to individualized motivational approaches.

Their role is especially notable in the treatment of severe tobacco use disorder. While most interventions are conducted in primary care, complex cases require specialized nursing support from UCAs. It is proposed that UCAs care for patients with severe organic comorbidities, pregnant women, or those with a history of failed cessation attempts in primary care.

5. CONCLUSIONS

This work, developed by an expert panel of professionals from ten UCAs in the Valencian Community, identifies and defines 33 care services considered minimum standards for addiction units. All proposed services are supported by scientific evidence and respond to both identified care needs and the accumulated experience of the intervention teams.

These services are already present in various UCAs across the region, with differing levels of implementation and emphasis, reflecting the need for adaptation to local population characteristics. Standardization of these services will facilitate more equitable, coherent, and efficient care throughout the addiction network.

It is concluded that quality care in addictions requires a comprehensive, flexible, and adaptive approach. Key elements include cohesive multidisciplinary teams, implementation of consensual protocols, incorporation of gender perspectives, and attention to psychiatric comorbidity. Internal and external collaboration, effective coordination, and continuous professional updating are essential conditions to achieve a model of excellence in care.

Study Limitations

This study has several limitations to consider when interpreting the results:

- The use of an expert panel, while valuable for gathering clinical experience and generating consensus, carries some subjectivity. Conclusions largely depend on participants' knowledge and perceptions, limiting generalizability to other care settings. The panel's composition, consisting solely of professionals from the Valencian Community, restricts extrapolation to other regions where service organization and resources may differ.
- Another limitation relates to the dynamic nature of addictions. Consumption patterns, emerging substances, and behavioral addiction trends are



constantly evolving. Therefore, the proposed services may become outdated if not periodically reviewed.

- While this study identifies services and formulates recommendations based on clinical experience and scientific evidence, future research should include impact analyses in terms of health outcomes, cost-effectiveness, or user and family satisfaction to assess the real efficacy of the proposals.

REFERENCES

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>
- Aparicio Azcárraga, P., et al. (2020). *Screening guide for HCV infection: Framework of the strategic plan for addressing hepatitis C in the National Health System*. Ministerio de Sanidad y Consumo. <https://www.sanidad.gob.es>
- Arias Horcajadas, F., & Orío Ortiz, L. (Coords.). (2023). *Clinical guide on behavioral addictions based on evidence*. SOCIDROGALCOHOL. <https://socidrogalcohol.org/proyecto/guia-clinica-sobre-adicciones-comportamentales/>
- Arias, F., & Madoz, A. (2009). Cannabis. In C. Gómez (Ed.), *Addictions manual for trainee medical specialists* (pp. 613–636). Socidrogalcohol.
- Becoña, E., & Cortés, M. T. (2011). Psychotherapy programs and psychological intervention procedures. In E. Becoña & M. T. Cortés (Coords.), *Addictions manual for trainee clinical psychologists* (pp. 143–170). Socidrogalcohol–PNSD. <https://socidrogalcohol.org/proyecto/manual-de-adicciones-para-psicologos-especialistas-en-psicologia-clinica-en-formacion-2/>
- Bobes, J., Casas, M., Terán, A., et al. (2010). *Guide for opioid addiction treatment with buprenorphine/naloxone*. Socidrogalcohol. <https://socidrogalcohol.org/proyecto/guia-para-el-tratamiento-de-la-adiccion-a-opiaceos-con-buprenorfina-naloxona/>
- Bruneau, J., et al. (2018). Management of opioid use disorders: A national clinical practice guideline. *CMAJ: Canadian Medical Association Journal*, 190(9), E247–E257. <https://doi.org/10.1503/cmaj.170958>
- Büchter, R. B., & Messe, M. (2017). Interventions for reducing self-stigma in people with mental illnesses: A systematic review of randomized controlled trials. *German Medical Science*, 15, Doc07. <https://doi.org/10.3205/000248>
- Clinical Practice Guideline Panel. (2008). A clinical practice guideline for treating tobacco use and dependence: 2008 update. *American Journal of Preventive Medicine*, 35(2), 158–176. <https://doi.org/10.1016/j.amepre.2008.04.009>
- Comisión Europea. (2021). *European Union drugs strategy 2021–2025*. Office of the Publications of the European Union.
- Comunitat Valenciana. (1998). Law 6/1998, of June 22, on pharmaceutical regulation of the Comunitat Valenciana. *Official Gazette of the Comunitat Valenciana*, 3274.
- Comunitat Valenciana. (2014). Law 10/2014, of December 29, on health of the Co-



- munitat Valenciana. *Official Gazette of the Comunitat Valenciana*, 7429.
- Council of the European Union. (2020). *EU drugs strategy 2021–2025*. <https://data.consilium.europa.eu/doc/document/ST-14178-2020-INIT/en/pdf>
- Cowlshaw, S., et al. (2012). Psychological therapies for pathological and problem gambling. *Cochrane Database of Systematic Reviews*. <https://doi.org/10.1002/14651858.CD008937.pub2>
- Dematteis, M., et al. (2017). Recommendations for buprenorphine and methadone therapy in opioid use disorder: A European consensus. *Expert Opinion on Pharmacotherapy*, 18(18), 1987–1999. <https://doi.org/10.1080/14656566.2017.1409722>
- España. (2001). Royal Decree 175/2001, of February 23, approving rules for correct preparation and quality control of magistral formulas and officinal preparations. *Boletín Oficial del Estado*, 65, 9500–9525.
- España. (2015). Royal Legislative Decree 1/2015, of July 24, approving the revised text of the Law on guarantees and rational use of medicines and health products. *Boletín Oficial del Estado*, 177, 62973–63085.
- European Monitoring Centre for Drugs and Drug Addiction. (2021). *Opioids: Health and social responses*. https://www.euda.europa.eu/publications/mini-guides/opioids-health-and-social-responses_en
- European Monitoring Centre for Drugs and Drug Addiction. (2021b). *Polydrug use: Health and social responses*. https://www.euda.europa.eu/publications/mini-guides/polydrug-use-health-and-social-responses_en
- European Monitoring Centre for Drugs and Drug Addiction. (2021c). *Stimulants: Health and social responses*. https://www.euda.europa.eu/publications/mini-guides/stimulants-health-and-social-responses_en
- European Monitoring Centre for Drugs and Drug Addiction. (2022). *Families of people who use drugs: Health and social responses*. https://www.euda.europa.eu/publications/mini-guides/families-health-and-social-responses_en
- European Monitoring Centre for Drugs and Drug Addiction. (2022b). *Homelessness and drugs: Health and social responses*. https://www.euda.europa.eu/publications/mini-guides/homelessness-and-drugs-health-and-social-responses_en
- European Monitoring Centre for Drugs and Drug Addiction. (2023). *Cannabis: Health and social responses*. https://www.euda.europa.eu/publications/mini-guides/cannabis-health-and-social-responses_en
- European Monitoring Centre for Drugs and Drug Addiction. (2023b). *Migrants and drugs: Health and social responses*. https://www.euda.europa.eu/publications/mini-guides/migrants-and-drugs-health-and-social-responses_en
- Fareed, A., et al. (2010). Methadone maintenance dosing guideline for opioid dependence: A literature review. *Journal of Addictive Diseases*, 29(1), 1–14.
- Fernández Miranda, J. J. (Coord.). (2008). *Opioids: Socidrogalcohol clinical guidelines*



- based on scientific evidence. *Socidrogalcohol*.
- Fernández Miranda, J. J., et al. (2020). *Co-occurrence of substance use disorder and other mental disorder*. *Socidrogalcohol*.
- Fonseca, F., et al. (2021). A gender perspective of addictive disorders. *Current Addiction Reports*, 8(1), 1–11. <https://doi.org/10.1007/s40429-021-00357-9>
- Gates, P. J., et al. (2016). Psychosocial interventions for cannabis use disorders. *Cochrane Database of Systematic Reviews*, 5.
- Generalitat Valenciana. (1998). Ley 6/1998, de 22 de junio, de Ordenación Farmacéutica de la Comunitat Valenciana. *Diario Oficial de la Generalitat Valenciana*, 3276. <https://dogv.gva.es>
- Generalitat Valenciana. (2003). Legislative Decree 1/2003, of April 1, approving the revised text of the Law on Drug Dependence and other addictive disorders. *DOGV*, 4473.
- Generalitat Valenciana. (2014). Law 10/2014, of December 29, on health of the Comunitat Valenciana. *DOGV*, 7434.
- Generalitat de Catalunya, Agència de Salut Pública de Catalunya. (2011). *Clinical practice guide on cocaine dependence treatment*.
- Ledo, A. I., & Terán, A. (2010). Cocaine. In C. Pereiro (Ed.), *Addictions manual for trainee medical specialists* (pp. 525–569). *Socidrogalcohol*.
- Martínez-Redondo, P., & Arostegui Santamaría, E. (2023). *Guide for comprehensive management of gender-based violence and substance abuse in women*. Federación Española de Municipios y Provincias & Delegación del Gobierno para el Plan Nacional sobre Drogas. Madrid.
- Ministerio de Sanidad y Política Social. (2009). *Common services portfolio of the National Health System and procedure for updating*.
- Ministerio de Sanidad, Servicios Sociales e Igualdad. (2015). Royal Legislative Decree 1/2015, of July 24, approving the revised text of the Law on guarantees and rational use of medicines and health products. *Boletín Oficial del Estado*, núm. 177, de 25/07/2015. <https://www.boe.es/eli/es/rdlg/2015/07/24/1/con>
- Monras, M., et al. (2000). Efficacy of group therapy for alcoholics: Results of a controlled clinical trial. *Medicina Clínica*, 115(4), 126–131. [https://doi.org/10.1016/s0025-7753\(00\)71485-0](https://doi.org/10.1016/s0025-7753(00)71485-0)
- NIDA. (1999). *Principles of drug addiction treatment: A research-based guide* (1st ed., Spanish). Washington, DC: U.S. Department of Health and Human Services. <https://www.drugabuse.gov/PODAT/Spanish/PODATIndex.html>
- NIDA. (2009). *Principles of drug addiction treatment: A research-based guide* (2nd ed.). Washington, DC: U.S. Department of Health and Human Services. <https://www.nida.nih.gov/PODAT/PODATIndex.html>
- NIDA. (2014). *Approaches to drug addiction treatment*. NIDA InfoFacts. <https://www.drugabuse.gov/PDF/InfoFacts/Metodos10.pdf>
- National Institute for Health and Care Excellence. (2015). *Developing NICE guidelines*:



- The manual. <https://pubmed.ncbi.nlm.nih.gov/26677490/>
- Nicholls, N., et al. (2010). Opioid dependence treatment and guidelines. *Journal of Managed Care Pharmacy*, 16, 14–21.
- Pascual, F., et al. (2013). *Alcoholism. Socidrogalcohol clinical guidelines based on scientific evidence* (3rd ed.). <https://socidrogalcohol.org/proyecto/guia-clinica-alcohol-basada-en-la-evidencia/>
- Pereiro Gómez, C., & Fernández Miranda, J. J. (2018). *Addictions guide for trainee specialists*. Socidrogalcohol. <https://socidrogalcohol.org/proyecto/guia-de-adicciones-para-especialistas-en-formacion/>
- Ritter, A., & Cameron, J. (2005). *A systematic review of harm reduction* (Monograph no. 06, Drug Policy Modelling Project Monograph Series). Fitzroy: Turning Point Alcohol and Drug Centre, UNSW Drug Policy Modelling Program.
- Santos Goñi, M. A., et al. (2010). Traumatic history in drug-dependent women: Sexual, physical and psychological abuse. *Trastornos Adictivos*, 12(3), 97–124. [https://doi.org/10.1016/S1575-0973\(10\)70021-0](https://doi.org/10.1016/S1575-0973(10)70021-0)
- Soriano, R., et al. (2020). *Technical document on addressing the chemsex phenomenon*. Ministerio de Sanidad.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2015). *Pocket guide: Medication-assisted treatment of opioid use disorder*. U.S. Department of Health and Human Services. <https://www.samhsa.gov>
- Terán, A., et al. (2008). Cocaine. *Socidrogalcohol clinical guidelines based on scientific evidence* (1st ed.). <https://socidrogalcohol.org/proyecto/cocaina-guias-clinicas-socidrogalcohol-basadas-en-la-evidencia-cientifica/>
- Torrens-Melich, M., et al. (2021). Gender perspective in dual diagnosis. *Brain Sciences*, 11(8), 1101. <https://doi.org/10.3390/brainsci11081101>
- UNODC, & WHO. (2023). *International standards for the treatment of drug use disorders: Revised edition*. <https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders>
- UNODC. (2004). *Substance abuse treatment and care for women: Case studies and lessons learned*. United Nations. <https://www.unodc.org/unodc/en/frontpage/2019/December/unodc-and-who-organize-international-training-on-substance-use-treatment-and-care-during-pregnancy.html>
- Verdejo-García, A. (2016). Neuropsychological assessment in addictions: Clinical guide. *Acción Psicológica*, 13(1). <https://doi.org/10.5944/ap.13.1.17392>
- World Health Organization. (2014). *Guidelines for the identification and management of substance use and substance use disorders in pregnancy*. <https://www.who.int/publications/i/item/9789241548731>
- Yakovenko, I., et al. (2015). The efficacy of motivational interviewing for disordered gambling: Systematic review and meta-analysis. *Addictive Behaviors*, 43, 72–82. <https://doi.org/10.1016/j.addbeh.2014.12.011>