UNITED NATIONS
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# Drug Dependence Treatment:

# Sustained Recovery Management

**Treatnet: International Network of Drug Dependence Treatment and Rehabilitation Resource Centres.**
**Good practice document**

# Sustained Recovery Management

# Good Practice

www.unodc.org/treatnet

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This good practice document has been prepared by a professionally and geographically diverse working group with participants from five drug dependence treatment centres as part of UNODC project GLO/H43 "Treatnet – International Network of Drug Dependence Treatment and Rehabilitation Resource Centres". It was peer reviewed to assure comprehensiveness and its relevance to different sociocultural environments as well as a balanced representation of different perspectives on the issue.

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During Phase I an international network of drug dependence treatment and rehabilitation resource centres in all regions was initiated, with a view to facilitating dissemination of knowledge and good practices. This document has been produced by members of one of four working group consisting of representatives from Treatnet members and the topics of the documents include:

- Community Based Treatment
- Interventions for Drug Users in Prisons
- The Role of Drug Dependence Treatment on the Prevention and Care of HIV and AIDS
- Sustained Recovery Management.

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# Introduction and Overview

**A Brief Background**

This manual is a product of Treatnet, the International Network of Drug Dependence Treatment and Rehabilitation Resource Centres, initiated by the United Nations Office on Drugs and Crime (UNODC). The goal of the network is to improve the accessibility, affordability, and the quality of drug dependence treatment and rehabilitation. Twenty drug treatment and rehabilitation organisations from all regions of the world have joined Treatnet as Resource Centres, and 15 providers are associate members.

Four good practice documents, developed by the Treatnet workgroups, are products of this initiative and are available to assist drug dependence treatment providers around the globe. Their focus is on:

- Community-Based Treatment Services;
- Drug Dependence Treatment in Prison Settings;
- The Role of Drug Dependence Treatment in HIV/AIDS Prevention and Care; and
- Sustained Recovery Management

Furthermore the Treatnet Capacity Building Package, (developed by the University of California Los Angeles Integrated Substance Abuse Programme), provides in-depth training manuals on the following topics:

- Screening, Assessment, and Treatment Planning;
- Elements of Psychosocial Treatment;
- Addiction Medications and Special Populations; and an
- Administrative Toolkit.

***Definitions of Good, Evidence-based, and Promising Practices***

Treatnet defines **good practice** as an umbrella term that encompasses evidence-based and promising practices. Good practices display the following features:

- Relevance to local needs;
- Ethical soundness;
- Sustainability likelihood (low cost, cost efficient, integrated, supported), and
- Replicability, that is, practices that have been sufficiently documented.

**Evidence-based practices** are supported by scientific studies and were ideally replicated in multiple geographic or practice settings. These practices

produce specific, consistent, outcomes and have been documented in scientific journals; sometimes they are available as manuals.

The strength of the evidence available can, in general, be ranked into specific gradations (British Hypertension Society, 2001) as follows:

**Strength of Evidence Gradations**:

**Ia:** Evidence from meta-analysis of randomized controlled trials;
**Ib:** Evidence from at least one randomized controlled trial;
**IIa:** Evidence from at least one controlled study without randomization;
**IIb:** Evidence from at least one other type of quasi-experimental study;
**III:** Evidence from descriptive studies, such as comparative studies, correlation studies, and case controlled studies; and
**IV:** Evidence from expert committee reports or opinions or clinical experience of respected authorities, or both.

**Promising practices** have been demonstrated to be effective, using objective measures, in one or more organisations. These practices may be at an early stage of development, but show promise of replication, and long-term sustainability with the possibility of becoming evidence-based practices.

**Who Can Use This Manual**

This document is intended as a practical guide for persons or organisations who want to develop or improve recovery supports for persons with drug use problems integrated in or in collaboration and coordination with treatment services available in the community. (See the Community Based Treatment Services manual, one of four training manuals designed to assist drug dependence treatment providers around the globe.)

The primary audience for this manual is:

- Practitioners in drug dependence treatment and rehabilitation services, especially in low-income countries; and
- Front-line health care personnel (e.g., social workers, medical and psychiatric support staff).

Additional audiences include, but are not limited to:

- Government policy makers;
- Non-Governmental Organizations (NGOs);
- Academic institutions;
- Advocacy and community groups;
- Educators and Employers
- The judicial system; and
- The general public.

**Overview of Chapters**

**Chapter I** introduces the emerging practice of sustained recovery management from a rather theoretical perspective by giving a brief overview of some of its underlying concepts drawn from a variety of fields, (e.g., Sustainable Livelihoods, Recovery Framework, and recovery capital). Some of these concepts, though not yet rigorously tested, are implicit in emerging good practice already in use in the area of drug dependence treatment and rehabilitation. The chapter furthermore introduces the key principles of Behavioural Health Recovery Management as an example of an alternative to the traditional "admit, treat, and discharge" model.

**Chapter II** presents the results of a literature review on various types of recovery supports to sustain recovery from drug dependence. This chapter also explores how drug dependence treatment and rehabilitation services can be effectively integrated within a sustained recovery management framework that helps address the needs of the client in a holistic way.

**Chapter III** is intended for those who are interested in the more practical "what" and the "how" of the implementation of a sustained recovery management approach. It responds to these questions by setting out guiding ideas, and giving a list of practical steps as a means of laying the groundwork for (re)building recovery supports (also referred to as recovery capital) in eight domains.

**Chapter IV** provides good practice approaches of projects that have developed rehabilitation and social reintegration approaches with a focus on recovery supports. The case studies, while presenting a regional and thematic balance, reflect the cultural and resource settings of specific regions.

**Chapter V** focuses on ways to advocate for recovery supports for drug dependent persons by targeting groups at every level of society: the inter-individual and community levels, as well as at the more arms-length institutional and national levels. It demonstrates how, through advocacy and wide outreach, it is possible to raise awareness at every level of society about the emerging promising practice of sustained recovery management.

**Chapter VI** deals with the components needed to document and evaluate programmes from a sustained recovery management perspective. It promotes a step-by-step approach to documentation, and lists nine steps needed to carry out a successful evaluation. A vocational programme is given as an example of what is required. (See also Appendix II for more information on service evaluation.)

# Chapter I: A Sustained Recovery Management Approach

*Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.*
(World Health Organization, 1986)

This document presents an integrated continuum of care framework and recommendations, developed through a review of literature and good practice, for effective long-term rehabilitation and social reintegration of drug dependent persons. In a "sustained recovery management" approach, drug dependence is seen as a multifactorial disease that often follows the course of a relapsing and remitting chronic disorder (A.T. McLellan, D.C. Lewis, O'Brien, et al., 2000; A.T. McLellan and C. Wisner, 1996). This chapter introduces the emerging practice of a sustained recovery management approach to drug dependence treatment, rehabilitation, and social reintegration.

The approach, as it is described here, brings together the Sustainable Livelihoods framework, derived from the area of development cooperation, and the drug dependence-specific recovery capital/recovery framework approach as an organizing concept and assessment tool for practitioners of drug dependence treatment and rehabilitation services. Its elements, coming from different areas, have only partly been applied and evaluated in this combination. Therefore, this promising practice remains in need of careful evaluation to verify its effectiveness. The case studies included in Chapter IV, from existing drug dependence treatment programmes that have successfully incorporated some of its key components, stand as examples of promising practice.

This chapter introduces and links the Sustainable Livelihoods framework and the Recovery Framework from a more theoretical perspective. It concludes with an introduction to the more practical approach of sustained recovery management that will be the major topic of the following chapters.

## Sustainable Livelihoods

The concept of Sustainable Livelihoods derives from the field of development cooperation. Its intent is to help practitioners to:

a) Better understand the livelihoods of marginalized groups and their contexts, as seen through their own eyes, and
b) Improve poverty reduction efforts.

According to FAO, the United Nations Food and Agricultural Organization, Sustainable Livelihoods is defined as:

> *The capabilities, assets—both material and social resources—and activities required for a means of living. A livelihood is sustainable when it can cope with and recover from stresses and shocks, maintain or enhance its capabilities and assets, and provide net benefits to other livelihoods locally and more widely, both now and in the future, while not undermining the natural resource base.*

Though the Sustainable Livelihoods concept has not been applied within the continuum of drug dependence treatment, rehabilitation[1], and social reintegration, it is suggested here (see also Figure I, Appendix I) as a guiding reference for those developing or working in sustained recovery management services.

Creating the necessary supports to maintain a sustainable livelihood gives persons in the process of rehabilitation and social reintegration more financial security and the opportunity to shift towards social environments and relationships conducive to stabilization and positive changes.

In this document, **Sustainable Livelihoods** is also understood as a comprehensive way to understand, assess and support the human, social, and vocational resources needed to support people to build stability and well-being in their lives and to reduce the negative health and social consequences of drug use.

The following characteristics make the Sustainable Livelihoods framework (Figure I, Appendix I), as adapted from DFID (UK Department for International Development), a broad and useful assessment tool in that it:

- Identifies appropriate **entry points** for livelihoods development;
- Provides a **checklist** of availability of livelihoods/resources;
- Draws attention to **multiple interactions** between key factors affecting livelihoods;
- Is **people centred**, that is, it is helpful in gathering multiple data and analysis on people's livelihoods; tracks how these are changing over time; and focuses on the impact of policy and institutional processes on people and households;

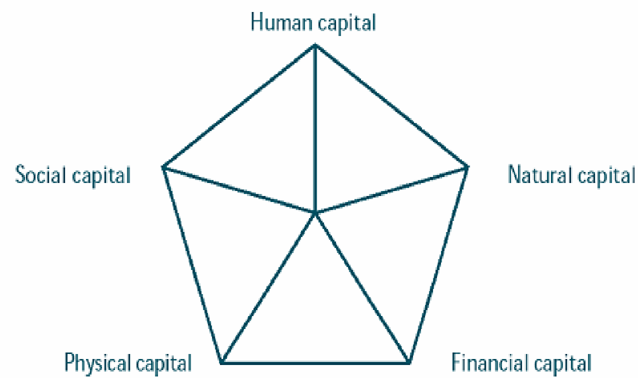
---

[1] It is well to note that, for some persons (especially vulnerable populations), it may be a case of social integration and 'habilitation.' [In some countries where drug dependence is long standing and worsened by adverse socio-economic environments, the question is asked, "How can someone be rehabilitated or reintegrated when they were never 'habilitated' or integrated in the first place?" Therefore, the rehabilitation process is going to take them to a completely new space and not a return to the extremely impoverished and socially dislocated context they were in before they started to use drugs.] (Paraphrased from an e-mail dated Jan 18, 2008, from David Macdonald, Demand Reduction Advisor, Afghanistan.)

- Is **holistic**, for example, organizes the factors that reduce or increase opportunities for improved livelihoods outcomes;
- Is **dynamic** in that it acknowledges the vulnerability context, which are the effects on livelihoods of shocks such as job loss, divorce, illness, death of loved ones, loss of assets due to natural disasters, and conflict;
- Is **strengths based** because it focuses on people's strengths and inherent potential gained through social networks, access to physical resources and infrastructure, including the ability to influence policy making and the institutional environment;
- Is **sustainability focused** in that it seeks sustainable solutions (e.g., those that can facilitate long-term recovery); and
- **Links the personal with the political** as seen in the multilayered Sustainable Livelihoods approach that is central to identifying supportive strategies in the immediate environment (e.g., personal efforts and assets, community-level initiatives and strengths), and linking with a wider public policy agenda for positive outcomes.

The Sustainable Livelihoods Framework and, specifically, its Asset Pentagon (Figure II, Appendix I) can be used as assessment tools to:

- Analyze the livelihoods of drug dependent persons in relation to the livelihoods of their communities by identifying and increasing their strengths, opportunities, and assets in key areas such as human capital, natural capital, financial capital, physical capital and social capital.




| | |
|---|---|
| **Human Capital** represents a basic requirement to gaining access to other livelihoods' building blocks. It includes good health, knowledge, skills (e.g., college education and vocational skills), all of which can ease the way to entering the labour market. It is the sum of all personal resources that can be utilized to combat poverty in the context of recovery and substance dependence. | **Financial and Physical Capital** comprise economic and financial assets (e.g., income, property, and investments), basic infrastructure, and producer goods such as tools and equipment) needed to support livelihoods: transport, secure shelter, water supply and sanitation, clean and affordable energy. |
| **Social Capital** includes all the resources that can be drawn from social networks, memberships and relationships of trust and reciprocity that can support the creation of "safety nets." High levels of Social Capital add significantly to Human Capital. | **Natural Capital** consists of natural resources from which livelihoods are derived (e.g., land, trees, key environmental services, and food). |

In the view that in an impoverished environment, people with drug problems are especially vulnerable and in need of access to scarce resources available in the community, other components of the Sustainable Livelihoods Framework (Vulnerability Context, Transforming Structures and Processes: Figure I, Appendix I) help place the sustained recovery management process within a broader socio-economic and political foundation to:

- Identify and address external factors (social, economic, and institutional) that can influence, ease, or inhibit the likelihood of sustained recovery and social reintegration;
- Explore means of transforming the underlying politico-economic and social factors that have an impact on overall poverty levels, marginalization, social exclusion, stigma and drug dependence; and
- Assess the effectiveness of prevention, treatment and rehabilitation programmes of drug dependence given specific contextual circumstances.

**Recovery and the recovery framework**

Drug dependence treatment—within an acute care, symptoms-focused paradigm—has fallen short of properly addressing the complex, multi-factorial nature of drug dependence that often follows the course of a relapsing and remitting chronic disease. There is disillusionment with the "admit, treat, and discharge", revolving door cycles of high dropout rates, post-treatment relapse, and readmission rates. As a response to this situation there is a shift towards a more long-term perspective of sustained recovery management (White 2007; White and Davidson, 2006) that is much broader and holistic in scope (Bradstreet, 2004) than linear recovery models.

While there is no overall accepted definition of recovery yet (Betty Ford Institute Consensus Panel, 2007, the (adapted) definitions below illustrate a strengths-based view of recovery, in line with long-term and holistic interventions, such as sustained recovery management:

> *Recovery is a continuum process and experience through which individuals, families, and communities utilize internal and external resources to address drug dependence and substance abuse problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive and meaningful life.*
>
> (Adapted from W. White, 2007)

and

> *Recovery is the summary term for positive function in most of the outcome domains typically measured among individuals who have attempted to overcome substance use problem*
>
> (Adpated from A.T. McLellan, M.

Chalk, and J. Bartlett, 2007)

*and*

> *Recovery may be the best word to summarize all the positive benefits to physical, mental, and social health that can happen when alcohol- and other drug-dependent individuals get the help they need.*
> (Betty Ford Institute Consensus Panel, 2007)

The **recovery framework** is aligned with the World Health Organization's definition of health ("Health is a state of complete physical, mental and social wellbeing", WHO, 1986) and links drug dependence treatment and rehabilitation with recovery-oriented systems of care that encompass all domains of a person's quality of life (e.g., physical, vocational, social, cultural, and spiritual.[2]

The key elements of the recovery framework listed below, as defined in the literature, bring to mind those of the Sustainable Livelihoods model and highlight the compatibility of the two approaches. Namely, it:

1) **Has a strengths-based, client-centred focus.** The model empowers the individual to move towards a healthy, productive, and meaningful life. Thus the ultimate owner of successful rehabilitation and social reintegration is the client (Cloud and Granfield, 2001; W. White, 2007).

2) **Is recovery outcomes driven.** Recovery is intended as a continuum process. With access to good practices and evidencebased services the client can be assisted through the stages of rehabilitation and social reintegration to build the necessary resources for a meaningful life in the community. There are many pathways to long-lasting change and stability, regaining a sense of self-identity and self-esteem, (re)discovering one's meaning and purpose in life; and developing stronger interpersonal and community relationships. Recovery supports can help explore the ways that are best suited to a client's needs.

3) **Realizes that context influences the recovery process and the likelihood of recovery outcomes.** A person's background, culture, gender, past experiences, external factors (e.g., punitive policies promoting social exclusion, stigma and discrimination, and adverse agro-ecological factors; institutional barriers), employment and training opportunities, housing and social exclusion, all greatly

[2] See also The National Institute on Drug Abuse "Principles of Effective Drug Addiction Treatment: A Research Based Guide" http://www.nida.nih.gov/PODAT/PODAT1.html, supporting the importance of access to longterm recovery supports

influence recovery outcomes (White and Kurtz, 2006). Further, very much in line with the Sustainable Livelihoods Framework, it can be stated that

> *[t]he extent to which someone enjoys good health and well-being is influenced by a very wide range of social, environmental and individual factors and is about much more than the management of symptoms (Bradstreet 2004).*

4) **Promotes cultural relevance and gender sensitivity.** It is open to the integration of cultural practices and community support into treatment and social reintegration. Also, it facilitates gender mainstreaming by taking into account, while planning projects, the barriers that make access to treatment difficult for women (e.g., stigma, inflexible schedules, distance from home, and lacking daycare for children).

5) **Aims at promoting assertive approaches to integrated and continuing care.** These approaches emphasize building long-term supportive relationships with clients, and providing continuity of service to increase their recovery capital. Duration and intensity of check-ups and monitoring also vary during periods of increased vulnerability for relapse (W. White and E. Kurtz, 2006).

6) **Integrates clients' respective families and/or significant others as both participants and partners in the recovery process.** This is demonstrated by actively involving them in client engagement, development of clients' recovery plans and processes. Social support can play an important role in the process of rehabilitation and reintegration.

7) **Sees the community as a reservoir of resources, opportunities, and support.** Recognizing that no single organization and/or institution can provide all the essential resources necessary to provide a continuum of care, it favours and promotes developing recovery supports through community networking and collaboration with multiple entities and resources (See White, in press). The focus is on educating the public, through advocacy, on the benefits of recovery, and collaborating with existing recovery support resources to develop integrated recovery strategies and services. Creating meaningful participation in the community is a key component of the recovery framework.

8) **Recognizes that combating and overcoming the stigma of drug dependence is essential to gain and maintain the community's support in the individual's recovery process.** Therefore, advocacy to influence and convince decision makers, educate service providers, and society at all levels about the issue

of drug dependence and the benefits of drug dependence treatment and rehabilitation for the individual and the community is encouraged. (See Chapter V.)

**Recovery Capital**

In this context, "**recovery capital**" is the sum of personal and social resources at one's disposal for addressing drug dependence and, chiefly, bolstering one's capacity and opportunities for recovery" (Cloud and Granfield, 2001).

Recovery capital can be used as a tool for drug dependence treatment professionals practitioners, to identify the strengths of their clients, support them in building up and maintaining a sustainable livelihood, while looking holistically at all domains of life. This approach meets individuals "where they are" and supports them along the continuum of treatment, rehabilitation and social reintegration.

Building recovery capital is *a strengths-based approach*. It involves identifying and building upon the client's major personal and social assets, which may have been developed earlier in life or are newly acquired. These assets can support treatment engagement and enhance motivation for treatment, the treatment process and ongoing recovery from drug dependence problems.

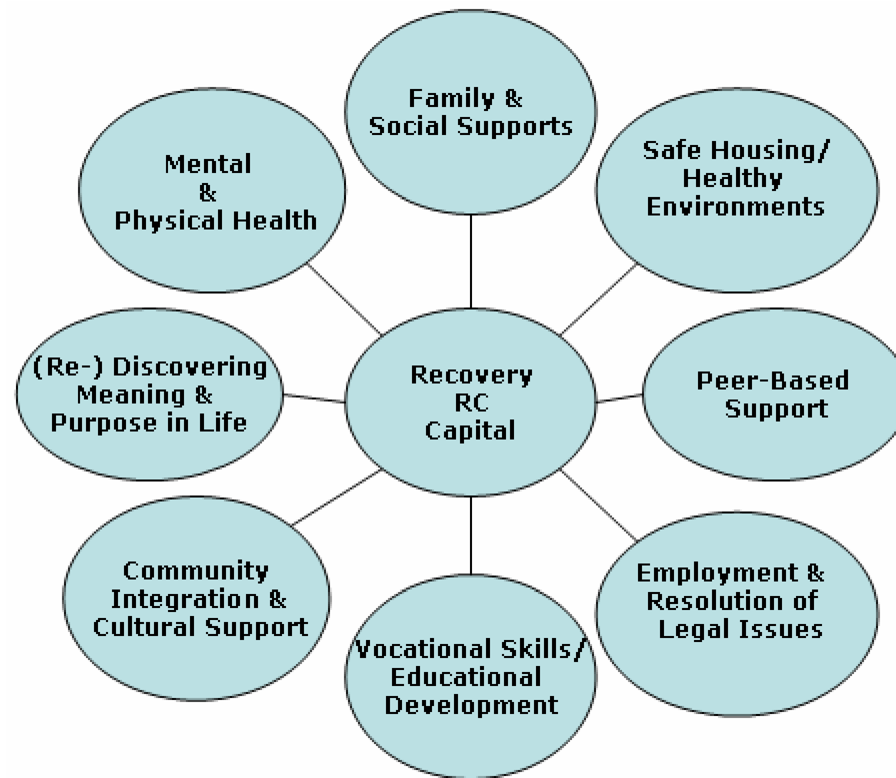
The eight domains of recovery capital identified by the Treatnet working group (shown in Figure III) are:

1) Physical and mental health;
2) Family, social supports, and leisure activities;
3) Safe housing and healthy environments;
4) Peer-based support;
5) Employment and resolution of legal issues;
6) Vocational skills and educational development;
7) Community integration and cultural support; and
8) (Re)discovering meaning and purpose in life.

A lack of such assets could hamper the recovery process and desired outcomes. As such, the concept of recovery capital complements the Asset Pentagon of the Sustainable Livelihoods Framework (Figures I and II, Appendix I).

***Figure III: The 8 Domains of Recovery Capital***

*Essential Supports for achieving rehabilitation and social reintegration*




**Source: Treatnet Working Group on Sustained Recovery Management**

### A Sustained Recovery Management Approach

The recognition of drug dependence as a multi-factorial health disorder, which often follows the course of a relapsing and remitting chronic disease, has spurred calls to shift the focus of drug dependence treatment from acute care to an approach of sustained recovery management in the community. Sustained recovery management applies many of the central components of recovery capital and the Sustainable Livelihoods framework. Service wise, a sustained recovery management approach offers the following:

- Uses a strengths-based approach, considering the resources available in the clients life;
- Takes into account the main areas of life/the eight domains of recovery capital (and their potentially compounding interrelationships) that can support rehabilitation and social reintegration for drug dependent persons;

- Integrates a broader range of drug dependence rehabilitation and social reintegration support services, to strengthen human, vocational, and social capital necessary for a healthy, stable and meaningful life.
- Uses broad, family- and community-focused, strengths-based, continual assessment processes;
- Implements early and assertive engagement by service professionals;
- Develops client- and family-generated recovery plans;
- Includes assertive management of co-occurring disorders and challenges to recovery;
- Uses peer-based models of recovery support and community resource development and mobilization;
- Shifts the centre of service activity from the institutional environment to the client/family's natural environment in the community;
- Puts emphasis on sustained monitoring, recovery coaching, assertive development and linkages to the community services for recovery support and, as needed, early re-intervention;
- Focuses on long-term evaluation of the effects of service combinations and sequences.
- Establishes a sustainable health care partnership between service providers and clients;
- Aims at easy access to services by shifting their location from remote institutions to the client/family's natural environment in the community;
- Emphasizes the importance of policy change and advocacy to reduce social stigma attached to drug dependence, and to promote recovery supportive policies and programmes (White, Boyle, and Loveland, 2002);

Building **social capital** is a visible, central element of sustained recovery management. It encompasses four of the eight domains of recovery capital in Figure III above, namely, family and social supports; peer-based support; community integration and cultural renewal; and healthy environments. It is also a central component of the Sustainable Livelihoods Asset Pentagon (Figure II, Appendix I). Cloud and Granfield (2001) define social capital as:

> *The resources that are developed through the structure and reciprocal functions of social relationships ... [and] the accumulation of social capital can lead to normative systems as well as assorted resources that serve as pathways to change.*

Granfield and Cloud (2001) and Cloud and Granfield (2001) highlight the possibility of achieving "natural recovery" from drug and alcohol dependence, without formal treatment or mutual aid interventions. Their findings show that, for some, recovery is sometimes facilitated within the context of very supportive social relationships of family, friends, and the community. On the other hand, without personal and social resources and supports, it might be harder for drug dependent persons to manage their own recovery processes

without additional support by accessible, available and affordable quality drug dependence treatment and rehabilitation services.

**Benefits of a Sustained Recovery Management Approach**

Most evaluations of existing sustained recovery management services have sought to determine the effects of post-treatment monitoring and support on long-term recovery outcomes (see McKay, 2005, for a review). Preliminary studies of these more assertive approaches to continuing care with adults (Dennis, Scott, and Funk, 2003) and adolescents (Godley, Godley, Dennis, et al., 2002) suggest that these approaches can:

- Lower relapse rates;
- Get those who need additional treatment back into treatment earlier;
- Generate longer periods of service involvement following re-admission; and
- Lower the percentage of clients remaining in need of treatment at follow-up.

**The eleven principles of behavioural health recovery management.** A practical example of a sustained recovery management approach is the Behavioural Health Recovery Management project, which has developed a disease management approach to drug dependence and serious mental illness that follows certain principles (Boyle, White, Corrigan, Loveland).

The principles share elements contained in disease management approaches for other chronic diseases such as diabetes, hypertension, and chronic asthma. They include the use of evidence-based medicine, clinical guidelines, patient education and empowerment, and ongoing monitoring and support. Further, the sustained recovery management approach goes beyond these common factors of disease management by including the community in recovery support, and putting greater emphasis on individual empowerment and peer supports.

The principles are:

**1) Focus on recovery.** The BHRM model emphasizes recovery processes over disease processes by working towards full and partial recoveries and by emphasizing client strengths and resiliencies rather than client deficits. Recovery re-introduces the notion that any and all life goals are possible for people with severe behavioural health disorders.

**2) Client empowerment.** The client, rather than the professional, is at the centre of the BHRM model. The goal is the assumption of responsibility by each client for the management of his or her long-term recovery process and the achievement of a self-determined and self-fulfilling life.

**3) Fighting stigma.** The BHRM model seeks to "normalize" or otherwise respect a person's experiences with behavioural health disorders and, subsequently, provides ongoing support services. The public begins to endorse positive images of behavioural health that undermine the prejudice and discrimination that frequently accompany service delivery.

**4) Use of evidence-based practices.** The BHRM model emphasizes the application of "evidence-based" interventions at all stages of the disease stabilization and recovery process, but the ultimate proof is the fit between the intervention and the client at a particular point in time as judged by the experience and response of the client.

**5) Use of clinical algorithms:** As knowledge and application of evidence-based practices advance, the challenge becomes knowing what treatment approaches to use with specific individuals as they progress through the stages of change and treatment. Medication algorithms have been developed that specify preferred first line prescriptions for specific diagnoses, dosing and time frames for evaluating the effects. Similar practice support algorithms are needed for clinicians utilizing psychosocial treatments.

**6) Application of technology.** The rapid advances in technology must be applied to recovery from serious mental illness and addictions. Technology being utilized in other fields may be adopted or adapted to addressing behavioural health issues.

**7) Service integration.** Based on the recognition that severe disorders heighten vulnerability for other disorders and problems, the BHRM model seeks to coordinate categorically segregated services into an integrated response focused on the person rather than on territorial ownership of the person's problems.

**8) Formation of recovery partnerships.** In the BHRM model, the traditional professional role of "expert" and "treatment provider" progressively shifts to a recovery management partnership with the client. Within this partnership, the professional serves primarily as a "recovery consultant."

**9) Ecology of recovery in the community.** The family (as defined by the client) and community constitute a reservoir of support for long-term recovery from behavioural health disorders. The BHRM model seeks to enhance the availability and the support capacities of family, intimate social networks and indigenous institutions (e.g., mutual aid groups, churches) to persons recovering from behavioural health disorders. The BHRM model also extends the locus of service delivery from the professional environment to the natural environment of the client.

**10) Provision of monitoring and support.** The BHRM model emphasizes the need for on-going monitoring, feedback and encouragement, linkage to indigenous supports and, when necessary, re-engagement and early re-intervention. This model of sustained monitoring and recovery support services contrasts with models that provide repeated episodes characterized by "assess, admit, treat, and discharge," as is traditional in the treatment of substance use disorders. It also contrasts with mental health programmes that focus on stabilization and maintenance of symptom suppression rather than on recovery and personal growth.

**11) Continual evaluation.** Service and support interventions must be matched to the unique and stage-specific needs of each client as they evolve through the stages of recovery. In the BHRM model, both assessment and evaluation become continual activities rather than activities that mark the beginning and conclusion of a service episode.

## Chapter Two: Components of Sustained Recovery Management[3]

As noted in Chapter I, the principles of sustained recovery management can be applied to the management of many other chronic disease states. Similarly, the recovery capital framework, which focuses on the sum of personal and social assets (e.g., family/social relationships, health, work, and a feeling of interconnectedness with the community), by extension, can be applied to promote a healthy lifestyle whether or not one is actively experiencing a state of disease.

That this is true is clearly seen when individuals without drug use problems experience serious life crises such as job loss, the death of loved ones, divorce, and/or ill health. The shock of such crises affects not only the individuals but often also their families, their relations to the community and, overall, their personal and communal sense of well-being. Failure to draw on family, medical, legal, and other needed support systems may prolong and entrench the state of crisis. This is no less true for persons challenged by drug dependence and their families.

Drug dependent persons frequently experience crises in the areas of medical, psychological, social, vocational, and legal well-being, partly due to their particular vulnerability related to negative health and social consequences of drug use and often co-occurring disorders. In addition, they face the social stigmatization and punitive barriers that often hamper sustained recovery and social reintegration (Braithwaite, 1999, 2001). Therefore, a continuum of care approach, addressing a range of areas, is especially necessary for sustainable drug rehabilitation and social reintegration efforts.

The management of substance dependence as multifactorial health disorder that often follows the course of a chronic disease requires time, empathy, and the integration of individual, family, and community resources. Programmes offering a continuum of care, case management, and a broader range of recovery support services are the most effective in addressing obstacles to entering the process of recovery, and enhancing long-term recovery maintenance (Siegal, Rapp, Li, et al., 1997; McLellan, Grisson, Zanis, et al., 1997; McLellan, Hagan, Levine, et al., 1998). Without such

[3] This section includes an extensive literature review that was carried out using mostly electronic databases such as PubMed, ScienceDirect, PsycINFO, ETOH, NCJRS; the Virtual Clearinghouse on Alcohol, Tobacco and Other Drugs; as well as relevant websites. In addition, previous UNODC publications were checked for references. The search was conducted using the following key words: addiction recovery and community reintegration. It then branched into the following: addiction treatment; natural recovery; recovery capital; addiction as a chronic disorder; recovery prevalence; recovery pathways and styles; addiction-social rehabilitation; co-occurring disorders; recovery and family/social support; recovery-housing; recovery-employment; recovery-economic self-sufficiency; recovery-religiosity/spirituality/life meaning; recovery management; and addiction-chronic disease management.

broad-spectrum support, stabilization, treatment, and recovery outcomes are frequently undermined. A lack of these supports increases the probability of repeated relapse. Emerging good practices are moving away from traditional drug dependence treatment delivered within an acute care framework, as those models often suffer from limited attraction and access; high dropout rates; weak systems of continuing care; and high post-treatment relapse and readmission rates.

**The Components of Sustained Recovery Management**

The following sections provide emerging evidence for each of the eight domains of recovery capital within a sustained recovery management framework. These domains are intended to promote key actions, highlight assets and experiences that may help facilitate the progression from treatment to long-term recovery and social reintegration support. Some persons have lost access to and knowledge about the resources available in the different domains of their life. In such instances, they might need professional support to regain access to:

1. Physical and mental health;
2. Family, social supports, and leisure activities;
3. Safe housing and healthy environments;
4. Peer-based support;
5. Employment and resolution of legal issues;
6. Vocation skills and educational development;
7. Community integration and cultural support; and
8. (Re)discovering meaning and purpose in life.

**Domain 1: Physical and mental health**

**Physical health.** Drug dependence treatment alters the client's relationship with psychoactive drugs and, to the extent possible, a reversal of co-occurring health problems. Thus, a sustained recovery management approach proposes that service providers take into account concurrent health problems at intake, so that clients can receive the necessary supports throughout and beyond the treatment period.

The following findings are worth noting:

- Studies to date have found that clients who receive long-term medical care integrated into substance dependence treatment and continued monitoring have better recovery outcomes than those who receive standard treatment (Weisner, Mertens, Pathasarathy, et al., 2002; Samet, Friedmann, and Saitz, 2001). Further, drug dependence needs to be insured, treated, and evaluated like other chronic illnesses (McLellan, Lewis, O'Brien, et al., 2000).
- An estimated 3% of the world's population is infected with Hepatitis C, which calls for greater public health efforts in the areas of prevention and medical treatment of this disease, but also for substance

dependence treatment to play an active role in the prevention and care of blood-borne diseases related to drug use.

- A study of alcohol-, heroin-, and cocaine-dependent individuals admitted to an urban hospital for detoxification found that 47% had at least one chronic illness (20% of which had two or more such conditions) and that 80% had prior hospitalizations for such conditions (DeAlba, Samet and Saitz, 2004).
- Morbidity and mortality rates revealed in follow-up studies of persons admitted for substance dependence treatment are quite high (2 1/2 times that of age-matched controls in a 10-year follow-up study) (Edwards, 1989), and mortality rates are dramatically increased for tobacco smokers (Vaillant, 1996).
- In spite of the general neglect of health and the severe medical problems that often accompany prolonged substance dependence problems, a significant portion of individuals entering treatment does not have an ongoing relationship with a primary care physician (DeAlba, Samet, and Saitz, 2004).
- When available, the medical care delivered within substance dependence treatment is generally limited to an intake assessment, supervision of detoxification, and referral for treatment of medical problems that would interfere with participation in substance dependence treatment.
- The maximum restoration of physical health is an important dimension of long-term substance dependence recovery. The risk of premature death for persons dependent on alcohol who have achieved stable remission is no greater than that for non-alcoholic control groups (Bullock, Reed and Grant, 1992).
- Maintenance medication with proven efficacy and effectiveness in preventing relapse and stabilizing drug dependent patients are available for opioid dependence. These medications belong to two main groups: long-acting agonists and antagonists. Opioid agonist therapy is one of the most effective treatment options for opioid dependence when methadone or buprenorphine are administered in an individualized dosage for a period of several months to years. Alternatively, a defined group of opioid dependent patients who are detoxified and highly motivated can be prescribed an antagonist medication (naltrexone) as part of continuing relapse prevention treatment (UNODC discussion paper on Principles of Drug Dependence Treatment, 2008).
- Studies show that methadone maintenance treatment is more effective when integrated with standard care, basic counselling, and on-site professional services. Significant reductions in opiate use within four weeks, and major increases in positive outcomes (McLellan, Arndt, Metzger, et al., 1993) could be seen.

Improvements in the quality of substance dependence treatment include:

a) Attempting to link each client to a primary care physician at admission (Samet, Larson, Horton, et al., 2003); and

b) Integrating primary medical care as a dimension of substance dependence treatment.

Fleming, Barry, Manwell, et al. (1997) reveal that such integration of primary care physicians has potential merit in terms of the influence they can exert on their patients' substance dependence patterns. These efforts, however, need to be tested for their effects on the long-term recovery process, and on the potential reduction in health care costs.

**Sustained Recovery Management with a Perspective on Gender**

- *Studies show that women entering substance abuse treatment are a highly vulnerable group and are most likely to present co-occurring, chronic medical problems (Claus, Orwin, Kissin, et al., 2007; Rosen, Ouimette, Sheikh, et al., 2002).*
- *Compared to men, women treated for substance abuse are more prone to be also victims of interpersonal violence (child abuse, rape, and battering). They, therefore, have a much broader range of physical and mental needs (Morrissey, Ellis, Gatz et al. 2005).*
- *Failure to address and understand the complexity of these issues, during and after treatment, or merely offering fragmented services, usually increases their vulnerability in the areas of: health, food and housing, parenting stress, child exposure to violence, lower social functioning and integration, and an overall decreased quality of life (Lincoln, Liebschutz, Chernoff, et al., 2006).*
- *Programmes that integrate specialized services for women (including pre-natal and child care) are associated with better treatment retention, length of stay, and positive treatment outcomes (Claus, Orwin, Kissin, et al., 2007).*

**Mental health.** Until now, research studies on the relationships between co-occurring psychiatric illnesses and substance use disorders, and their influence on treatment and long-term recovery outcomes, have revealed significant findings:

- The co-occurrence rate of psychiatric and substance dependence disorders is quite high (Regier, Farmer, Rae, et. al., 1990; Kessler, Nelson, McGonagle, et al., 1996). Half of all persons experiencing serious mental illness go on to develop a co-occurring substance dependence disorder (Rache-Beisel, Scott, and Dixon, 1999. See, also, Krausz, M., et al. 1998).
- As with co-occurring health problems, it is important for service providers dealing with drug dependent clients to take into account concurrent psychiatric problems at intake, so that clients may also receive the necessary supports throughout the treatment period.
- Psychiatric symptoms are more prevalent and closely linked to poly drug use. Gender, physical health, drug dependence and personal

relationships were more powerful predictors of psychiatric symptoms than substance dependence (Marsden, Gossop, Stewart, et al., 2000).

- Of the total pool of those with substance dependence-related problems, the best predictors of treatment seeking are global distress and psychiatric co-morbidity. A Korean study of the influence of psychiatric co-morbidity on alcohol and drug dependence found that psychiatric co-morbidity was associated with more severe substance dependence disorders, later onset of those disorders, and a greater likelihood of help-seeking (Cho, Hahm, Suh, et al., 2002).

> ***Notes on Mental Health Recovery***
>
> *The prevalence of co-occurring mental illness, substance abuse, and trauma (with even higher rates for women) present several challenges:*
>
> - *Substance abuse treatment programmes need to screen for other conditions in order to:*
>
>   *a) Identify the comprehensive needs of clients entering drug treatment and rehabilitation; and*
>   *b) Facilitate referrals for further assessments and treatment services.*
>
> - *The lack of adequate assessment tools that are easy and quick to administer by staff members and counsellors, with varied levels of clinical training, remains a key barrier to screening. (See Appendix II for suggested screening and assessment instruments.)*
>
> - *Addressing substance use along with multi-factorial diseases requires well-coordinated and integrated care supports. (Claus, Orwin, Kissin, et al., 2007).*

Co-occurring psychiatric and substance use disorders have generally been treated using:

a) *Parallel models* in which each condition is treated by a separate service team over the same time span;
b) *Sequential models* in which treatment for one disorder is completed and followed by referral and admission to treatment for the second condition;
c) *Collaborative models* that attempt to coordinate care of both conditions across mental health and substance dependence treatment service teams; and
d) *Integrated models* in which both disorders are treated at the same time and by the same staff using a clinical design reflecting knowledge of treatment and recovery from both conditions (CSAT, 1994).

While collaborative care is an improvement, and integrated care is recommended, (Minkoff, 1989; Muser, Noordsy, Drake, et al., 2003), parallel and sequential models of acute intervention continue to be standard practice in most countries. However, this lack of integration may contribute to the link

between psychiatric co-morbidity and poor post-treatment outcomes (McLellan, Luborsky, Woody, et al., 1983; O'Brien and McLellan, 1996; McLellan, Lewis, O'Brien, et al., 2000).

The good news is that providing psychiatric care as an addition to substance dependence treatment (McLellan, Arndt, Metzger, et al., 1993) as well as integrated models of care have been found to enhance rehabilitation and social reintegration outcomes (Mangrum, Spence, and Lopez, 2006). Nonetheless, these outcomes are often further challenged by issues such as:

- Educational/vocational impairment;
- Disruptive family relationships;
- Inadequate housing or homelessness;
- Violent perpetration or victimization;
- Enmeshment in criminal and drug cultures;
- Involvement in the criminal justice system; and
- A lack of basic resources (e.g., transportation, daycare) to allow easy access to needed services.

***Gender Notes on the Importance of Integrated Services***

*Women display substantially higher addiction severity (Lincoln, Liebschutz, Chernoff, et al., 2006) and the most complex set of co-occurring psychiatric disorders and psychological distress (i.e., depression, anxiety, and psychosis/suicidal thoughts, stemming from sexual abuse and interpersonal trauma). For women, coupling drug rehabilitation with provision of psychiatric care is often important, though not sufficient. These provisions also need to be complemented with well coordinated recovery support services that address concurrent needs, such as, medical and child care needs, lack of vocational skills, fewer financial assets, and low income (Lincoln, Liebschutz, Chernoff, et al., 2006).*

*The following quote from a study on predictors of relapse and facilitators of recovery (VanDeMark, 2007), points at the overwhelming difficulties facing women, in particular, when uncoordinated and fragmented assistance (in this case, welfare, housing, and drug treatment services) obstruct their path to drug rehabilitation, social reintegration, and recovery. The following excerpt speaks volumes:*

> *Not having the resources I need hurts my recovery. I can't get housing because of my [criminal] record. Can't get my kids unless I have housing. Can't get transitional assistance unless I have my kids. Even though I have [a diagnosis of] bi-polar [disorder], I can't get disability because of my substance abuse. I can't get to meetings because I have no transportation. I exhausted my program options.*

*This example shows the urgency for integrated systems of continuum of care that can respond to multiple problems complicated by high severity and long duration.*

*Studies consistently reveal that providing a greater number of collateral services (e.g., medical, psychiatric, family, employment services) as part of substance dependence treatment is associated with better substance dependence outcomes and better social adjustment (McLellan, Alterman, Metzger, et al., 1994). Directly providing such supplemental resources, or linking clients to them through assertive case management can increase positive outcomes across many domains by as much as 25–40%. (McLellan, Hagan, Levine, et al., 1998).*

**Domain 2: Family, Social Supports, and Leisure Activities**

**Supportive family relationships.** Not only individuals, but also families and communities with a need for rehabilitation are exposed to the acute care models of drug dependence treatment. Failure to achieve a successful "cure" may result in putting individuals and their families through endless cycles of detoxification and stabilization that lack the interventions and duration to create and support sustained recovery.

Supportive family relationships play a major role throughout the drug dependence recovery continuum. Yet, there are disparate findings on the extent to which they can influence or be affected by long-term recovery. On the one hand, family members can play a significant role in prompting substance dependent persons to seek treatment (Hingson, Mangione, Meyers, et al., 1982). Also, family participation and support in both treatment and recovery efforts exert a significant influence on long-term recovery outcomes for adults (Isaacson, 1991) and adolescents (Risberg and Funk, 2000).

On the other hand, sustained substance use in a client's living environment can hamper recovery efforts (Catalano, Hawkins, Wells, et al., 1991; Godley, Kahn, Dennis, et al., 2005). Sometimes changes in family structure and vitality on a societal level (e.g., the increasing shift to city living) influence the family's capacity to prevent alcohol and other substance use problems. Not surprisingly, families often are less prepared to effectively address such problems when they arise (Spielmann, 1994; Boyce-Reid, 1995).

While the long-term positive effects of recovery on family life would seem obvious, researchers have discovered that such long-term effects may be preceded by a period of intense confusion and dislocation (Brown and Lewis, 1999). Family structure, roles, and rules are dramatically altered through the process of drug dependence, and must be reformed during the process of rehabilitation and social reintegration. Brown and Lewis call this latter family adjustment process the "trauma of recovery" (Brown and Lewis, 1999, p. 181). They found that the chaotic family environment of the drug dependence years continues into the early years of recovery and that, without support, this adjustment may threaten both the marital relationship and the stability of the entire family.

The effects of drug dependence and recovery are even more profound where intimate partners are both drug dependent. Post-treatment recovery or relapse of one partner is predictive of whether the other partner returns to substance dependence or continues along the path to rehabilitation and social reintegration (McAweeney, Zucker, Fitzgerald, et al., 2005).

**Social supports and leisure activities.** Studies on adolescent treatment outcome reveal ways in which family and social relationships interact with leisure and alternative activities. Brown (1993) identified the main factors associated with long-term, post-treatment recovery outcomes. They are:

- Supportive family relationships aimed at recovery;
- Relationships with non-using peers;
- Recovery support group participation; school involvement; and
- Recovery-conducive employment.

**Specific Factors Affecting Women's Addiction, Treatment, and Recovery**

*Women' social context and personal relationships (friends, intimate partners, children but also drug dealers) play an important role in both drug dependence and recovery outcomes, more so than men's (Claus, Orwin, Kissin, et al., 2007; Stark, 1992). Where both partners are drug dependent, women are more vulnerable to relapse. They usually feel more socially alienated, particularly if they have been abused physically and sexually. Therefore, upon returning to their communities, after treatment ends, and if lacking appropriate social and family supports, they are more likely to reconnect with their pre-treatment supporters, some of whom (principally their partners) enable their drug use (Falkin and Strauss, 2003). This reality poses a few challenges in providing drug treatment for women, specifically:*

- *Acknowledging the likelihood that women will return to their partners, programmes need to integrate them in the therapeutic process, and develop "couples-specific" programming (Simmons, 2006).*
- *Encouraging treatment programmes and providers to help women differentiate between family and social networks that provide constructive support during and post-treatment, and those who hamper their efforts to remain drug-free (Falkin and Strauss, 2003).*
- *Focusing on appropriate strategies for managing relationships with partners and social networks that may hamper their recovery (Falkin and Strauss, 2003).*

*Most women in treatment are served through mixed-gender programmes. Thus, their needs and the complex patterns and interdependence of drug dependence, as they pertain to women, are overlooked (Grella and Greenwell, 2004). This reality confirms the need for family-oriented models of treatment, and family-focused, post-treatment monitoring, support, and early re-intervention services.*

*The design and delivery of treatment for women need to take into account that gender is deeply embedded and affected by personal, social, and treatment factors (Saunders, Baily, Phillips, et al., 1993). Thus, the importance of promoting gender-specific treatment and recovery support services that address gender-related vulnerabilities for substance use disorders, special needs in treatment, and obstacles to long-term recovery (Claus, Orwin, Kissin, et al., 2007; Greenfield, Brooks, Gordon, et al., 2007; Carten, 1996; Morrissey, Ellis, Gatz, et al., 2005; Falkin and Straus, 2003).*

*Programmes that integrate specialized services for women (i.e., pre-natal and child care) are associated with better treatment completion, length of stay, and treatment outcomes. (Ashley, Marsden, & Brady, 2003). Women who are allowed to bring along their children during treatment have demonstrated higher rates of retention (Chen et al., 2004; Coletti et al., 1992; Hughes et al., 1995).*

*Studies show that women would favour programmes that provide:*

- *A continuum of coordinated and family-focused services: a safe medium for their recovery and their children, and opportunities to improve the quality of family life (Claus, Orwin, Kissin, et al., 2007; Stark, 1992).*
- *"Gender-specific" treatment and substance abuse education tailored to their needs, such as case-management and social services, mental health services, vocational and job training, in an environment that supports them and their children and enhances the quality of family life.*
- *Referral systems and linkages to facilitate transition to continuity of care (Marsh, D'Aunno, and Smith, 2000).*
- *Less confrontational, less structured and rigid styles of treatment and interpersonal group dynamic communication. In single sex-group sessions, women tend to be more expressive, whereas mixed-gender settings can promote adverse psychological effects (Hodgins et al., 1997).*

**Domain 3: Safe Housing and Environments Conducive to Health and Recovery**

**Safe housing and environments.** Research reveals the fragile balance between recovery and relapse that typifies the reality of many individuals following primary treatment for substance dependence problems. Also noted was the profound effect the post-treatment family and social environments can exert on recovery outcomes. Further, abstinence-supportive living environments can increase the rates of recovery outcomes (Humphreys, Moos, and Finney, 1995; King and Tucker, 1998; Jason, Davis, Ferrari, et al., 2001).

The above-mentioned effects have shaped a long tradition of residential therapies, halfway, three-quarter-way houses, and structured environments, and fuel the modern "recovery home" movement (White, 1998). Halfway-houses in North America and in Europe, seen as a step-down level of care following residential treatment, are springing up rapidly as examples of supported housing (Nemes, Libretto, Skinstad, et al., 2005). Residents in these facilities are expected to work, pay their rent, and provide each other mutual support within an environment that may or may not include, or be linked to, professional treatment services. Nevertheless, a continuum of care approach, which provides access to a professional treatment provider and integrates rehabilitation treatment with social reintegration services, is recommended.

Collectively, these efforts show the importance of support in the physical and social environment during the early stages of recovery and maintenance. Early studies of communal living environments were primarily descriptive (Jason, Davis, Ferrari, et al., 2001), but the first randomized trial of placement in supported housing or a traditional aftercare environment revealed that those in the communal housing situation experienced lower substance use, higher monthly incomes, and significantly lower arrest and imprisonment rates (Jason, Olson, Ferrari et al., 2006).

In "recovery villages" (e.g., as units within public housing projects or specialty programmes within shelters), recovering individuals and their families can sustain themselves in physical and social environments conducive to rehabilitation and social reintegration (Graham, Graham, Sowell et al., 1997; Leaf, Thompson, Lam, et al., 1993).

There is increased interest in integrating drug dependence treatment services and shelter services for those who are homeless (Leaf, Thompson, Lam, et al., 1993). However, most of these programmes admit only those who are abstinent. "Wet hotels" provide housing services to homeless alcohol dependent persons. Service providers and policy advocates trying to introduce these programmes, have faced objections from those who see them more as an encouragement to continuing alcohol dependence than to promoting recovery (W.R. Miller, 1983; Wittman, 1993; J. Körkel, 2005). In practice, there are two different philosophies of supportive housing services

for drug dependent persons. One provides housing as a reward for sobriety; the other views stable housing as an important support to motivate and aid recovery. Research and advocacy activities supporting the latter philosophy appear to be growing (Tsemberis, Gulcur, and Nakae, 2004).

### Domain 4: Peer-based Support

**Peer-based support.** The international proliferation of recovery support groups (Humphreys, 2004) is currently being supplemented by new models of peer-based recovery support services and new "paraprofessional" service roles. Examples of these include recovery coaches and recovery support specialists (White, 2004b). Peer-guided models of recovery management effectively contribute to the process of long-term recovery (Durlak, 1979; Hattie, Sharpley, and Rogers, 1984; Riessman, 1990). This approach is particularly used within the area of drug dependence recovery (Connett, 1980; Blum and Roman, 1985). Moreover, peer-supported recovery approaches assist the individual seeking recovery within the community.

Such supports exist on a continuum and include:

- Recovery mutual aid groups such as 12-step programmes;
- Peer-based (non-clinical) recovery support services that function as both an add-on to professional treatment (for those with high problem severity), and an alternative to professional treatment (for those with lower problem severity and higher recovery capital); and
- Clinical services delivered by professionals who are in long-term recovery support services.

**Gender Notes on Peer-based Supports**

*Participation in meaningful and responsible social roles plays is important for women's recovery from substance abuse. The following are predictors of relapse and facilitators of recovery (VanDeMark 2007):*

- *Social support and participation in peer support groups encourage lower alcohol consumption and increased abstinence among substance abusers; and*
- *Engagement in helping others promotes lower relapse rates.*

### Domain 5: Employment and Resolution of Legal Issues

**Employment and economic self-sufficiency.** Increased employment is a desired outcome of drug dependence treatment and recovery, but the relationship between these factors is a complex one. Recent studies include the following findings:

- Individuals entering drug dependence treatment have high unemployment rates, and employment counselling is an expressed need for more than half of individuals admitted to drug dependence treatment (Hser, Polinsky, Maglione et al., 1999; Henkel, Dornbusch, Zemlin, 2005).
- Employment counselling, vocational training, and job-seeking skills training are not components of most drug dependence treatment programmes, nor are assertive linkages to such services a routine component of drug dependence treatment (Room, 1998).
- Employment counselling increases post-treatment employment rates, but employment counselling and post-treatment employment status are not predictors of abstinence. This finding suggests that successful recovery is possible without stable employment (Reif, Horgan, Ritter, et al., 2004).
- Providing standard drug dependence treatment does not significantly increase post-treatment employment rates (Magura, 2003).
- Programmes that place greater emphasis on combinations of supportive and complementary services (e.g., housing, employment) have better recovery outcomes than those that offer strictly clinical interventions (Kaskutas, Ammon, and Wesiner, 2004).

Low wages, high unemployment rates and lack of job skills can have a negative impact on rehabilitation and social reintegration outcomes. Therefore, it is important for persons in recovery who have begun this process to become economically self-sufficient (McLellan, Lewis, O'Brien, et al., 2000).

To achieve this goal, new recovery support organizations (e.g., the Recovery at Work project in Atlanta; White, in press) are also experimenting with recovery work co-ops as a transition from treatment to mainstream employment. These co-ops are small businesses within the community that serve as places of safety within which people in recovery can return to mainstream employment or obtain first-time employment. Such services integrate achieving stable employment within the complementary and supportive goals of stopping criminal activities, clearing up existing legal problems, participating in community life, and performing acts of community service.

Promising practices for specialized approaches to increase vocational functioning in recovery include conditional rewards for employment, and the integration of broad employment supports (counselling, skills training, rapid job placement and continuing support) within drug dependence treatment programmes (Magura, Staines, Blankertz, et al., 2004). A study of successful recovery of substance dependent women found that completion of treatment in a gender–specific programme followed by a drug-free environment and achievement of economic self-sufficiency to be the key predictors of successful recovery (Gregoire and Snively, 2001). Further, projects such as the "Occupational Guidance Service for Recovering Drug Addicts" in Spain also seek to develop a large network of companies

committed to helping those recovering from drug dependence successfully enter or re-enter the mainstream workforce (http://eddra.emcdda.eu.int/).

***Gender Notes on Employment and Economic Self-sufficiency***

*The findings from VanDeMark's (2007) study of predictors of relapse and facilitators of recovery indicate the need to refrain from punitive and stigmatizing policies. Instead, they encourage establishing treatment programmes that:*

- *Provide access to women's basic needs;*
- *Link them to constructive social networks; and*
- *Encourage them to assume roles of responsibility in work, family, education, and parenting.*

*Perpetuating stigmatization actually increases the tendency towards substance dependence and illegal behaviour. The following quote from a female respondent, in the same study, also confirms the relevance of psychological factors to recovery:*

> *[What is helpful to my recovery is that I care for me today. I am somebody. I'm not a people pleaser. I am a go-getter. I do have dreams; bottom line, I have goals to accomplish.]*

**Resolution of legal issues.** It has been noted that, among persons entering the criminal justice system, a high percentage have substance use problems. This has led the system to explore creative alternatives to imprisonment for substance dependent offenders. Some of the most significant of these include:

- Diversion programmes;
- Pre-trial release programmes (conditional upon entry into treatment);
- Drug education programmes;
- Assessment and referral services;
- Mandated treatment through specialized drug courts;
- Specialized intensive probation services;
- In-prison treatment; and
- Pre-release and post-release counselling and referral programmes (Lipton, 1995).

One trend is the development of specialized courts that integrate the resources of the criminal justice system with community-based drug dependence treatment agencies in the rehabilitation of drug dependent criminal offenders.

What makes drug courts stand out from traditional courts is:

- The unique combination of judicial monitoring (regular status hearings);
- Drug dependence treatment and case management services;

- Drug testing;
- Probation supervision;
- A non-adversarial collaboration between prosecution and defence counsel; and
- Multi-agency case conferences for service planning and progress reviews (Office of Justice Programmes, 1997).

A critical review of research on the effectiveness of drug courts, (an approach that is so far primarily implemented in the United States), indicates that drug dependence and criminal activity are reduced while participants are in drug court. Studies using comparison or matched samples show lower re-arrest rates for drug court participants than for the comparison group. A majority of the studies found lower relapse rates for drug court participants after they had participated in the programme. Cost analysis estimates indicate that drug courts are less expensive than traditional adjudication. (www.ncsconline.org; Belenko, 2001)

***Some Objectives and Findings of a Clinical Justice Programme in Spain***

*A specific programme for police stations caters to all arrested persons who have a substance use-related problem. The three chief objectives of the programme are:*

- *To evaluate the degree of the subject's intoxication and dependence at the time of arrest;*
- *To "enlist" arrested drug [dependent persons] who, for whatever reason, have not accessed the treatment network, into such treatment and referring them to the respective centres; and*
- *To continue treatment for patients who have already initiated care.*

*When assistance is provided in the context of court trials, this service attempts to enable the system to apply the most suitable security measures in each case where judicial problems derive from addictive behaviour, to ensure that the perpetrator's circumstances play a relevant role in the legal proceedings. Findings indicate:*

- *Global and individualized treatment according to different patient needs significantly lowers addiction-related offences.*
- *The number of persons visited in 2002 was 2860, including 829 for the first time; 12.18% of these were referred to conventional treatment centres.*
- *The above result would not be possible without the appropriate training for and co-ordination among the various professionals taking part in the process.*

***Excerpted from: "Evaluation and Support Units for Drug Addicts in Courts and Police Stations in the Provinces of Alicante, Castellon, and Valencia" project. For more on this approach, see the Spanish case study in Chapter IV.***

Another area of growing interest is providing treatment in closed settings. A recent follow-up study of prison-based treatment found that, while nearly 46% of those leaving prison are rearrested within a year of release, only 37.4% of inmates who received brief substance-focused treatment, and only

23.5% of inmates who received intensive treatment were rearrested in the year following their release. (Please see: http://www.jointogether.org/news/research/summaries/2005/study-finds-prison-based.html, 21 January 2005)

This study reflects two trends in research findings:

1) The rates for those who are re-arrested and returned to jail are lower for those drug dependent offenders who receive treatment inside prison.
2) The degree of that effect is affected by treatment dose and intensity. The longer and more intense the treatment episodes, the lower the relapse rates.

Efforts are underway to enhance these effects by preparing previously dependent inmates for prison release (e.g., The Esbjerg Model in Denmark), and linking inmates treated in prison to local treatment and recovery support groups during their community re-entry (For good practice examples from Europe see: http://eddra.emcdda.europa.eu/). Treatnet developed a good practice document on *Drug Dependence Treatment in Prison Settings*, which is available for additional information.

**Domain 6: Vocational Skills and Educational Development**

**Vocational skills and educational development.** Substance dependence problems can prevent one's successful (re-)entry into educational institutions and the workplace. It can have a negative effect on one's education and vocational performance, and contribute to one's disengagement from educational activities and legal employment (Magura, 2003). These findings underscore the need for: recovery support services that focus on educational and vocational training and placement; and early intervention programmes in schools and workplaces to resolve substance dependence related problems. Examples of these are student assistance and employee assistance programmes.

Substantial efforts are underway to enhance the educational and vocational outcomes of persons recovering from severe substance dependence problems. These include formal recovery programmes in high schools (and the establishment of special recovery schools), as well as colleges and universities (White and Finch, 2006). These programmes integrate enhanced access (e.g., scholarship programmes for individuals in recovery), educational guidance (special tutoring), and in-school recovery support groups and counseling.  Evaluations to date have noted low relapse rates within such programmes, and high levels of academic achievement (White, 2001).

*This example of recovery capital in action is taken from the case study in Chapter IV on "Special Employment Programme for At-Risk Youth" in* ***Teguchigalpa, Honduras, Central America****.*

*Denis, 18, is a husband and father of a four-month-old daughter. His wife was unemployed, but Denis did not go to school or work; he did nothing. His sole access to financial capital was his grandmother, until she died.*

*Then he heard about the project to reintegrate at-risk youth and former drug dependent persons into special employment programmes from a friend. He enrolled in the hospitality services course, earned a scholarship, was given a uniform and materials, and now works in a hotel in the city. According to Denis, the course helped him a lot. Without it, he would have no means of livelihood. His "days of unhappiness and agony are gone."*

### Domain 7: Community Integration and Cultural Support

**Integration and cultural renewal.** A broad extension of the zones of recovery capital is reflected in efforts to address substance dependence in the community through cultural support and community development. These efforts integrate culture-specific approaches to personal transformation with strategies that strengthen the community. Such strategies are exemplified here in the "Wellbriety Movement" within Native communities of North America, but many other examples might be found. The strategies of this specific movement include:

- Engagement of tribal leadership;
- Recovery education (e.g., *Well Nations Magazine* and recovery-themed books such as *The Red Road to Wellbriety*);
- Recovery awareness walks such as "Hoop Journeys";
- Training indigenous leaders to organize recovery circles such as "Firestarters";
- Hosting recovery celebration events in local Native communities; and
- Advocating for culturally informed social policies and treatment approaches (www.whitebison.org).

*This example of recovery capital is taken from the case study in Chapter IV on "Community Integration and Cultural Support",* ***Alkali Lake*** *is a Native Reserve in British Columbia, Canada*

*Alcohol dependence was a major problem on the reserve and every man, woman, and child was seriously affected by it. With alcoholism, came poverty, hunger, sickness, and physical and sexual abuse. The Shuswap tribal community in Alkali Lake was plagued by alcohol dependence until two local tribal members made a commitment in 1972 to stop alcohol use and to address alcohol dependence that affected their community.*

*In order for people to be able to imagine themselves living a healthier, alcohol-free life there had to be tangible opportunities and incentives that could support a new way of life. Opportunities were needed for meaningful employment, recreation, and a social life that was alcohol-free. Most immediately, there had to be accessible and fairly continuous opportunities for healing, personal growth, and learning. What, in fact, was developed in Alkali Lake was a series of interconnected interventions and opportunities as well as built-in rewards and consequences that constituted a healing pathway.*

**Domain 8: Pathways to (Re)discovering Meaning and Purpose in Life**

**Meaning and purpose in life.** In their studies on the relevance of recovery capital, Granfield and Cloud, 2001 (and Cloud and Granfield, 2002) noted that natural recovery from drug dependence is often preceded by personal, transformative changes and a conversion to a new way of life that may be induced in many different ways. For some persons, there is a faith-based conviction threaded through their lives upon which they may draw in their attempts to regain balance. Yet others may draw upon different grounding and centring practices (e.g., yoga, meditation, Tai Chi Chuan, aerobics) as part of their cultural traditions or personal assets—old and new.
Faith-based frameworks of recovery usually advocate the resolution of substance use problems through the support of religious experience and rituals, and by being rooted in a community of shared belief (White and Whiters, 2005). They are primarily aimed at a reconstruction of personal identity, values, and interpersonal relationships. Non-religious frameworks of recovery, such as Women for Sobriety and Secular Organizations for Sobriety, tend to promote and facilitate reintegration into the community, through employment, education, and community life. They stress the importance of strength of character, self-reliance, assertive problem solving, and lifestyle balance.

All of them share the placement of one's past, present, and future relationship with alcohol and drugs within the larger context of one's personal identity, self-esteem, and destiny (White and Nicolaus, 2005). They help to reintegrate the recovering person into the community through participation in shared cultural practice. The criteria would be for any of these frameworks (whether personal, cultural, or religious) to integrate and be open towards evidence-based drug dependence treatment and rehabilitation practices, while considering the client's needs, recovery capital, and personal strengths.

**The vision that emerges from this literature review** is the transition from traditional approaches to drug dependence and rehabilitation to a sustained recovery management approach. This approach is aimed at helping drug dependent persons achieve meaningful, productive, and sustainable livelihoods in their communities. Favouring a long-term, continuum of care approach, sustained recovery management integrates clinical interventions, community development activities, and processes of personal, economic, social, and cultural renewal. This integrated and holistic approach can stimulate the many components of recovery capital within individuals, families, and communities worldwide.

# Chapter Three: Laying the Groundwork for Building Recovery Capital

This chapter is intended for those who are interested in integrating a sustained recovery management approach into their programme, and are questioning the "what" and the "how" of its implementation.

As stated in Chapter I, this integrated approach emerges from good practices applied at different treatment centres around the world. Studies identified through the literature review in Chapter II support this shift from the traditional, acute-care approach to an integrated continuum of care approach for drug dependent persons through sustained recovery management. Recognizing that sustained recovery management may be best implemented in a framework of community based treatment and rehabilitation, Treatnet also produced a good practice document on Community Based Treatment.

Sustained recovery management uses the Sustainable Livelihoods framework (Figure I, Appendix I) and the recovery capital model with its eight domains (Figure III, Chapter I) as comprehensive assessment tools to help practitioners understand the contextual opportunities and obstacles easing or hampering livelihoods and recovery capital development of their clients. They also provide a solid foundation for developing a realistic treatment and rehabilitation plan, as well as a means to assessing progress, effectiveness, and outcomes. (See Figure IV, Appendix I for a graphic representation of the sustained recovery management framework.)
It is important to first recognize that assessing recovery capital is just one component of sustained recovery management, and cannot exist in isolation from the broader socio-economic, political, and environmental context that also plays a key role, but a more detailed description of the influences of the wider environment is beyond the scope of this document.

**Laying the Groundwork for Building Recovery Capital**

The following sections compile a set of practical ideas and activities, to help practitioners build upon each of the eight domains of recovery capital. Suggested actions contribute to an integrated care approach that includes systematic support for the rehabilitation, social reintegration, and sustained recovery of persons affected by drug dependence.

This approach effectively shifts the emphasis from pathology measures to strengths-based recovery indicators. Evaluation can then focus on the impact of service combinations and sequences on a person's overall life over time.

***Activities for (Re)Building Recovery Capital***

*Supports that can open and ease the way for the development of recovery capital for drug dependent persons as they move towards rehabilitation and social reintegration are facilitated by:*

- *Implementing a sustained recovery management plan that uses a strengths-based approach beginning with a comprehensive assessment (using the recovery capital model) of each client's needs, strengths, assets, and vulnerabilities. (See Figure III, Chapter I for relevant domains.);*
- *Placing greater emphasis on the contextual (physical, economic, social, cultural, political) opportunities and obstacles that could make drug rehabilitation and social reintegration succeed or fail;*
- *Shifting away from an exclusive focus on diagnosis and treatment of substance dependence to sustained healthcare and recovery partnership (The recovery plan is broader in scope: it includes all eight domains of recovery capital, and focuses on a continuum of care approach before, during, and after primary treatment.);*
- *Improving access to services by identifying potential barriers and conditions that prevent such access (See Figure I, Appendix I for the Vulnerability Context that includes: social discrimination, institutional and funding barriers, and access to resources.);*
- *Making programme services and the process of delivery culturally relevant, gender sensitive; providing supportive environments; and proactively identifying and addressing potential barriers that could promote exclusion, discrimination and/or continued relapse;*
- *Being client-centred, which empowers the individual to move towards a healthier, more productive and meaningful life (Client choice and consent are encouraged because it supports clients—along with their families and significant others—in developing and driving their own recovery plans. This confers on them a greater sense of dignity and ownership of the process of rehabilitation and recovery);*
- *Giving special attention to gender-specific approaches that can address the needs of women that differ, to some extent, from those of men;*
- *Providing a cost-effective sustained recovery management programme that provides long-term support; a continuum of care; regular check-ups; and interdisciplinary service models that integrate contributions and support from a variety of professionals (e.g., social workers, public health nurses, psychologists, medical doctors), and well-trained paraprofessionals (e.g., coaches and spiritual leaders) as well as family, peer-based supports, and the community);*
- *Replacing fragmented services with strategic partnerships, networks and coordination arrangements between governmental (public) and non-governmental organizations to increase the network of resources, supporting available drug treatment and rehabilitation services, and providing a continuum of care; and*
- *Ensuring that adequate follow-up is part of treatment and rehabilitation in order to: assess and reduce potential risk factors with regard to drug consumption; encourage protective factors for a healthy lifestyle; and provide adequate support for sustained recovery and social reintegration.*

**Steps towards Building Recovery Capital**

*Domain 1: Physical and Mental Health Supports*

**Physical and mental health** supports are important elements of drug rehabilitation and social reintegration processes. Beneficiaries are not only persons in the process of recovery, but also their families, their immediate environments, and the community at large. They are:

- Integrating primary health care and substance dependence treatment;
- Addressing physical and mental health needs together with substance dependence as part of a sustained health care model;
- Putting in place a system to facilitate referrals for further assessments and treatment services;
- Ensuring that sustained recovery management of both substance dependence treatment and primary/mental care services are carried out by an interdisciplinary team of professionals, involving paraprofessionals (peer-groups), as far as possible, to ensure cross-disciplinary support, cost-effectiveness, and a continuum of care throughout the process of treatment, recovery, and social integration;
- Making available follow-up services to treatment within the community, through networking with primary health care institutions, government agencies, NGOs and peer-group supports;
- Ensuring that adequate assessment and screening tools are easy and quick to administer by staff members with varied levels of clinical training, (see Appendix II for WHO's Quality of Life Assessment tool, and the Treatnet Addiction Severity Index) and are able to identify both substance dependence and other co-occurring diseases;
- Offering psychosocially assisted pharmacological treatment of opioid dependence and co-occurring psychiatric disorders; and
- Having in place specialized programmes for women who are most vulnerable when drug dependence is coupled with interpersonal violence such as child abuse, rape, and battering. (See Chapter II for more details on gender-specific measures.)

The prevention of negative health (and social) consequences of drug use through the following services—as part of a comprehensive package of drug dependence treatment and rehabilitation—are also ways to help people with drug related problems to stabilize their life (UNODC discussion paper: "Reducing the adverse health and social consequences of drug abuse: A comprehensive approach" (2008), available at: http://www.unodc.org/unodc/en/frontpage/reducing-the-harm-of-drugs.html):

- Offering non-discriminatory services to drug dependent persons aimed at protecting them from the adverse health and social consequences of drug dependence;
- Providing reliable information and counselling on the physical and psycho-social risks of drug abuse (overdose, infectious diseases,

cardiovascular, metabolic and psychiatric disorders, and impaired driving);
- Offering low-threshold pharmacological interventions (e.g., opioid-agonists and antagonist drugs), for immediate health protection and stabilization;
- Providing vaccination programmes against Hepatitis to drug dependent persons;
- Offering medication and emergency kits for managing overdoses;
- Offering services for the prevention and management of sexually transmitted diseases, particularly to those involved in the sex trade;
- Establishing voluntary HIV counselling and testing, and antiretroviral treatment for HIV-infected drug users;
- Making available measures to prevent the acute consequences of stimulants use so as to contribute to the prevention of related emergencies;
- Equipping street-workers and peer outreach workers units so that they are adequately trained to contact drug dependent persons in need of assistance; and
- Setting up needle/syringe exchange programmes for injecting drug users, where appropriate, under sound medical practice.

*Domain 2: Family, Social supports, and Leisure Activities*

**Family involvement, social supports**, and leisure activities have been shown to contribute to better outcomes in the treatment and rehabilitation process. The following actions show how families can play a key role in the treatment and rehabilitation process for drug dependent persons:

- Include the family throughout the treatment, rehabilitation and social reintegration process.
- Offer training and educational programmes to family members and significant others that educate them about: the adverse effects of substance dependence; early detection; the basic components and process of the treatment plan; and the key steps of the client's recovery goals to help prevent relapse and improve treatment outcomes.
- Provide family-based therapy that includes information on building communication skills, parenting skills, couples support, recognizing and preventing child abuse, and other supports to help restore family structure, vitality, trust, and build an environment that is conducive to recovery processes.
- Set up family-focused post-treatment monitoring and follow-up aimed at identifying and addressing obstacles to long-term recovery and preventing relapse.
- Make available gender-specific and relational models to help women and men learn appropriate strategies for positive relationships with partners and social networks that could encourage relapse and thus hamper their recovery.

- Link clients to significant others or relevant support networks that provide companionship, communication, and affection where lacking, necessary, and appropriate. (E.g., significant others can be extended family members, friends, neighbours, community members, or housemates in communitarian lodgings such as halfway houses.)

**Leisure activities** can help develop skills and knowledge that lead to healthy ways of living, a functional family, and positive social relations. Participating in cultural and recreational activities such as sports, handicraft workshops, and group excursions is an important aspect of the process of treatment, rehabilitation and social reintegration of drug dependent persons. These activities can contribute to a comprehensive education offer for persons in recovery. Actions to promote this outcome include the following:

- Make an initial assessment and identification of clients' preferences, skills, and needs that can help develop a leisure time plan during rehabilitation;
- Establish and develop group activities to support the development of social skills that can ease the rehabilitation process;
- Have skilled personnel to lead recreational, cultural, and sport activities that contribute to harmonious socialization;
- Incorporate rehabilitation programmes that offer practical activities to deliver information and encourage motivation (e.g., games, group field trips to ecological and cultural places, handicraft and artistic workshops, sports events and the development of recreational proposals by the patients themselves);
- Develop strategic alliances with public or private organizations that offer recreation activities, sports, and cultural activities. (E.g., short-term intensive training can be organized in coordination with institutions specializing in occupational therapy, sports, education, and cultural activities.); and
- Monitor leisure time activities, designed through mutual agreement between the therapeutic team and the person in rehabilitation, since it allows assessing treatment outcomes and reacting in a timely manner should problems occur.

*Domain 3: Safe Housing and Environments Conducive to Health and Recovery*

Loss of **safe housing and environments conducive to health and recovery** is a common situation for drug dependent clients. It is a serious risk factor for relapse and decreases the chances of social reintegration and a healthy lifestyle. Providing safe housing is an important factor in the recovery process. It allows continued contact with service providers but grants a higher level of independence and reintegration into the community than is the case with inpatient treatment. A range of benefits can be ensured. For example:

- Supported housing (half-way houses) provide a drug-free ambience that may help sustain abstinence and support the recovery process.
- Collective living promotes the development of positive peer interactions and building up support groups and networks.
- Stable housing provides an adequate setting for family contacts and visits and the re-establishment of trust among family members.

Different housing models and arrangements (e.g., state or publicly owned social welfare houses, halfway homes, wet hotels) are available that provide different kinds of supports along the continuum of rehabilitation and social reintegration. These supports range from housing services for the homeless and chronic drug dependent persons to housing possibilities that are more integrated in the community, and fostering growing independence and reintegration into the job market and productive work.

Examples to promote community housing:

- Families, public authorities, and society at large are informed about the benefits of housing provision for drug dependent persons. This is done through broader information-education-communication strategies to community members, education services, and policy makers.
- Formal and informal leaders may choose to mobilize the community to provide housing for recovering users.
- Housing strategies for drug dependent persons and recovering clients are included in the local governments' social welfare programmes.
- Participation of the private sector could contribute to the sustainability of housing initiatives. Thus it is important to include them in discussions about strategies, scope of the plan, and possible outcomes, including alternative financing for sustainability.
- Housing provision services need to have close links with drug dependence treatment services.
- Financial support can be obtained from various sources: Where possible, through direct contributions from the families of drug dependent persons; on a limited basis from marketing products or services offered through the vocational component of a rehabilitation programme; or from public or private assistance.

*Domain 4: Peer-based Support*

**Peer-based support** is necessary for persons in the process of rehabilitation and social reintegration who may be going through a transition period in their lives that requires changes in social behaviours and roles. During this period clients may feel insecure, fearful, and anxious, and such feelings may increase the risk of relapse. While facing uncertainty, it is important to have positive life strategies that may include self-help, peer group, or tutoring groups support. Support groups may act as positive mirrors, generate confidence, and offer support in times of crises. Ways of providing this critical support in a more structured way include:

- Sharing experiences through the individual recovery process and implementing this action (of sharing) in every rehabilitation process in a self-help group setting;
- Having clear rules and regulations, particularly those regarding confidentiality, that are known to all members in the group;
- Moderating self-help groups using professional or especially trained staff, if resources and group consensus or organizational setting allow; (Their main function would be the modulation and monitoring of individual and group achievements.);
- Developing a qualification model for self-help tutors who can update their knowledge on drug dependence and group moderation with the support of treatment institutions;
- Assigning a tutor or guide for orientation and counselling to each group member, so that the tutor can establish a close and trusting relationship with the person and act as a positive role model in the rehabilitation process. (A tutor who is knowledgeable about drug dependence treatment and rehabilitation could make the best use of contact mechanisms with the therapeutic team to assess the advances, achievements, and difficulties in the rehabilitation process.)
- Employing Recovery Coaches as peer support. (See US case study in Chapter IV.)

*Domain 5: (Self-)Employment and Resolution of Legal Issues*

**(Self-) Employment** issues are frequently linked to drug dependence. Many persons with long years of drug dependence have had difficulties in finding jobs, and unemployment is usually one of the major reasons for relapses. (See German case study in Chapter IV.) Invariably, they need support and guidance in reintegrating themselves into the job market. The following initiatives, when integrated into a drug dependence treatment and rehabilitation programme, can positively contribute to recovery outcomes, when current market needs are taken into account:

- Employment counselling, including job seeking training and rapid job placement;
- Development of vocational skills;
- Recovery work co-operatives as "safe sanctuaries" for those in transition from treatment to rehabilitation and social reintegration;
- Screening for potential barriers (personal, social, structural) to achieving economic self-sufficiency, and providing assertive linkages between services to help drug dependent persons obtain meaningful and rewarding employment, while resolving challenges,.such as, legal and criminal issues, lack of safe housing, and access to transportation; (The easing of these barriers significantly improves the abilities of persons in recovery to participate in meaningful activities and reintegrate into their communities and society at large.)
- Establishing a close working relationship between treatment providers and industry, private sector companies, and/or employment agencies

to make it easier for persons in the rehabilitation process to (re)enter the job market;
- Making it possible for persons in recovery and/or their family members to learn how to access and manage micro-credits so that they can get small scale loans to set up small enterprises, which is an important aspect of creating sustainable livelihoods; and
- Implementing programmes for the development of micro enterprises with the support of governmental and nongovernmental institutions.

**The resolution of legal issues** is of great importance for drug dependent persons in the process of rehabilitation and social reintegration and is linked closely to the aspect of finding employment. Integrating legal support into the rehabilitation process could help prevent the destabilizing effect of unsolved legal issues, which could, because of the associated stress, be a risk factor for relapse.

Ways of averting relapse because of the pressures of unresolved legal issues could include:

- Making an initial assessment of the legal situation on a standardized and confidential basis, with the client's approval; and
- Taking advantage of legal advice through non-governmental or public institutions (e.g., universities' legal offices or non-profit organizations), all the while strictly respecting the autonomy and privacy of users.

Rehabilitation service providers may wish to establish ongoing communication with members of the judicial system. As always, clients' privacy needs to be respected and the confidentiality requirements that are part of the rehabilitation process need to be strictly observed.

*Domain 6: Vocational Skills and educational development*

Acquiring occupational and **vocational skills** builds self-worth and self-esteem. This is also true for drug dependent persons. Work supports the creation of individual and social participation and responsibility. Some of the positive outcomes of acquiring marketable vocational skills and involvement in productive activities are experiencing higher levels of satisfaction and security, and reducing the risk of relapse. Steps to make this possible include:

- Making vocational assessment and counselling services part of rehabilitation and social reintegration programmes aimed at the creation of sustainable livelihoods;
- Developing the vocational component of the programme and embedding it into the treatment and rehabilitation plan, based on the client's initial assessment;
- Conduct a market analysis to identify current needs for skills and products;
- Making vocational training responsive to market needs;

- Adapting and renewing vocational support and counselling services to respond to technology and market changes, in order to enhance sales options for the programmes' products and services;
- Making simple and easy-to-manufacture products that are useful, have low production costs, and a ready market.

**Education** is a necessary asset for a full life and the assurance of a sustainable livelihood. Access to different educational schemes and models is one way to address problems related to drug use and drug dependence. Treatment providers often work with individuals who, due to the particular circumstances in their lives, might not have sufficient schooling, or did not take the necessary exams to obtain a certified degree or qualifications required to enter the job market. Having an education improves one's chances in the job market and may be an additional factor in sustaining recovery.

The following actions are aimed mainly at young people, since they are a highly vulnerable group for substance use, but also because of the important role of formal education in this stage of life. However, education aimed at exploring vocational skills and work training is, at any stage of life, a key factor for supportive interventions to be carried out. Some strategies are:

- Implementing school policies aimed at supporting strategies for rehabilitating and reintegrating students with drug dependence problems;
- Integrating measures to address the special needs of young people in recovery through the development of appropriate curricula and methodologies;
- Training teachers to address drug dependence as any other chronic disease, since their attitudes can help to reduce stigmatization and enhance support in the school environment to students in recovery;
- Implementing coordination mechanisms between the health and educational sectors on strategies to address drug problems;
- Offering educational opportunities in appropriate settings, and adapting to factors such as age, learning ability, and availability;
- Including treatment and rehabilitation services that allow outpatient/community interventions that can increase options for continuity in school;
- Encouraging joint family/teacher efforts to prevent drug use and relapse while encouraging healthy and protective leisure time activities at home; and
- Providing counselling sessions (in addition to supporting access to the formal education system), that integrate an educational/informational segment on ways to deal with peer and environmental pressures that could lead to relapse.

*Domain 7: Community integration and cultural renewal*

**Community integration and cultural support** often have a startling effect on alcohol and/or drug dependence. In some more traditional settings, complementary cultural and indigenous activities, when embedded in or closely linked to a treatment programme, may help to induce relaxation; facilitate self-regulation of physiological processes; release emotional trauma; alleviate isolation and alienation; encourage personal transformation; promote spontaneous manifestations of leadership skills, and, more importantly, create a sense of interconnectedness between the self and the community (Winkelman, 2003).

These methods are most helpful when:

- Applied as complementary offered components to drug dependence treatment and rehabilitation programmes to address relapse;
- Integrated into major rehabilitation programmes, community centres, training programmes, weekend retreats, as well as prison systems;
- Provided as additional counselling approaches that may help address severe psychological and emotional trauma through culturally accepted (traditional) methods;
- Used to facilitate cognitive-emotional integration, social bonding, and community affiliation;
- Incorporated in promoting self-expression and conflict resolution;
- Used to promote a sense of purpose and grounding in life;
- Employed as a means to engaging tribal/traditional/community leadership and encouraging training for indigenous/traditional leaders and healers to organize recovery circles;
- Applied to hosting indigenous recovery celebration events; and
- Employed in advocating for culturally informed social policies and treatment approaches.

Also in less traditional settings, activities that create a sense of community and open opportunities for (re-) integration can be helpful and may serve some of the above mentioned functions.

*Domain 8: Meaning and Purpose in Life*

Meaning and purpose in life is central to leading a full and healthy life. Regardless of how this desire for meaning in life manifests, most persons know when it is absent and seek it.

The following steps are suggested in assisting clients in the process of rehabilitation and social reintegration to uncover what, for them, constitutes meaning in life:

- Making an initial assessment, taking into account spiritual interests of clients, is useful in defining the content of the therapeutic counselling process;
- Suggesting different types and practices of spiritual practice, depending on the cultural context, might have an added value (e.g., as a relaxation strategy to face fears, anxiety, anger, and create a mental sense of recovery and well-being);
- Encouraging spiritual practice in groups, if applicable in the cultural setting, might support the connection with others and a sense of belonging; and
- Working with therapeutic staff to develop skills to approach and explore the spiritual and religious interests of clients in the process of rehabilitation and social reintegration.

Once the "what" and the "how" of implementing the various aspects of recovery capital—an essential part of sustained recovery management—have been realized, the next step is to increase recovery supports, through a systems approach, additional funding or in-kind-contributions, for drug dependent persons. Chapter V provides helpful strategies for accomplishing this aim. It outlines: a) how to advocate for changes in policy, structure, and processes by influencing decision makers, and b) how to raise awareness and create buy-in by targeting groups at every level of society.

# Chapter Four: Case Studies

The case studies and testimonials presented here relate to some of the eight domains of recovery capital explained in the previous chapters. Case studies were selected with regard to regional balance and to cover many of the possible domains that can support the development of recovery capital. They reflect the cultural, economic, and social context in which they were implemented, and are in line with the definition of "good practice" Treatnet has agreed upon. (See Introduction and Overview.) Key areas covered in the case studies include background information, contact details, objectives, processes, achievements, challenges, and lessons learned.

Case studies come from Bolivia, Cambodia, Canada, Germany, Honduras, India, Nigeria, Spain, and the United States. Emphasis is placed on those from developing countries. Those whose practices may not yet have been scientifically evaluated are also included. Testimonials give voice to how drug dependent persons and, in some cases, whole families and communities, were able to draw upon their various assets, as outlined in the Sustainable Livelihoods framework, to reduce drug dependence and begin the process of rehabilitation and social reintegration.

As these case studies show, recovery capital can be applied to a whole range of situations. Its principles can also be applied to life situations where there has been a need for recovery and balance such as job loss, divorce, death of a loved one, and recovery from codependence.

**Promising Practices in Action**

The following "good practices" are drawn from projects that have developed or implemented rehabilitation and social reintegration approaches with a focus on sustainable livelihoods, as well as building specific recovery capital domains:

- Promoting Micro Enterprises and Vocational Training in the Cochabamba Tropics: Bolivia
- Education: Cambodia
- Cultural Support: Canada
- Vocational Skills Training and Employment: Germany
- Special Employment Programme for At-Risk Youth: Honduras
- Family Support: India
- Vocational Skills Training and Employment: Nigeria

- Legal Support: Spain
- Peer Support: United States of America

## DOMAIN: PROMOTING MICRO ENTERPRISES AND VOCATIONAL TRAINING

## CASE STUDY: COCHABAMBA TROPICS, BOLIVIA

### BACKGROUND INFORMATION

**Project Name:** Vocational Training and Promotion of Micro-enterprises in the Cochabamba Tropics

**City/Country:** Cochabamba Tropics, Bolivia

**Contact Details Including Contact Person:** Mr. Carlos Diaz, UNODC Country Office, Bolivia, Casilla 9072 La Paz, Bolivia
Tel: (591-2) 279 5935, 279 5938, 277 3286; Fax: (591-2) 211 2746

**Websites**: http://www.unodc.org/bolivia/index.html; www.proyecto-bole07.org; carlos.diaz@unodc.org

**Project Status:** Closed. (On 18 July 2007, after six years working in the Cochabamba Tropics, the tripartite meeting decided to close project BOLE07. In September 2007 the UNODC Country Office in Bolivia will initiate project I80 Vocational Training and Promotion of Micro-enterprises in the Yungas of La Paz.

**Funding Source:** UNODC; International Labour Organisation (ILO); Vice Ministry of Coca and Alternative Development and UNODC

**Years of Operation:** Ongoing since December 2000 until July 2007

**Target Group:** Youth (male and female) who were engaged in coca cultivation, as well as local development institutions that were strengthened by the project

### Issue That Has Been Dealt with in the Case Study:

Vocational training, promotion of micro enterprises, and gender mainstreaming

### Project Background:

For more than 20 years, the United Nations Office on Drugs and Crime (UNODC) has supported the Andean countries in their efforts to promote viable options for employment and income generation for low-income families in rural areas. Traditionally, strategies for alternative development and the creation of a sustainable livelihood have focused on agricultural production by supporting production systems, including the processing and marketing of traditional products in coca production regions, such as coffee, bananas, palm hearts, pineapples, and other tropical fruits.

This case study describes an experience in an interagency cooperation project between UNODC and the International Labour Organization (ILO), which has applied a strategy in support of integral development in coca production areas. Recognizing urban tendencies and population dynamics in the coca producing area of the Tropics of Cochabamba, a vocational training and support plan for the micro-enterprise sector strategy was designed specifically to promote labour skills for the non-agricultural market among young people between 15 and 34 years of age.

**Objectives:**

- To eliminate growing and trafficking of coca in the region and, instead, to establish an alternate sustainable economy;
- To teach vocational skills to youth so that they can enter the labour market;
- To promote opportunities for men and women to obtain productive jobs that allow for freedom, equality, security, and human dignity.
- To apply a gender-sensitive approach so that women can achieve equitable participation in vocational training that will enable them to be integrated into the labour market; and
- To promote self-employment through creation of micro enterprises.

**Process/Activities:**

- Specific courses were identified for women based on their interests and competencies.
- Ninety-eight training modules were developed based on market demand. The courses lasted from 1 to 6 months with an average strength of 25 students and an average duration of 110 hours. Some of the courses identified were: Food processing; dress making/tailoring; harvesting and packing of agricultural crops; carpentry; masonry; baking and cooking; hospitality services; painting; electrical work; car mechanics; and artisan crafts.
- Micro enterprises were promoted by addressing issues such as production process, business administration, cost calculation, and access to credit.
- Ongoing coordination with government offices was encouraged and implemented.
- Human resources development was undertaken to support various projects.

**Lessons Learned:**

- Removing barriers that could prevent women from participating in the project were taken into account (e.g., schedules, distance from home, custody of small children, and teaching in the local language).
- The methodology of learning-by-doing was most effective.

- Given that vocational training is a continuous process, municipalities might wish to consolidate project activities related to vocational training and promote micro enterprises. In this context, municipalities can promote the creation of vocational training centres to generate micro-credit access for micro enterprises.
- Local development in the Cochabamba Tropics requires working on market access, and introducing new technology for production in order to increase productivity and competitiveness.
- It would be beneficial for municipalities to promote a new school curriculum in educational institutions that incorporates vocational training in trades.
- It is important to work collaboratively with beneficiaries/target groups in order to know which areas of vocational training interest them.
- Vocational training modules need to be constantly updated.
- Since trades are in demand in the labour market, a focus on vocational training would ensure ready placement of trained personnel while satisfying this demand.

**Outcome/Achievements:**

- The project supported 212 micro enterprises and improved their productivity and competitiveness. Of 2,028 people, 46% were women working in these enterprises.
- The creation of an employment bureau, with the support of municipal government, allowed for 744 young people to be integrated into the labour market. Out of the total, 280 were female.

**Challenges:**

- To create a modern and sustainable economy, alternative agricultural products were cultivated with the support of the Alternative Development Project. Although private investors were creating a large

source of employment, one of the main problems was the lack of trained human resources to support such a process.
- The social, economic, and political context posed a challenge for the project. Project leaders had to continuously adapt their intervention strategies in order to respond to beneficiaries' interests, meet the needs of qualified persons in the region, while maintaining close coordination with both parties.
- Expanding project E07 activities to Yungas of La Paz will be challenging.

**Cultural or Situational Issues Related to This Project:**

Traditionally, a large number of youth were involved in the production of coca. Many had no education. Due to lack of business knowledge and technical support, they were unable to initiate any micro-enterprises. These issues have been systematically dealt with through this programme. Also, the project has taken into account cultural issues such as teaching participants in their own language, and respecting their traditions by encouraging music and handicraft.

**Evaluative Data Available Related to the Project:**

An independent external evaluation was carried out in June 2007. The main conclusions of this assessment are:

- Of the beneficiaries who have received vocational training from the project, 26.4% are now productively employed.
- The incidence of non-qualified workers was reduced from 57% to 23%.
- The income of the target group has increased by 31%.
- The competence (knowledge and skills) of the target group generated by the project is utilized by at least 50% of project beneficiaries.
- The majority of project beneficiaries agreed that vocational training courses carried out by the project responded to their requirements.
- Employment at micro-enterprises supported by the project was increased by 196%. Of the workers in micro-enterprises, 50% have stable jobs.
- Eighty-one percent of micro-enterprises have permanent labour activity.
- Fifty-seven percent of micro-enterprises supported by the project are using accounting and management procedures.

A publication describing this project is available through the UNODC Country Office in Bolivia at http://www.unodc.org/bolivia/es/index.html.

**Key Findings:**

- The importance of networking with various departments such as government, NGOs and other UN agencies from the beginning of the project was realized.

- Even though the new learning acquired was within the framework of an alternative development project, it is believed that the strategies implemented would be applicable to projects on the creation of sustainable livelihoods for rehabilitation and reintegration.
- Although not directly addressing persons affected by drug abuse, this project might also be of interest for services working in the area of rehabilitation and reintegration.

The following testimonials have been taken from the publication on the project in Bolivia.[4] As noted earlier, the project was not focused on rehabilitation from drug dependence. However, the outcomes demonstrate clearly how drawing on some of the domains of recovery capital was able to support the rehabilitation and reintegration of persons into mainstream society in the tropics of Cochabamba. Some of the outcomes were:

- Developing meaning and purpose in life;
- Developing vocational and/or educational skills;
- Obtaining employment; and
- Assisting communities and their cultures to provide recovery supports for individuals and families.

[4] UNODC, Government of Bolivia and ILO (2007): Training young people, dignifying employment and building an entrepreneurial culture in the tropics of Cochabamba.

***Testimonials***

***La Moxenita: Indigenous art embodied in a micro-enterprise***

The Fabricano family, composed of seven members, concentrates on making carved handicrafts made from wood and other natural materials. Mr. Fabricano was a leader in coca production from Isiboro Sécure Sub-central Federation. He decided to change and to move to Villa Tunari where he could provide better education for his children.

*He contacted the project because he was motivated to transmit his art to young people and other craftsmen. So the project contracted him as a trainer to make handicrafts. Mr. Fabricano says: "The project has trained us to improve product design and finishing, to estimate our production costs and develop better business management practices. Besides, it helped us to participate in handicraft fairs where we sold our products at better prices." When demand is high, Mr. Fabricano subcontracts to other craftsmen whom he trained to make handicrafts with features similar to products offered by "la Moxenita," the name of his small business. Mr. Fabricano points out. "We have been working with the project for a long time and, because of this, we have promoted handicrafts from the tropics of Cochabamba at a departmental and national level. Now, our aim is to export our products."*

***Cat's Claw Handicraft: Hand-made furniture for export***

Mr. Luis Condiri *makes furniture with cat's claw wood and bark. Helped by his relatives and a couple of workers, he was able to produce enough furniture for export to China and Spain.*

*In the past, the craftsmen were engaged in coca production, but as he himself says, "That belongs to the past." Through the project's support, he was able to improve and expand his business. In his words, "First, they helped me with business management because I really needed it. At the beginning we sold just to sell, without knowing if we had profits or not; so they helped us to manage the business. After that, they took us to Expocruz fair in Santa Cruz where we signed an important contract with the Rio Selva Resort hotel to make 30 sets of dining room furniture. We are sure that without the project's support it would not be possible for us to be where we are now." The project also provided Mr. Condori with some small machines to support and develop production.*

***Other Testimonials***

*Mr. Raúl Santos,* together with his workmates, organized a carpentry workshop. He says, "The project encouraged us to form an association, so we could sign big contracts to produce furniture. They also trained us in the treatment of wood and furniture production, and gave us some tools that make our work easier."

Mrs. Cinda Postigo, *53, is now making handicrafts. She says, "I became interested in producing handicrafts, and so I attended the project's training courses. Gradually my son also started to be interested and now we are so completely engaged in this job that we have to hire workers to work our land."*

Mrs. Nora Rojas *prepares food for a living. She says, "I received training to diversify and improve my offerings. They gave me an oven and other utensils to make and preserve products and raw material. I now have a job because of the project. My life has changed, and now I can offer my children a future."*

DOMAIN: EDUCATION

## CASE STUDY: CAMBODIA

**BACKGROUND INFORMATION**

**Project Name:** Mith Samlanh/Friends International: Restaurant and Hospitality Skills Training towards Sustainable Reintegration of Former Street Youth

**City/Country:** Phnom Penh, Cambodia

**Contact Details Including Contact Person:** Sebastien Marot, 215, Street 13, Sangkat Chey Chumneas Khan, Daun Penh, Phnom Penh, Cambodia
Postal Address: PO Box 588, Phnom Penh
Tel: 855 23 220596; Tel. & Fax: 855 23 426 748; E-mail: friends@everyday.com.kh

**Website**: www.streetfriends.org

**Project Status:** Ongoing since 1994

**Funding Source:** Friends International

**Years of Operation:** 14 years since 1994

**Target Group:** Drug-dependent children who are living and working on the street

### Issue That Has Been Dealt with in the Case Study:

Education, vocational training, and employment for drug-dependent street children

### Project Background:

Friends International founded Mith Samlanh in 1994. The Cambodian organization offers several services at its centre and in the community for street children, such as, providing: cultural activities for children; innovative education material; and vocational training.

### Objectives:

The objective is to offer vocational skills training opportunities for drug-dependent street youth. In order to promote sustainability, restaurants were established to provide jobs for youth who have been trained in hospitality services.

### Process/Activities:

- The restaurant and hospitality services training were launched in February 2001. A curriculum was designed, and a location was

identified to provide training. After that, students were identified to attend the programme.

- The students received training in cooking and hospitality services.
- The agency established a few restaurants. First, the trainees learnt to prepare lunch for all children admitted to studies. Second, a small business canteen was established. Third, a restaurant was opened called Friends. It offered Asian-Western fusion flavour. In 2003, a fast-food restaurant named Popzone, which specializes in Cambodian cuisine, replaced the canteen project. Romdeng, an upscale Cambodian-cuisine restaurant, then replaced this project in 2005.
- The trainees are given opportunities to gain firsthand experience in the hospitality business. They learn how to serve customers, take orders, cook, and maintain good hygiene. Thirty-six students in the Tapas restaurant, and 27 in the Khmer restaurant are trained on a regular basis.
- Since 2003, a French restaurant called Cafe du Centre has been established to generate income.

**Lessons Learned:**

- Since the trainees have been given opportunities to work in the restaurants, the quality of training has improved tremendously. The result is a dramatic reduction in dropouts, and increased employability of graduates.
- Based on the needs of the children and also market research conducted, a new laundry workshop was opened in June 2006.

**Outcome/Achievements:**

- Until 2006, more than 100 individuals have received hospitality services training.
- Seventy-four youths have been employed, representing a 90% success rate in student placement.
- Other youths have stabilized their lifestyle and are reintegrated into society.
- The government has recognized the Mith Samlanh/Friends International training programme and its approach. As a result, an official from the Ministry of Social Affairs signs diplomas given to the graduates.
- The curriculum is designed as a modular system that allows students to advance at their own pace while being regularly monitored by teachers.
- Profit from the restaurants contributes significantly to the other activities of Mith Samlanh. Through regular revenues, the project has become self-sustaining.

**Challenges:**

- An ongoing issue is the inability to find qualified teachers for the students.
- The centre's clients were having difficulty in handling personal issues. Therefore, a team was created at the centre to provide client support.
- Fair pricing was a potential threat (i.e., having a price structure similar to other restaurants). Placing some of the trainees in other restaurants also helped in maintaining good relationship with other restaurant owners.
- Mith Samlanh faced the possibility of having to move from its current location, an ideal location to conduct programmes for street children. The funds available from the business enterprises and a loan received from the bank were used towards the purchase of land. Fund raising activities were also conducted.

**Cultural or Situational Issues Related to This Project:**

Cambodia is one of the poorest countries in the world, and available resources are very limited. The project provides children with cultural and entertainment activities that allow their personal expression and growth. A team of teachers organises workshops that include dance, singing, painting, theatre, and sports. Children regularly organise shows and exhibitions for their peers and a wider audience.

**Evaluative Data Available Related to the Project:**

In 2006, 468 students were trained in the vocational training centre. Two hundred and five students graduated and received the diploma from Mith Samlanh and the Ministry of Social Affairs, Veterans and Youth Rehabilitation. One hundred and ninety-nine students have been placed in employment; of these, 59 are girls.

**Key Findings:**

Learning from experience, the centre has successfully initiated 10 types of vocational training programmes, and developed full-fledged businesses. Other vocations providing training are: beautician; car mechanics; tailoring; electronic equipment repair; welding; electrician, and farming. Roughly around 350 trainees have enrolled.

***Testimonial***

*I am Chai, and I am 19 years old. I started living on the streets when I was 17. I come from a middle-class family. My mother was very good to me, and my father, who led the family, unfortunately, died in a traffic accident. Things changed when my mother took a second husband who was as cunning as a fox. But, mother loved him very much, and they had a good life together.*

*One day, when my mother's husband was drunk, he raped me. Later, he tried to rape me again, so I decided to run away. I went to live on the streets and quickly made new friends who introduced me to Yama (methamphetamine) that helped me to be happy for a short while. I kept using and my new friends, who had been good to me, started treating me badly.*

*Fortunately, on the streets, I met a social worker who introduced me to Mith Samlanh services, a drop-in centre for drug users. I met many new friends there with the same problems. I was supported in preparing a plan for my future, which I'd never done before. I decided to enter a drug treatment programme to get clean.*

*After treatment, I learned to sew at the training centre. I was very happy because I found many good new friends. The new environment helped me to make a new life without returning to drugs. My life is good with my new job, money, and good friends.*

Chai, supported by the human and social capital she had already accumulated in her family circle before the death of her father, was able to stop drug use. Initially, this gave her the strength to escape an abusive situation. However, as a runaway she became part of the vulnerable population of street youth. But, as a result of meeting a social worker on the streets, she was able to enter drug treatment. She also learned a new skill that provided her with income. In effect, the services offered at *Mith Samlanh* enabled Chai to add significantly to her social capital by making new friends, while acquiring financial capital through sewing. This result was affected through using the organizing principle of recovery capital within the multipronged framework of Sustainable Livelihoods.

**DOMAIN: CULTURAL SUPPORT**

**CASE STUDY: ALKALI LAKE COMMUNITY STORY, CANADA**

**BACKGROUND INFORMATION**

**Project Name:** Alkali Lake Community Story (Aboriginal healing movement in Canada)

**City/Country:** British Columbia, Canada

**Contact Details Including Contact Person:** Edna Robbins, Executive Assistant, Esketemc First Nation, P.O. Box 4479, Williams Lake, British Columbia, V2G 2V5, Canada

Tel: 250-440-5611, Fax: 250-440-5721; E-mail: alib5@wlake.com

**Website**: http://www.aboriginalcanada.gc.ca, http://www.esketemc.ca/start.htm, http://www.aboriginalcanada.gc.ca/acp/site.nsf/en/ao26134.html

**Project Status:** Ongoing, since 1975

**Funding Source:** No information available

**Years of Operation:** 32 years

**Target Group:** The Shuswap Tribe

**Issue That Has Been Dealt with in the Case Study:**

Recovery supported by the traditions and culture of the community

**Project Background:**

Alkali Lake is a Native Reserve in British Columbia, Canada. Alcohol dependence was a major problem on the reserve and every man, woman, and child was seriously affected by it. With alcoholism, came poverty, hunger, sickness, and physical and sexual abuse. The Shuswap tribal community in Alkali Lake was plagued by alcohol dependence until two local tribal members made a commitment in 1972 to stop alcohol use and to address the alcohol dependence that affected their community.

**Objectives:**

The aim is to work towards community healing, which is considered as moving individuals, families, and communities into a state of optimum well-being and prosperity.

**Process/Activities:**

Some community members managed to stop drinking and maintain a non-drinking lifestyle. They became an example of positive role modeling and it was attractive for others to follow.

One of them, by then chief of the reserve, used his formal leadership capacity to start a core group of non-drinking community members. Some of the initiatives introduced were:

- Banning bootlegging;
- Giving welfare money in the form of vouchers, not cash, which could be exchanged for food or other necessities;
- Giving persons who committed alcohol-related crimes, such as drunk driving and assault, the choice to go for treatment instead of prison/jail; and
- Creating a safe place (i.e., a caring environment) within the larger community.

This approach led to having a group of people in the community who mutually supported one another in their recovery process. The group gradually developed new and healthier ways of relating to each other, and new approaches to pursuing the goals of a successful life. They created a social space for others to move into when they wanted to make the shift.

**Lessons Learned:**

Through sharing their story, the people of Alkali Lake Community helped other communities deal with similar issues. One of the communities that benefited is Hollow Water, Manitoba.

**Outcome/Achievements:**

Initiating an incentives-and-opportunities-chain provided the support needed by community members to ensure the best possible chance of succeeding in recovery. Thus, the following actions were undertaken:

- Children were taken care of while their parents were in recovery treatment.
- Their homes were cleaned up and repaired.
- A variety of economic enterprises were initiated to provide employment (e.g., a piggery, laundromat services, restaurants, and a mechanic shop.
- A strong self-help group, culturally adapted and changed to fit the community reality was available.
- Opportunities were provided for personal growth through training to help community members rebuild their internal lives.

**Challenges:**

In order for people to be able to imagine themselves living a healthier, alcohol-free life there had to be tangible opportunities and incentives that could support a new way of life. Opportunities were needed for meaningful employment, recreation, and a social life that was alcohol free. Most immediately, there had to be accessible and fairly continuous opportunities for healing, personal growth, and learning. What, in fact, was developed in Alkali Lake was a series of interconnected interventions and opportunities as well as built-in rewards and consequences that constituted a healing pathway.

**Cultural or Situational Issues Related to This Project:**

A key element in the transformation of Alkali Lake Community was the conscious decision to put spirituality at the centre of the process. This approach involved a rediscovery of native spiritual traditions and tools such as the sweat lodge, the sacred pipe, and other healing ceremonies.

**Evaluative Data Available Related to the Project:**

- By the end of 1973, less than a dozen members were non-drinking.
- By 1975, 40% of the community abstained from alcohol through treatment and community support. By 1979, that number had risen to 98%. No information could be obtained on the current situation.

**Key Findings:**

Over a period of 10 years, the community's sustained effort at achieving sobriety reduced the tribe's alcohol dependence rate from nearly 100% to less than five percent (Chelsea and Chelsea, 1985; Taylor, 1987). This kind of approach rests on the premise that personal and community sobriety flourish in a climate of family health, cultural vitality, political sovereignty, and economic security. The following anecdote describes conditions as they existed in Alkali Lake before recovery action was taken:

***Testimonial***

*"It was one day in 1972 when seven-year-old Ivy C. refused to go home with her mother, because of the severe drinking of both her parents. Her mother, Phyllis, made a decision to stop drinking. After four days, Ivy's father, Andy, also stopped drinking. They were now the only two non-drinking people in the entire community.*

*As a result of that decision, Phyllis and Andy C. decided to confront the problem of alcohol dependence in their community. Subsequently, Andy, was elected Chief of the Shuswap Tribe. He promoted AA meetings, addressed the drunkenness of public officials, and initiated interventions to motivate community members to seek treatment. Tribal traditions were revitalized for both adults and children in the community. Educational and job development programmes were initiated for those in recovery."*

**For more on this story of recovery capital, see the following website:**
*http://www.4worlds.org/4w/ssr/Partiv.htm. (Last accessed February 9, 2008.)*

This anecdote points out the importance that various aspects of the Asset Pentagon play in attaining recovery capital. Drawing on previously dormant social and spiritual capitals, in the form of returning to the teachings of their Native heritage, allowed the community in Alkali Lake to affect Wellbriety.

## DOMAIN: VOCATIONAL SKILLS TRAINING AND EMPLOYMENT

## CASE STUDY: NUREMBERG, GERMANY

### BACKGROUND INFORMATION

**Project Name:** Mudra Alternative Jugend und Drogenhilfe

**City/Country:** Nuremberg, Germany

**Contact Details Including Contact Person:** Mr. Max Hopperdietzel, Sturmstr. 6–8, 90478, Nuremberg, Germany, Tel: + 49 911 24 13 87

**Website:** www.mudra-online.de; www.mudra-arbeitsprojekte.de

**Project Status:** Ongoing since 1980

**Funding Source:** Employment Agencies, other government institutions, local governments and some private donations. Thirty to 60% of the vocational training and employment services budget is covered by selling goods and services.

**Years of Operation:** 28 years since 1980

**Target Group:** Persons in recovery from drug dependence

**Issue That Has Been Dealt with in the Case Study:** Vocational training for persons in recovery from drug dependence

**Project Background:**

Mudra, located in the South of Germany, is a vocational training centre that provides diversified and integrated treatment approaches for persons with a history of long years of drug dependence. It has been operational since 1980. In addition to vocational training, Mudra manages a street-work programme, a drop-in centre, a counselling centre, an abstinence programme, and pharmacological treatment. Clients with long years of drug dependence have had difficulties in finding jobs, and unemployment was seen as one of the major reasons for relapses.

**Objective:**

To provide vocational training for persons recovering from drug dependence, including those receiving pharmacological treatment, who need support in reintegrating into the job market

**Process/Activities:**

Some of the vocational training services available are:

- The Forest Project that is responsible for the production of firewood, various forest operations, and a carpentry workshop;
- Costume jewellery making and tailoring (since 1989) to provide jobs for women;
- The Day Labour Project (since 1994) that entails clearing out flats and houses (short-term employment that usually lasts not more than one day a week);
- The Landscaping and Gardening Project (since 1995);
- The Office Project (since 2004) that supports four commercial apprentices;
- Teaching key job skills that are useful for a variety of job settings; and
- Motivational counselling as part of vocational training.

**Lessons Learned:**

- Getting a job helps clients to build self-confidence and recovery capital.
- Work has to be challenging but easy to learn. Work that brings visible results, such as chopping a huge stack of firewood or making some nice costume jewellery, enhances motivation and increases continuation rates.
- Even after many years of drug dependence, most clients can do hard physical work. They also enjoy the feeling of being tired at the end of the day as a result of their work.
- Networking with other institutions, such as employment agencies, plays a major role in sustaining the project.
- It is a good idea to consider vocational training and job projects as part of the continuum of care services needed to support clients in recovering from drug dependence.

**Outcome/Achievements:**

The office project, which is recognized by the government, provided commercial apprenticeship for two years. Usually, three apprentices are provided work experiences after inpatient treatment.

**Challenges:**

- It is difficult for clients to enter the job market, partly due to the overall situation on the labour market. Besides recovering from drug dependence, many have other health problems such as Hepatitis C, or legal problems such as criminal records. Therefore, training has to be especially well tailored to the needs of young persons in recovery.
- Clients who are HIV+ find it difficult to do hard physical labour.
- Relapse is common in the process of rehabilitation. In case of relapses, wherein the client is unable to function, he or she is discharged from the centre with a clear message that the door is always open.

**Cultural or Situational Issues Related to This Project:**

None has been noted.

**Evaluative Data Available Related to the Project:**

A small study conducted at Mudra documents that health-related costs for insurance companies decreased during and after employment in the programme.

**Key Findings:**

- Forty to 50% of clients are immigrants; 75% are male, and 70% use either methadone or buprenorphine in their pharmacological treatment.
- Twenty clients who were long-time drug users use the forestry services. Some have been doing so for more than 30 years, as well as some young persons with no education or job experience. Participants must be relatively clean or be in pharmacological treatment, and be capable of doing physical work. The average age of clients is 30–35; few are under 18 or above 50 years of age.
- Seven women made costume jewellery, did tailoring, and cleaning services.
- Clients who are capable of doing physical labour do manual work.
- Approximately 20 younger clients from in-patient therapy on apprenticeship training do landscaping and gardening work.

> ***Testimonial***
>
> *Michael had been heroin dependent for over 25 years. Repeated attempts to provide pharmacological treatment with methadone were unsuccessful. After brief periods of abstinence following treatment, he always returned to using heroin.*
>
> *For many months, Michael had sought to enrol in an employment programme at Mudra, a drug dependence treatment organization in Nuremberg, Germany. This programme provides a livelihood for persons in substitution treatment through their participation in one of the Mudra work projects. In Michael's case, it was the Forest Project. The work involves cutting down trees in coordination with the local forest administration, and producing firewood for sale.*
>
> *The director of the Mudra programme had been repeatedly warned not to hire Michael based on his history of repeated failures in treatment and return to active drug use. But the director decided to give Michael a chance to recover. To everyone's surprise, Michael did very well. He went to work every day and remained in pharmacological treatment. Michael told the staff at Mudra that he had been raised on a farm and loved working outdoors.*
>
> *Michael had a criminal charge pending, and when he appeared in court, the staff from Mudra testified about how well he was doing, and requested that he be spared a prison sentence. Unfortunately, the judge sentenced him to four months in jail. Nevertheless, Michael assured the Mudra staff that he would serve his term, remain off all drugs, and return to work when released. That is exactly what he did, and he is still doing well.*

Michael's story shows the importance of diversified treatment approaches in building recovery capital. Namely, it is helpful to focus not only on individual strengths and goals that can support the recovery of those seeking rehabilitation and social reintegration, but also on the ranges of capital that may already be part of their repertoire. In Michael's case, he was encouraged to draw on his already existing spiritual and physical capital—his love for outdoor activities. This preference, together with his desire for a job that connected him with nature, was crucial to his success in recovery. The current social capital that he built up with the Mudra staff was another aspect of support that enabled him to remain drug free.

## DOMAIN: SPECIAL EMPLOYMENT PROGRAMME FOR AT-RISK YOUTH

## CASE STUDY: HONDURAS, CENTRAL AMERICA

### BACKGROUND INFORMATION

**Project Name:** Special Employment Program for Unemployed Youth Without Professional Training, and at Risk of Psychosocial Disintegration in Honduras

**City/Country:** Tegucigalpa, Honduras, Central America

**Contact Details Including Contact Person:** Ms Marlene Zacapa, Project Coordinator HON/H88, United Nations Office on Drugs and Crime, Mexico

**Website:** http://www.unodc.org/mexico/index.html

**Project Status:** Ongoing since 2004; first phase closed

**Funding Source and In-Kind Contributions:** United Nations Office on Drugs and Crime (ONUDD); National Anti- Drug Council of Honduras (CNCN); Municipality of Tegucigalpa (AMDC); Honduran Institute for Professional Training (INFOP); Honduran Institute to Prevent Alcoholism and Drug Dependence (IHADFA); a local NGO

**Years of Operation:** 3 years, November 2004–October 2007

**Target Group:** At-risk youth with problems of substance dependence and delinquency

### Issue That Has Been Dealt with in the Case Study:

Reintegration of at-risk youth and former drug dependent persons into special employment programmes in Honduras

### Project Background:

The partners of this cooperative pilot project were the central government, the municipality, the civil society, private enterprises and UNODC (project AD/HON/04/H88). An inter-institutional technical council was established for the coordination of the activities, along with financial assistance from UNODC. A social and labour integration office was established in February 2005 by the project and within the structure of the Municipality's (Mayor's) office as part of the project's log frame and work plan.

### Objectives:

The general objective of this programme was to promote the inclusion of social and labour integration initiatives into the political youth and employment strategies in Central America. The more specific project objectives were to a) validate a model of special employment programmes

for the integration of unemployed and at-risk youth into the labour market, and b) identify the means necessary to integrate such types of programmes into the political strategies at the municipality level.

**Process/Activities:**

The main project activities were:

- **The identification and assessment of youth to participate in the project.** The youths who were selected as beneficiaries of the programme were awarded scholarships and given school supplies and uniforms. Psychosocial support was provided.
- **Training activities.** Seven one-year professional training courses were initiated. Training workshops were set up to provide training in car painting, air conditioning and refrigeration, bartending and restaurant services, carpentry, cooking, graphic design, and working as an electrician. At the end of the course, certification was awarded by the Honduran Institute of Professional Training, one of the participating institutions. Education about alcohol and drug abuse was provided as part of the "Formation on Values" component.
- **Integration into the labour market.** The social and labour insertion office of the Municipality of Tegucigalpa established contacts with private companies and organizations for the integration of the beneficiaries at the end of the training period.

**Lessons Learned:**

- Inter-institutional agreements between organisations that work towards the same goal have created an environment of mutual collaboration and sustainability.
- The staff does not only need technical expertise, but also dedication and commitment to work with marginalized populations as well as a good knowledge of their living environment and realities.
- The social and labour integration of youth at risk initiative through the establishment of local labour offices is an experience worth repeating in other municipalities, but more cooperative agreements with the private sector would make the programme more effective.
- To be effective and efficient, projects of this type need to address different levels of intervention, such as with youth, families, and communities.
- The integration of health and drug dependence status, if included in the psychosocial assessment, would address the problem of co-occurring diseases.
- Mainstreaming education on values has been successful and, therefore, needs to be systematized.
- It is necessary to provide an alternative choice for those youth interested in professional training, but who did not fulfill the entry requirements of a completed primary education. Otherwise, these

youth might be at especially high risk for delinquency and drug dependence.

**Outcome/Achievements:**

- The project's first phase ended in December 2007. A second phase is planned.
- One hundred and nine young persons between 15 and 20 years of age were trained by the project. Seventy-nine of them have entered the labour force already. Five are in the process of entering employment. The rest have not entered the work market as yet for a number of reasons: Some are furthering their education, others have entered the military service, and some had personal problems.
- Five institutions participated in the project and made satisfactory contributions.
- The employment agency that was created by the project offers services not only to the young project beneficiaries, but also to the broader population in need of this type of support. Three hundred persons were assisted in 2007.
- A training curriculum was developed that could be shared with others who are developing similar initiatives in this area.
- Establishing strategies for the expansion of the project in the region is envisioned.

**Challenges:**

- The inter-institutional collaboration was sometimes challenging, especially due to changes in political institutions.
- Some young persons were already earning an income in the informal labour market. But, upon entering the programme they had to give up their source of income. Therefore, some families wanted their children to leave the programme.
- The programme budget did not allow for capacity building for more young people.
- The difficult living circumstances of the youth made it hard at times for them to comply with course requirements.

**Cultural or Situational Issues Related to This Project:**

In Honduras, 30.4% of the economically active population is either underemployed or unemployed. There are 745,500 people without sufficient employment. The population of Honduras is young, with 41.6% being under 15 years of age.

The three neighbourhoods of Tegucigalpa in which the project took place are known for high population density, lack of public infrastructure services, poverty, juvenile delinquency groups or *maras* (gangs), crime and drug consumption. Therefore, they are at high risk of social disintegration.

**Evaluative Data Available Related to the Project:**

- A project evaluation/systematization report was published in October 2007 ("La inserción laboral a partir de la formación técnica vocacional de jóvenes en riesgo social").
- The project has trained 109 young people, 9 more than was originally envisaged. Thirty-seven percent of the participants were female and 63% were male.
- Graphic design, cooking and training to be an electrician were the most popular courses.
- Social reintegration initiatives have been included into labour and youth politics.
- Because of missing data, acquiring information about the level of the national labour market needs and developments was problematic.
- Data collection, monitoring, evaluation, and follow-up could be improved.

**Key Findings:**

- The project gained strength and sustainability through working collaboratively with the inter-institutional technical council established by the project. Some form of professional and institutional development could be seen as a secondary outcome of the project. Forms of co-financing are currently being explored.
- The close cooperation with the community and its institutions has helped to achieve project goals.
- A second chance to acquire professional training and social and labour integration seems to reduce risks for social disintegration of the direct beneficiary. This initiative also helped families to increase their income through having a member in their household with marketable job skills.
- There is a need for continuing programmes for youth, especially for those in this at-risk target group.

***Testimonial***

*Denis is 18 years old and lives in Colonia Nueva Suyapa. He is married and father of a four-month-old daughter. His wife is not employed. Before entering the project, Denis did not work, did not study, and basically "did nothing." He was dependent on financial support from his grandmother, until she died in November 2006.*

*Denis learned about the course through a friend who also participated. He decided to take part in professional training to qualify himself for employment in the hospitality services sector. The project supported him in many ways: he earned a scholarship, and was given a uniform and materials. Denis now works in a hotel in the city where, he says, "he has good working hours and a good working atmosphere."*

*He states that the course has helped him a lot, because, without the project, he would not be working at all. He has a minimum wage salary, which is not much, but at least he has enough to respond to his and his family's basic needs. Denis feels content and likes working with people. His days of unhappiness and agony are gone.*

Denis' access to financial capital ended with his grandmother's death. However, drawing on his social capital, in the form of a friend who told him about the course, he was able to develop financial capital in the form of a job, and provide for himself and family. He also developed a sense of meaning and purpose in his life; "his days of … agony are gone."

***Testimonial***

*My name is Cecia Patricia Mejia and I am 20 years old. I live in Colonia Villa Nueva, and finished the sixth grade at school. There are seven persons in my family. Before I entered the project, I was at home and took care of my nephews. I entered the project through a friend who was already enrolled in it. I thought that the project would be very good; so I went. Later, they asked for my papers and said I should come to the training centre for an interview; and then they called me.*

*I chose cooking because I like it; we also did a pastry and baking course, which were great. The cooking classes were also great, because, thanks to the course, many doors opened for me. Participating in the project and talking with the psychologist helped me to feel more self-assured.*

*They took us to youth meetings, and we had a lot of fun being with the others. They also talked with us about drugs. Later, we did our cooking internships. I did mine at the Hotel Honduras Maya, and it was a very good experience. I like the way we were treated—with friendliness and respect.*

*After my internship, I found work and I feel very happy now because, thanks to the project, I have changed in many ways. For example, in the meetings with the psychologist I felt that I could achieve things for myself. I would like to be a better cook or a well-known chef; be able to work to help my mother and move on and stand out; be happy to see and feel I am useful for something; and to be better every day—a better person and a better daughter.*

Like Denis, Cecia drew on her social capital in the form of a friend who was already enrolled in the project. Prior to taking cooking classes, Cecia took care of her nephews. But after completing her course and her internship, she began to notice that "many doors opened for [her]."

Cecia was able to add several of the domains of recovery capital to her repertoire of assets capital: developing a vocation skill; obtaining employment; and developing her own meaning and purpose in life.

## DOMAIN: FAMILY THERAPY PROGRAMME AND VOCATIONAL TRAINING

## CASE STUDY: CHENAI, INDIA

### BACKGROUND INFORMATION

**Project Name:** Family Therapy Programme of the TT Ranganathan Clinical Research Foundation and TEJAS Vocational Training Centre

**City/Country:** Chennai, India

**Contact Details Including Contact Person:** Dr. Shanthi Ranganathan, Honorary Secretary,TT Ranganathan Clinical Research Foundation , TTK Hospital, IV Main Road, Indira Nagar, Chennai 600020, India

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**Website**: www.addictionindia.org

**Project Status:** Ongoing, since 1985

**Funding Source:** Self-funded

**Years of Operation:** Family therapy programme since 1985, and Vocational training since 1999

**Target Group:** Wives and parents of drug-dependent persons

**Issues That Have Been Dealt with in the Case Study:**

Family programme for the wives and parents of drug-dependent persons; vocational training for some women; and helping families to recover and become functional through family therapy

**Project Background:**

TT Ranganathan Clinical Research Foundation (also known as TTK Hospital) started their primary care treatment programme for drug-dependent individuals in 1982. The families who accompanied clients for treatment were deeply affected emotionally and economically through the drug dependence of their family member, especially in the case of relapses. Recognizing the fact that relationship with the family is an essential element in recovery, in 1985, TTK Hospital developed and initiated an exclusive two-week programme for families. One family member must attend this free programme, which was designed with the twin purposes of helping families to get out of their problems and become functional while, at the same time, developing their preparedness to support the patient in recovery.
At some point, the centre felt the need to equip some family members with a vocational skill leading to economic and social rehabilitation. TEJAS Vocational Training Centre was set up at the TTK Hospital in 1999 with support from Deutscher Orden and the European Commission. *Tejas*, which means "brightness" in Sanskrit, offers a safe and supportive environment for family members to acquire training in a vocational skill.

**Objectives:**

- To provide information about drug dependence and its effects on the family system;
- To provide a safe and acceptable environment for families to express their feelings and to discuss their issues;
- To enable families to recognize and grow out of their dysfunctional coping behaviour and negative personality traits; and
- To provide opportunities for some of the women to acquire a vocational skill that leads to economic empowerment.

**Process/Activities:**

In the family therapy programme, the day starts with the serenity prayer and a meaningful story conveying a thought for the day. This approach gives families an opportunity to reflect on and share their feelings about the thought. This is followed by input sessions that provide information about drug dependence and practical coping methods. Trained counsellors provide group therapy and individual counselling. Al-Anon meetings are also held twice a week at the premises to enable mutual assistance in handling problems.

On completion of the two-week programme, family members who are looking for vocational skills training to earn a livelihood join TEJAS to learn tailoring. Tailoring was identified as a viable vocation skill because of market demand. It is also easy to learn, and entrepreneurship is possible with a small investment.

Contact was made with potential buyers. A ready market was found in industrial areas in the form of cooking contractors who would place orders for bags. Once training was completed, small loans were made available to those interested in buying tailoring machines to work on their own; others would take orders from the centre and work from their homes. Some persons in recovery and their families continue to work in the unit and earn a stable income.

**Lessons Learned:**

- The centre found that family therapy, including learning a vocational skill, empowers families, which is the ultimate gain.
- By learning tailoring skills, family members are able to be economically independent and take care of their children in spite of their spouses' repeated relapses. This has also contributed to the strengthening of self-confidence in family members.
- Many women have established their own small tailoring units in their homes, and are able to manage their families' needs with the income earned.

**Outcome/Achievements:**

- The family therapy, and vocational training units were initially functioning in a very small area. At that time, a former client, who has been sober for more than 15 years, donated a wing (to show his gratitude) to establish the vocational centre.
- The TT Ranganathan Clinical Research Foundation now enjoys greater recognition due to the popularity of their products.

**Challenges:**

- Initially, the organisation's management was sceptical about the ability of the women to make jute bags, because this was the first time they had worked in this capacity.
- Since they were promoting jute bags in place of polythene ones for the first time, they were not too sure about the marketability of their new products.

**Cultural or Situational Issues Related to This Project:**

During weddings and other auspicious occasions, it is customary in South India to give betel leaves and coconut in polythene bags to invitees. On these occasions, generally, 500 to 2000 bags are ordered. In Tamil Nadu, the government banned the production of polythene bags. At that juncture, the tailoring unit came up with eco-friendly jute bags that found a niche in the open market. Now the unit attracts regular orders for bags used during weddings and conferences. Other items produced in the unit are industrial uniforms, fancy silk, cotton, and jute bags that are given as gifts on special occasions.

Almost all the family members of recovering users are women. Many would have had minimal education and no vocational skills and, thus, would never have had gainful employment. This programme allows women to be self-reliant. Also, since it is a women-only environment, women feel comfortable and have developed a sense of fellowship among themselves.

**Evaluative Data Available Related to the Project:**

The TATA Institute of Social Sciences in Mumbai conducted an evaluation of the family programme to assess its effectiveness through individual interviews and focus group discussions. Families whose dependent partners had not recovered were also interviewed.

The number of beneficiaries who attended the two-week programme in the last five years is around 3,026, with the majority being wives. Around 90 women in the age group between 25–40 years, many of whom had never worked before, were trained as tailors.

**Key Findings:**

- A dramatic improvement in the health status of family members;
- Awareness of family members about their dysfunctional and enabling behaviour leading to a paradigm shift in their lives;
- Improved harmony in family life; and
- Incorporation of a planned pattern of living and effective use of leisure time.

As part of the funding procedure, Deutscher Orden and the European Commission conducted an evaluation of the TEJAS project.

***Testimonial***

***Anu's*** *husband had been alcohol dependent for the past 20 years. After several months of persuasion, she was able to take him to the TTK Hospital for treatment. When Anu was told that she had to attend the family programme as well, she was visibly upset and responded, "It is only my husband who drinks without control. You treat him and set him right. I don't need to attend any programme." The counsellor spent time with her and made her understand the benefits she would derive by attending the programme. A few other family members who were already in therapy shared their experiences with her. Finally, she reluctantly agreed to participate in the programme.*

*After treatment, Anu went home and attended follow-up sessions with her husband. She was looking different; she was no longer the angry, confused and desperate Anu from before. She met her counsellor and said, "It was beyond my understanding then how profoundly treatment was going to help me. Initially, I found it excruciating to share my feelings in group therapy with people I'd never seen before, or to listen to their problems. Yet, it was in this group that I learned how to manage."*

*Through her counsellor, Anu came to know about the availability of free training in tailoring for family members of recovering drug-dependent persons. Since she was very comfortable in the environment, she opted for training in tailoring. She also regularly attended Al-anon meetings conducted at the centre for families, and worked towards her own recovery.*

Once Anu was persuaded to enter into treatment along with her alcohol-dependent husband, she built social capital through sharing feelings with others in group therapy. As a result, she was able to learn coping skills, and acquire a vocational skill that added to her recovery capital. In this way, she was able to effect a profound change in her own life and that of her family.

**DOMAIN: VOCATIONAL SKILLS TRAINING AND EMPLOYMENT**

**CASE STUDY: ABEOKUTA, NIGERIA**

**BACKGROUND INFORMATION**

**Project Name:** Dater Unit, Aro Neuro Psychiatric Hospital

**City/Country:** Abeokuta, Nigeria

**Contact Details Including Contact Person:** Dr. T.A. Adamson, Provost and Medical Director, Neuropsychiatric Hospital, P.M.B. 2002, Abeokuta, Ogun State. Nigeria.

Tel.: +234-803-3081461/+234-39-240571
E-mail: adamson@hyperia.com

**Website**: None, at present

**Project Status:** Ongoing since 2004

**Funding Source:** The federal government (75%); clients/relatives (25%)

**Years of Operation:** Three

**Target Group:** Drug-dependent persons seeking treatment and rehabilitation

**Issue That Has Been Dealt with in the Case Study:**

Treatment and vocational training for drug-dependent persons

**Project Background:**

The Drug Abuse Treatment, Education, and Research Centre (DATER) is a 32-bed unit with occupational and vocational facilities. It is located on the premises of the Neuropsychiatric Hospital, Abeokuta, Nigeria. DATER was established in 1983 for the treatment and rehabilitation of drug-dependent persons. In 2004, a vocational rehabilitation unit was established at the Centre with equipment donated by UNODC. Since the establishment of this unit, DATER has been offering a formal vocational training programme in a hospital-based treatment setting as part of its treatment package.

**Objectives:**

The aim of the programme is to provide treatment for drug-dependent persons, and to equip them with different vocational skills.

**Process/Activities:**

- Family members bring clients to the centre for treatment.
- Treatment is provided at DATER for 12 weeks. This process consists of drug education sessions; individual, group, and family therapy; and a 12-step programme (AA/NA). Follow-up is provided for two years.
- A three-month vocational training in computer appreciation, tailoring, hairdressing, and barbering is offered.
- Vocational training runs concurrently with treatment programmes.
- Qualified persons are assisted to obtain jobs appropriate to their skillsets.

**Lessons Learned:**

The centre can further achieve its objectives by sharing experiences and exchanging resources with other centres.

**Outcome/Achievements:**

- Dater Unit, Aro Neuropsychiatric Hospital is the first modern drug treatment centre in the country.
- The centre specializes in the management of patients with dual diagnoses.
- It is also a main centre for providing specialized training in alcohol and drug dependence treatment.

**Challenges:**

The centre is looking into ways of improving its vocational training facilities. To further improve its services, the centre is also in the process of developing a treatment evaluation programme.

**Cultural or Situational Issues Related to This Project:**

- Patients are admitted to Dater Unit, Aro Neuro Psychiatric Hospital from every part of the country.

- It is also the coordinating centre for the proposed National Network of Drug Abuse Treatment and Rehabilitation Resource Centres.

**Evaluative Data Available Related to the Project:**

On average, 21 drug dependent persons are admitted to the centre every year. Most of them are male (95%), single (80%) and their mean age is 32.4 years (range 17–52 years). About half of the persons admitted have had, or are currently enrolled in, post-secondary education. Only a quarter of them was employed at the time of admission. The mean length of stay on admission is 23 weeks, with about 70% of them staying for at least a minimum of 12 weeks, which is the time needed to complete the treatment programme.

**Key Findings:**

Of the 47 patients who completed the centre's treatment programme between 2005 and 2007, only nine were readmitted during that period.

***Testimonial***

*Many of the centre's ex-patients have been able to sustain their recovery. Some of them have been invited back to the centre as motivational speakers for the benefit of those currently in treatment.*

*In addition to benefiting from the centre's vocational training programme, some of these ex-patients have gone ahead to develop themselves educationally, while some have benefited from tremendous social support. For example, following discharge from the centre, two ex-patients had attended a vocational training centre owned and managed by a Christian religious organization and have since been very involved in the activities of the religious group. One of them is now employed by the religious group, while the other is self-employed.*

Participants in the programme run by the Drug Abuse Treatment, Education and Research Centre drew on their existing social capital in the form of their family support system. The centre's vocational training programme provided them the opportunity, while seeking treatment, to expand their domains of recovery capital by developing a vocational skill, which led to them obtaining employment and (re)developing meaning and purpose in life. Many of the graduates of the programme who sustain their recovery return as motivational speakers to encourage those currently in treatment.

## DOMAIN: LEGAL SUPPORT

## CASE STUDY: THE PROVINCES OF ALICANTE, CASTELLON, AND VALENCIA, SPAIN

**BACKGROUND INFORMATION**

**Project Name:** Support Units for People with drug problems/drug dependent persons in Courts and Police Stations

**City/Country:** The provinces of Alicante, Castellon, and Valencia, Spain

**Contact Details Including Contact Person:** Snr. Miguel Castellano Gómez Paseo de la Alameda, 16, 46010, Valencia, Spain

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**Website**: www.gva.es

**Project Status:** Ongoing since 1997

**Funding Source:** Ninety percent comes from the national government, and 10% comes from regional authorities.

**Years of Operation:** 10 years since 1997

**Target Group:** Drug-dependent persons in the criminal justice settings, namely, courts, detention centres and police stations

### Issue That Has Been Dealt with in the Case Study:

Providing services to drug dependent persons in courts, prisons, and police stations

### Project Background:

The programme was initiated to provide support units for drug dependent persons in courts, prisons and police stations. Concurrently, it intends to help the court system apply the most suitable security measures to persons with legal problems due to drug dependence. Its aim is also to ensure that drug dependent persons' living circumstances play a relevant role in their legal proceedings. This approach can lead to a reduction in the charges and the adoption of alternatives to imprisonment, which, in turn, enhances the possibility of social mainstreaming.

The organisations involved in this programme are:

- Asociación AVANT (Padres y Familiares para la Lucha contra la Drogodependencia): NGO/Voluntary organisation;
- Asociación para la Prevención, Asesoramiento, Tratamiento e Investigación en Temas de Marginación y Drogas (P.A.T.I.M.): NGO/Voluntary organisation; and
- Asociación Provincial Alicantina de ayuda al Drogodependiente (APRALAD): NGO/Voluntary organization

**Objectives:**

The goal is to enforce the law while bearing in mind persons' drug dependence, and their social environment and conditions, to be able to objectively and judiciously apply the most appropriate alternative measure in each case. The belief being that, most of the time, if drug dependence is treated, criminal behaviour disappears.

**Process/Activities:**

- Counselling drug users arrested for offences relating to their drug dependence;
- Providing an alternative to imprisonment by admission into treatment centres and providing follow-up;
- Sensitizing the judicial bodies about the psychosocial situation, diagnosis, treatment guidelines, prognosis, and follow-up in connection with each case;
- Assessing clients regarding drug-related problems; and
- Referring clients for medical, methadone maintenance or conventional treatment.

**Lessons Learned:**

- Many drug dependent persons are engaged in criminal behaviour to support their dependence. Sixty-seven percent of the offences were related to property, and 12% related to public health.
- Individualized treatment significantly lowers drug-dependence-related offences.
- Sensitizing law enforcement officials and providing direct assistance to arrested drug-dependent persons help in achieving the above-stated objectives.

**Outcome/Achievements:**

- One thousand and twenty-four clients received treatment in various centres in 2002; of these, 523 did so for the first time.
- Assistance was given to 324 clients to reduce their penal liability.
- Alternatives to imprisonment were offered to 153 clients.

- Two thousand eight hundred and sixty persons were either initiated or continued treatment in 2002. Of these, 829 did so for the first time, and 1,273 used follow-up support.
- Since 1997, specific units (UVADS–Drug addiction evaluation and support units) have been created in the central police court and detention centres in three provincial capitals.

**Challenges:**

It was realized that professionals working in the field of drug dependence had no knowledge of legal issues as it applied to their clients. Thus, it became necessary to provide seminars and conferences geared to informing them about relevant legal, judicial, and technical aspects. Conversely, police officers, particularly community police, had no knowledge of issues related to drug dependence. So, basic training courses on drug dependence, particularly for the "community police", were provided.

**Cultural or Situational Issues Related to This Project:**

Though it has taken the better part of 10 years, there has been a major shift in how persons in the legal system now view persons with drug dependence issues. They are no longer seen as delinquents and transmitters of diseases, but as persons in need of support to recover their health and lives.

**Evaluative Data Available Related to the Project:**

Many drug dependent persons engage in marginal or criminal behaviour to support their habit. The programme catered to 3,884 patients. In our sample, 67% of the offences were against property, 12% against public health, and 11% against persons.

Global and individualized treatment, according to different patient needs, significantly lowers drug-related offences. Intervention was provided in over 2,130 cases. The most prominent types of intervention included: information guidance (32%); follow-up reports (28%); legal counsel (18%); and expert reports (10%).

In 2002, 2860 persons were visited, including 829 for the first time; 12.18% of these were referred to conventional treatment centres. This would not be possible without the appropriate training for and co-ordination among the various professionals taking part in the process. In addition to co-ordination meetings, seminars and conferences were organized for the various communities of people concerned.

**Key Findings:**

The above-mentioned cross-pollination of knowledge domains between professionals working in the field of drug dependence and community police

has proved helpful in contributing to providing the best possible community services for drug-dependent persons.

**DOMAIN: PEER-BASED SUPPORT**

**CASE STUDY: FAYETTE COMPANIES, PEORIA, ILLINOIS, USA**

**BACKGROUND INFORMATION**

**Project Name:** Recovery Coaching and Personal Recovery Planning

**City/Country:** Peoria, Illinois, USA

**Contact Details Including Contact Person:** Michael Boyle, President; David Loveland, Director of Research

Tel: 309-671-8005; Fax: 309-671-8021

**Websites**: www.bhrm.org; www.fayettecompanies.org

**Project Status:** Ongoing

**Funding Source:** Illinois Division of Alcoholism and Substance Abuse

**Years of Operation:** Since 2004

**Target Group:** Drug-dependent women in any setting (e.g., residential treatment, jail, on-the-job, in a shelter, community, or home)

**Issue That Has Been Dealt with in the Case Study:**

Recovery coaching and personal recovery planning for women

**Project Background:**

Recovery coaching services is a voluntary, peer-based intervention programme for women, coordinated with drug-dependence treatment services, but operates independently of these services. All women who have entered a drug dependence treatment programme, including detoxification services, can receive recovery coach services. Referrals to recovery coaches are made at any point during a treatment episode. For residential programmes, referrals occur mostly during the last month of treatment. Recovery coach services are provided to women in any setting (e.g., residential treatment, jail, on-the-job, or in a shelter), but most of the contacts and activities occur in the community or home. Women receive recovery coach services onsite while they are in a residential treatment programme. However, most of these contacts occur in the community to help

women's transition from residential treatment (e.g., searching for housing, employment, or completing forms for entitlements). Recovery coach services are time unlimited; women have the option of receiving these services after completing the continuum of drug dependence treatment or in place of treatment for those who have left treatment against medical advice.

**Objectives:**

The objectives are to help women establish a recovery plan that they can manage and sustain over time. The intention is to help women's transition back into the community and develop a sustainable recovery plan. Therefore, the programme is designed to help women for three to six months with extended services for those who need it.

**Process/Activities:**

Fayette's three residential programmes for women provide most of the referrals to the programme. Eighty percent of the women referred to the programme receive a minimum of three face-to-face contacts with recovery coaches.

Recovery coaches contact individuals within seven days after a referral has been made while they are still in treatment. Recovery coaches use multiple techniques to keep women engaged in the programme and in the recovery process. The recovery coaches are trained in techniques, including strengths-based case management practices, behavioural technologies, and motivational interviewing. The programme is designed to:

- Help women develop a recovery plan that identifies their self-defined goals (e.g., getting a job, finding an apartment, or returning to school);
- Highlight existing assets and resources they can use to achieve their goals (e.g., work experience or vocational training, access to supportive family members, having positive personal attributes, or having some college education);
- Help them identify barriers/problems that can undermine the achievement of each goal (e.g., lack of transportation, no access to medications/medical care, unstable housing, legal problems, outstanding debt, or being anxious in social settings);
- Help women acquire needed resources in the community (e.g., affordable housing, medical care and medication, psychiatric services, transportation, food stamps, public aid, or childcare services) that can help them achieve long-term recovery; and
- Coach women on how to manage symptoms, such as panic attacks or depression, or to walk them through a relapse prevention plan.

Specific techniques used by recovery coaches include the following:

- Functional analysis to help women understand how certain behaviours occur (e.g., relapse or over eating) or do not occur (e.g., exercising or socializing without alcohol);
- Motivational interviewing to explore ambiguity over certain behaviours (e.g., pros and cons of staying in a relationship or smoking marijuana while on probation);
- Application of weekly behavioural plans that help women translate broad goals into functional and achievable steps, such as the multiple steps required for acquiring a job, meeting new friends, or finding activities that de-emphasize the use of alcohol or other drugs;
- Coping skills training to teach women how to manage certain situations (e.g., modelling and role playing a job interview, participating in an AA meeting, or being assertive with family members). Coping skills training can also involve helping women manage symptoms of anxiety, PTSD, or depression in public settings, such as during an AA meeting or on the job;
- Contingency management to reward participants for working on a recovery plan or for completing a step in a behavioural plan. Recovery coaches have access to discretionary funds to help women cover the cost of transportation (bus passes); clothing ($5.00 coupons for goodwill); food ($5.00 supermarket coupons); vocational issues (training books, notebooks, or a calculator); or basic rewards (movie tickets or restaurant coupons). Coaches can also use the fund to reward participants for maintaining contact (cover the cost of lunch or a coffee);
- Behavioural plans and steps that help women learn how to find rewarding activities that promote recovery and avoid activities that promote substance use. These plans usually involve family members or friends in the process;
- Helping women link with community mental health services and assist them in finding resources to cover the cost of psychotropic medications (Because Human Service Centre (HSC) is also the primary provider of community mental health services, women assigned to the recovery coach programme are given priority for enrolment in the mental health division at HSC.); and finally
- Using recovery coaches to help women expand their recovery support network. This process includes working with family and friends and engaging these individuals in all phases of the recovery planning process. Recovery coaches can provide family and friends with information on addiction or how to help women manage symptoms of their psychiatric disorder. Coaches can also help women connect with self-help groups and faith-based organizations.

**Lessons Learned:**

On average, women who received recovery coach services attended more days of outpatient treatment than women who did not receive these services after discharge from a residential programme. These results suggest that the Recovery Coach Programme can be used to complement existing services

and keep women engaged in treatment. Preliminary results of the programme indicate that recovery coaches have been successful at helping women acquire essential resources in the community.

**Outcome/Achievements:**

Service data from the first 18 months indicated that recovery coaches have approximately three to five contacts a month with women in the programme (range 1 to 15). Total contact time averages 1 to 1.5 hours/month. Monthly contact rates remain fairly constant over time while women are enrolled in the programme. Seventy-five percent of women leave the recovery coach programme within six months (average is five months) and 25% remain open to coaching for 7 to 16 months. Most contacts occur in person, however, about 30% occur by phone, again mostly for women who require less coaching services. More phone contacts are used in the later months.

Phone contacts are also used to keep women who are struggling to manage their recovery, but are resistant about receiving more services or returning to treatment in an engaged manner. Coaches are encouraged to take women out for coffee, breakfast or lunch to keep lines of communication open and to provide women with resources (e.g., housing leads, food stamps, or linkages to mental health services) while they work through their ambiguity regarding their substance use.

**Challenges:**

- Keeping individuals engaged in the programme; (Approximately 30% of the individuals referred to the recovery coach programme are difficult to engage.)
- Conflict between the treatment goals of the addiction treatment programme and the model of recovery coaches;

- The likely possibility that a client will leave treatment against medical advice or be administratively discharged for ongoing use of alcohol or other drugs, but remain open and active with a recovery coach;
- Ideological conflict between the professional-based primary addiction treatment model and the strengths-based, consumer driven model of recovery coaches;
- Rules within the residential programme that may conflict with recovery coach services, such as meeting off grounds; leaving a group to work on another activity; working on other issues before completing specific phases of treatment;
- Rules within the outpatient programmes that discourage working with other agencies or programmes during hours of treatment;
- Changes in peoples' treatment needs as a result of receiving recovery coach services during a waiting period (e.g., no longer needing residential treatment after achieving some level of control with a recovery coach); and
- Increased ambiguity in the definition of "actively enrolled in treatment" as a result of offering the recovery coach programme as an alternative to primary treatment. (E.g., can people who are court ordered to drug dependence treatment receive only recovery coach services and still be considered "actively enrolled in treatment"?)

**Cultural or Situational Issues Related to This Project:**

Since there is funding for only two recovery coaches, it is difficult to have a complement of recovery coaches who fully reflect the cultural diversity of individuals receiving these services.

**Evaluative Data Available Related to the Project:**

Preliminary results of the programme indicate that recovery coaches have been successful in helping women acquire essential resources in the community. A five-month follow-up on 73 women has revealed:

- Four percent were employed at baseline; at follow-up, 57% (37/65) of those who were able to work (eight were in a residential programme or incarcerated) have acquired a part-time (20) or a full-time job (17).
- Seventy-one percent have seen an improvement in their living situation after leaving residential treatment or while receiving outpatient services. Many have moved from a shelter or transitional housing to independent apartments. At follow-up, 40% were in an unstable living situation (e.g., shelter, transitional housing or incarcerated), and 60% were living independently or with a partner or family member. Although 40% were living in transitional housing at the time of this report, most of these women were homeless at discharge from a residential treatment programme. Recovery coaches usually helped them connect with shelter resources and, therefore, improved their housing situation as well.

- Twenty-six percent were in the process of enrolling in school (e.g., obtaining financial aid or completing applications) or actively enrolled in General Equivalency Diploma or college courses.

**Key Findings:**

- Recovery coaches have been successful at linking women with the Federal Qualified Health Clinic in Peoria for medical and psychiatric services (*N*=27) and HSC's mental health services (*N*=21). They have also linked women with food stamps and food banks, temporary housing assistance (e.g., coverage for electric bills or down payments), and clothing.
- Recovery coaches routinely advocated for women involved with the Department of Children and Family Services (DCFS), a child protection agency, or the criminal justice system. Recovery coaches frequently attended DCFS or other court proceedings on behalf of women and often testified on their behalf.

**Testimonial**

*My name is Tiffany. I entered residential treatment on September 18, 2007. During my stay, I was able to begin a new, drug-free life and was referred to a Recovery Coach, Beth. At the time, I was clueless about what a Recovery Coach was until I met her.*

*To say the least, I was surprised. Beth has gotten to know me and understand my needs. She was very knowledgeable. She linked me to all community resources, including housing, the Department of Human Services, available jobs, and women's 12-step meetings to keep me comfortable in my early sobriety among other things.*

*Beth isn't only my Recovery Coach but also a mentor and a wonderful friend in recovery. I now have been drug-free for five months. I was blessed to have a Recovery Coach who has helped me in many ways. I think all women in early sobriety should have an opportunity to have a Recovery Coach and the services they offer. Thanks Beth!*

**For more on peer-based supports, see the US case study in Chapter IV**.

Many of the women in the programme were able to build social capital by developing trusting relationships with their recovery coaches. Through the support and advocacy of their coaches, some of them were able to improve their living situations after leaving residential treatment by getting jobs, moving from transitional housing to independent apartments and enrolling in school. Thus, in addition to social capital, they were able to develop the physical/mental health, housing and financial aspects of recovery capital.

# Chapter Five: Advocacy

Chapters III and IV provide practical suggestions for actions to implement sustained recovery management and strengthen the eight domains of recovery capital. The focus of this chapter is on *how to convince decision makers* to increase recovery supports for drug dependent persons[5] through advocacy by aiming at target groups at every level of society.

This chapter is divided into three parts:

- The first identifies target groups for advocacy on the personal, community, institutional, and national levels;
- The second suggests ways to raise public awareness on the issues of rehabilitation and social reintegration for drug dependent persons; and
- The third provides a short list of easily accessible information sources on the emerging concepts that are part of the sustained recovery management framework (mainly, sustainable livelihoods and recovery capital).

Advocating for policy, structure, and process changes is required to overcome the economic and political barriers and the social stigma that usually slow or prevent the achievement of sustainable livelihoods, social reintegration, and sustained recovery for drug dependent individuals (Braithwaite, 1999, 2001). Advocacy, of course, has to take into account the overall situation of the community in achieving a sustainable livelihood. Positively transforming the institutions, organizations, policies, and legislation that influence drug dependent individuals' access to sustainable livelihoods and recovery capital would enable these individuals to earn an income and reduce their vulnerability context and need to engage in illegal activities. Overall, it encourages a shift to environments that are more conducive to health and social reintegration.

Sustained recovery management—an emerging approach—recognizes just that. It places equal attention on:

(a) Reinforcing the client's ability to draw on her or his past and present resources; and
(b) Transforming the broader contextual environment.

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[5] 1961 Single Convention on Narcotic Drugs, Article 38: Measures against the abuse of drugs: 1. The parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends. 2. The Parties shall as far as possible promote the training of personnel in the treatment, after-care, rehabilitation and social reintegration of abusers of drugs. 3. The Parties shall take all practicable measures to assist persons whose work so requires to gain an understanding of the problems of abuse of drugs and of its prevention, and shall also promote such understanding among the general public if there is a risk that abuse of drugs will become widespread.

**Sustained recovery management** moves away from the identification of risk factors for relapse only. Instead, it supports the client's desire to work towards a "healthy, productive, and meaningful life" by integrating all eight domains of recovery capital (e.g., physical/mental health, housing, employment, and family supports) in the treatment of drug dependence and through the continuum of recovery. It also takes into account that not having an environment that supports recovery seriously puts at risk the chances for rehabilitation and social reintegration.

Figure I, Appendix I gives an adapted version of the Sustainable Livelihoods framework. It shows the inherent interdependence between building recovery capital and the vulnerability context of drug dependent persons. It also shows how the external environment—which comprises, among other things, policies, legislation, institutions, structures, and processes—can influence the interaction and, therefore, outcomes.

Given that drug dependence often brings with it concurrent health and psychosocial problems, nothing less than the broad, systematic, science-based approach that has been guaranteed for many other chronic diseases is required for the treatment and rehabilitation of drug dependent persons. Emerging good practice from existing drug dependence treatment programmes, as described in case studies (Chapter IV), and related excerpts in this manual, show the value of adopting an integrated, broad-based, continuum of care approach such as sustained recovery management.

In order to raise awareness at every level of society about this promising practice, two things are needed: advocacy and wide outreach.

Target groups at the personal and community levels include: Families, the neighbourhood/community, treatment professionals, related service providers, health professionals, law enforcement/the legal system, educators, employers, local media, self-help/peer groups, religious groups, formal/informal community leaders, and community donors.

At the more arms-length institutional and national levels, target groups can be: Local governments, regional, state, and national governments, international organizations, donor organizations, national media, and health insurance companies.

### Target Groups at the Personal and Community Levels

#### *Families*

A sustained recovery management approach makes client- and family-generated recovery plans central to the process of rehabilitation and social reintegration. Since families of recovering persons usually play a crucial role in the rehabilitation process, they need to be involved in creating a supportive environment for their recovering family members. Unrealistic

expectations of a straightforward "healing" after treatment need to be replaced, however, by a more realistic approach.

> **The Central Roles of Family and Community in the "Journey to Wellness"**
>
> *The fact that most Alkali Lake people had gone to treatment and stopped drinking did not mean that their healing process was complete. Years of accumulated loss and hurt do not simply disappear as a result of one therapeutic experience. What remains is a life-long journey into wellness that is exceedingly demanding because it requires that the traveller learn beliefs and values and new habits of thinking, feeling, acting and being in relationships with others…. Alkali Lake people became avid learners, involving themselves in many different kinds of training to strengthen their capacity to make this journey.*
>
> *Another strategy that became very much a part of life in the "new" Alkali Lake was healing circles, A.A. meetings and other kinds of support groups. These meetings contributed significantly to rebuilding bonds of love, trust, and acceptance among the people. Gradually, as people began to feel that it was safe to do so, they began to talk about some of the deeper hurts they were carrying that had been covered up by alcoholism.*
>
> ***Excerpted from the Alkali Lake Community Story, Canada at: http://www.4worlds.org/4w/ssr/Partiv.htm. Last accessed February 9, 2008***

Understanding, empathy, and a commitment to wellness on the part of family members and the entire community support building recovery capital. This is where the task of overcoming stigma and discrimination begins.

***Neighbourhood/Community***

Social reintegration into the home community of persons in the process of rehabilitation and social reintegration plays an important role in (re)building recovery capital. It helps communities overcome the stigma often attached to drug dependence, and creates a broader supportive environment for persons in recovery. Therefore, advocating in the neighbourhood directly affected is crucial.

***Treatment professionals***

Since recovery capital and sustained recovery management are somewhat new approaches to drug dependence treatment, they need to be promoted and discussed further in the community of treatment professionals. Furthermore, gaining acceptance of these approaches requires that they be presented not as rivalling existing treatment systems but, rather, as complementing them.

### *Related service providers*

The efforts to assist individuals needing treatment require the combined efforts of *all* institutions and authorities involved, such as work agencies, the broader health system, and social welfare institutions. Case management can help link the work of treatment professionals on different levels of care in a meaningful way, thereby providing a necessary continuum of care. Case management is also essential to improving cooperation with other service providers. However, developing this mindset needs work, and this is where broad and concerted advocacy comes in.

### *Health professionals*

As noted in Chapter II, a significant portion of individuals entering drug dependence treatment does not have an ongoing relationship with a primary care physician. Considering the important role of health care in building recovery capital, primary care physicians are an essential part of the rehabilitation team. Moreover, the availability of specialists for all kinds of co-occurring disorders would be *immensely* helpful.

### *Law enforcement/Legal system*

Law enforcement officers and members of the legal system who have a positive attitude towards recovering persons can be very motivating for individuals and their families. They can also be a good influence and can change the mindset of neighbourhoods and communities by their example. The following excerpt shows the importance of creating linkages between law enforcers and community-based treatment services.

***Transforming Perceptions about Drug Dependence and Recovery through Partnership Building***

*Mudra is an NGO in Nuremberg, Germany, that started to work with drug dependent persons in 1980. The government and police caused many problems for the budding organization because, back then, street work and drop-in centres were seen as rivals to abstinence-orientated therapy. Aftercare and vocational training were seen as rather a waste of money.*

*At first, police raids and judicial enquiries plagued the centre. So Mudra started to contact senior police officers and tried to convince them of the benefits of its work. It was an uphill battle, but 25 years later, Mudra staff conduct training for new police officers in the region on a regular basis, and coordination meetings between Mudra and senior police officers are frequently held.*

***For more on this centre, see the German case study in Chapter IV.***

***Educators***

Given their role in drug dependence prevention, teachers and other educators are an important advocacy group for also promoting sustained recovery management. Moreover, they can publicize the principles of recovery capital and make it easy for others to understand the needs, vulnerabilities, and strengths of drug dependent persons who are in the process of rehabilitation and social reintegration.

***Employers***

(Re-)entering the workforce and earning one's own livelihood can be a crucial part of the reintegration process that helps to stabilize rehabilitation and raise self-confidence. Thus, it is important for drug dependence treatment and recovery services to establish partnerships with potential employers in the community.

***Local media***

Local newspapers, radio stations, and television can strongly influence public opinion towards supporting persons struggling with drug dependence. If they report recovery success stories and not just drug-related crimes, the local media can play an important role in the advocacy work for rehabilitation and social reintegration. Media skills trainings could be offered to staff of treatment and rehabilitation services so that they can advocate directly on television shows and radio stations.

***Self-help/Peer groups***

It is important that the different self-help and peer groups be involved, wherever available, in the process of recovery.

***Gender Notes on the Value of Peer-based Support for Drug Dependent Women***

*On average, women who received recovery coach services attended more days of outpatient treatment than those who did not receive these services after discharge from a residential programme. Results suggest that the Recovery Coach Programme can be used to complement existing services and keep women engaged in treatment.*

*Preliminary results of the programme indicate that recovery coaches have been successful in helping women acquire essential resources in the community. A 29-month assessment of 166 women (i.e., complete data on 166/186) has revealed:*

- *Forty-seven percent of women improved their employment situation from baseline to follow-up (5% experienced a decline in employment over time). At baseline, 15% were employed, at follow up, 57% were employed at least part time. Another 28% were looking at follow-up, 13% were not looking for employment, and 2% were volunteering.*
- *Sixty-four percent of women have improved their living situation after leaving residential treatment or while they were receiving outpatient services (10% experienced a decline in their housing situation). Many have moved from a shelter or transitional housing to independent apartments.*
- *Twenty-four percent of women were in the process of enrolling in school (e.g., financial aid or completing applications) or actively enrolled in General Education Development or college courses.*
- *Women were also connected to a range of services and resources in the community, including the Federal Qualified Health Clinic (30%), food stamps (31%), and resources for medication (26%). On average, women were connected to 1.75 additional resources in the community (beyond employment, housing or education) with a range of 0 to 11.*

***Source:*** *Excerpted from a Report on the Recovery Coach Programme (Fayette Companies, Peoria, Illinois, USA) outlining the value of peer support for drug dependent women.*

Self-help and peer-based groups have extensive experience with all areas of treatment, and might promote the concept of recovery capital from their side. A promising new approach is the use of web-based peer support services.

***Religious groups***

In many parts of the world, religious groups are among the first organizations to offer help to persons with drug dependence problems and an interest in religion; in some countries they are the only ones who do so. They can support the rehabilitation process substantially by offering those in need of it the possibility of finding a deeper meaning in life. Further, they can help to (re)integrate persons in recovery into supportive social systems.

***Formal/ informal community leaders***

Enlisting both formal and informal community leaders in the task of rehabilitation and social reintegration can open many doors to healing and well-being. Thus, the influence of informal leaders in particular needs to be taken seriously. The following excerpt shows the healing influence that community leaders can have on promoting and supporting rehabilitation and social reintegration.

> ***The Transformative Power of Community Leaders***
>
> *The Shuswap tribal community in Alkali Lake was plagued by alcoholism. In 1972, two local tribal members, Phyllis and Andy, made a commitment to stop using alcohol. The following anecdote describes conditions before recovery action was taken:*
>
> *One day, seven-year-old Ivy refused to go home, because of the severe drinking of both her parents, Phyllis and Andy. Phyllis decided to stop drinking; four days later, so did Andy. Now the only two non-drinking members of their tribe, they decided to confront alcohol dependence.*
>
> *Eventually, Andy was elected Chief of the Tribe. He promoted AA meetings, arrested bootleggers, confronted the drunkenness of public officials, and staged interventions to get community members into treatment. Tribal traditions were revitalized for everyone in the community. A range of support systems, including educational and job development programmes, were developed and made available for those in the recovery process.*
>
> ***For more details, see the Canadian Alkali case study in Chapter IV.***

#### *Community donors*

Since drug dependence is still widely regarded more as a weakness of character than as a chronic disease, it is not always easy to gain the funding support of local donors. Nonetheless, it is important that advocacy efforts target potential community donors, as reluctant as they may seem initially.

### Target Groups at the Institutional and National Levels

#### *Local governments*

Local governments focus on local problems. To enlist their support in promoting the benefits of recovery capital, it helps to make them aware of the effectiveness of sustained recovery management. Where possible, success stories could be drawn from local examples as living proof of the impact of sustained recovery management. Support from local governments is crucial to the implementation of community-based systems for rehabilitation and reintegration.

#### *Regional, state, and national governments*

When persuaded of its benefits, the state and national levels of governments are the ones concerned both with funding and determining the legal framework for sustained recovery management initiatives. Consequently, they are among the most important target groups for advocacy. Government representatives are suitable contact persons for advocacy, since they can bridge the gap between regional initiatives and national government policy. Political parties are potentially valuable advocates for getting the word out on

the value of building recovery capital in a sustained recovery management setting. The publication *Investing in Drug Abuse Treatment: A discussion Paper for Policy Makers* was prepared by UNODC especially for this target group.

***International organizations***

International organizations often take the lead in advocating for disadvantaged persons. Their mandates, high profile, and global reach make them excellent agents for spreading information worldwide and to many levels of stakeholders: from local neighbourhoods to regional, state, and national governments. Advocacy material prepared by international organizations such as the United Nations Office on Drugs and Crime and the World Health Organization may be adapted to support local or regional advocacy strategies.

***Donor organizations***

Similar to local donors, nationwide and international donor organizations often do not see substance dependence problems as the most deserving of attention. When government funding is scarce, however, donor organizations can be an alternative source of funding and co-financing. Thus, advocacy work in this area is urgently needed, and it is important to highlight the link between drug dependence treatment and social (re)integration *and* the reduction in crime and poverty. It might also be pointed out that a sustained recovery management approach may help to promote other goals that a particular foundation is focusing on. So it is very important to develop tailor-made proposals for each foundation.

***National media***

Politicians and other decision makers tend to watch the media closely. So, just as local media can help to change attitudes towards substance dependence, likewise, national and some international media can have considerable influence on swaying public opinion. Therefore, it is a good idea to partner with other actors in the field of drug dependence treatment and rehabilitation to establish and maintain good relations with the media, and to participate, when and where possible, in media-based advocacy campaigns, or provide journalists with accurate information.

***Health and social security insurance companies***

Even where health and social security insurances are widely available and affordable, their services do not always cover the various kinds of drug dependence treatment, let alone provide benefits towards building recovery capital in a sustainable livelihoods context. Thus, it would be a good idea to provide data that show how rehabilitation and reintegration can lead to a reduction in relapse rates. And that this, in turn, can lead to a reduction in repeated inpatient treatments and, ultimately, saves money. Also it would be

worth exploring further the benefits of community based social security schemes and how they could be linked with the approach of sustained recovery management.

**Advocacy Methods**

***One-on-one interaction***

A cost effective and efficient way to share the concept of recovery capital and the creation of sustainable livelihoods through a sustained recovery management approach is by talking to others such as colleagues, decision makers, and clients, during informal meetings, conferences, presentations, or on other occasions.

***Case studies and stories***

Case studies and stories are good ways to attract attention, and are considered a main medium in knowledge transfer concepts. Case studies can prepare the ground for circulating the principles of recovery capital, sustainable livelihoods, and sustained recovery management.

Case studies and stories are especially suitable for all kinds of media. They help to attract the attention of politicians and decision makers, and sometimes can change public opinion easier than can theoretical concepts. It is a good idea to place more emphasis on sharing the positive aspects and the success stories of recovery. ("Faces and Voices of Recovery" is an excellent example of this approach.)

***Branded products***

Many vocational training programmes, occupational therapies, and sheltered workshops sell excellent products to the public. When these brands are connected with high quality and beautiful work, they can go a long way in creating a positive view in the public's mind about the benefits of rehabilitation and social reintegration.

***From Drug Dependence to Self-Sufficiency through Production and Creativity***

*The TT Ranganathan Clinical Research Foundation in Chennai, India, runs a vocational training programme. Its workshop, Tejas, makes beautiful bags that are traditionally used as wedding presents. The product has become so sought after that Tejas is now a well-known brand.*

*The success of the product contributes to the funding of the institution. Moreover, it is also helping to shift public opinion about persons with drug dependence problems and their families.*

***For more details on this project, see the Indian case study in Chapter IV.***

***Articles in popular magazines***

Popular magazines can be one of several ways to use print media as an avenue for advocacy, because they can reach readers who are usually not aware of the issues of drug dependence and the positive results of sustained recovery management. For example, articles and case studies that share an understanding of drug dependence and the benefits of treatment and recovery, based on success stories, can be submitted for publication. Also, profiling a centre and its success stories in ways that others can relate to can change public opinion towards drug dependence.

***Brochures and posters***

Brochures and posters succeed as instruments of advocacy when there is already some interest in the topic. Brochures are relatively costly to produce, and work best when used specifically to target events and lectures. Well-designed, eye-catching posters can have broad visual appeal.

***Professional conferences/meetings, and articles in professional journals***

Sustained recovery management is still new to practitioners in the drug treatment and rehabilitation community; recovery capital is also a comparatively new concept. So, an excellent avenue for advocacy among peers is using attendance at professional conferences, meetings, and presentations as opportunities to engage colleagues in discussion on the issues. Articles published in professional journals are other ways to promote dialogue on these topics. Further, since evidence-based results are of special importance to this community, it would be important to conduct or support evaluation studies on sustained recovery management projects, and provide data in a way that satisfies close scrutiny.

***Training programmes***

Training programmes addressing the opportunities and problems connected with sustained recovery management could be made available to different target groups at all levels: e.g., parents, health professionals, law enforcement authorities, all kinds of service and drug treatment professionals, educators, and peer groups.

***Websites***

Creating new websites about recovery capital and sustained recovery management, or linking them to existing websites is an effective means of advocacy.

Change, though sometimes slow, does come. However, it does not come about in a vacuum, and that is why advocacy is so important. To promote change, advocacy is key.

***Information Sources***

The following sources are just a few examples of easily accessible documents on the web. Search engines help to identify more publications on specific approaches.

- **UNODC**

The United Nations Office on Drugs and Crime has published a wide range of documents that deal with aspects of rehabilitation and reintegration. A good example is the drug dependence treatment toolkit, which is also available on CD. In 2003, as part of this series, UNODC published "Investing in Drug Abuse Treatment: A discussion Paper for Policy Makers." That is of special relevance for advocacy purposes. Please see: http://www.unodc.org/unodc/en/treatment_toolkit.html for more information.

- **WHO**

The World Health Organisation supports countries in advocacy and capacity building for the prevention and management of substance use disorders in all vulnerable groups. It seeks an integrated approach to all substance use problems within the health care system, in particular primary care.
See http://www.who.int/substance_abuse/en/

- **HBO Addiction Series**

This series, supported by the Robert Wood Johnson Foundation, brings together North American experts on drug dependence treatment and rehabilitation, to provide information on the disease and possible interventions to a general public. Please see, http://www.hbo.com/addiction/ for more information.

- **Sustainable Livelihoods**

"Livelihoods Connect," which bills itself as the learning platform for creating sustainable livelihoods to eliminate poverty, delivers information about the concept of sustainable livelihoods in general, and includes a toolbox: http://www.livelihoods.org/newuser.html, and http://www.livelihoods.org/index.html.

For guidance sheets on the SL approach, methods and tools, please see the following:
http://www.livelihoods.org/info/info_guidancesheets.html#1.

- **Faces and Voices of Recovery**

The homepage of "Faces and Voices of Recovery" contains many success stories about rehabilitating and reintegrating drug dependent persons, and other helpful information. See
http://www.facesandvoicesofrecovery.org/main/index.php.

# Chapter Six: Sustained Recovery Management: Documentation, Monitoring and Evaluation[6]

*"With only scarce resources for treatment, duplication and inefficiency in the delivery of services cannot be tolerated."*

WHO 2000[7]

Ensuring long-term, sustainable, positive outcomes for people with drug dependence problems is a major challenge for drug dependence treatment and rehabilitation service providers. Evidence-based programmes, research findings and knowledge of good practices are not always available or easily applicable to different geographic areas. Therefore, it is necessary to utilize evaluation methods that guaranty good practices and services to ensure long-term rehabilitation and social reintegration of drug dependent individuals.

This chapter focuses on the needed components to help your organization in documenting, monitoring and evaluating sustained recovery management programmes. As noted in Chapter I, such an approach includes key theoretical concepts taken from a variety of areas: Sustainable Livelihoods, recovery framework, and recovery capital. Some of these approaches are emerging, while others are mostly not yet applied in the area of drug dependence treatment. Because of the broad scope of areas covered by sustained recovery management services, an evaluation needs to be well designed to allow a meaningful interpretation of the data gathered.

Systematic data collection, monitoring and evaluation efforts are important, because they can provide critical information about how to:

- Conceptualize and design interventions and programmes;
- Provide critical information on programme implementation problems or deviations from the initial plan;
- Monitor how closely the programme adheres to an Evidence- Based Model;
- Make proper decisions (e.g., a programme that has proven effectiveness may also be implemented in other centres);
- Conduct advocacy campaigns;
- Develop persuasive arguments for funding needs to facilitate the integration of established and emerging interventions to create a continuum of care framework;

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[6] More information on service evaluation can be found in Volume D of the UNODC/Treatnet training package and the WHO/UNDCP/EMCDDA Evaluation Workbooks Serieshttp://www.unodc.org/treatment/en/UNODC_documents.html

[7] Quoted in Treatnet Evaluation of Substance Abuse Treatment Programmes

- Assure drug dependent persons and their families that they are receiving adequate supports to initiate and sustain recovery in their own communities; and
- Insure that resources are not wasted.

**A Step-by-Step Evaluation Approach**

The following steps need to be considered[8] when deciding to conduct a programme evaluation:

***Step 1: Set up an evaluation group***

The evaluation needs to engage people affected by the programme. It is important to establish a multi-professional evaluation team (e.g., managers, therapists, researchers, community representatives, potential employers, and local businesses) together with the programme-affected individuals such as clients, family members, and community leaders. The evaluation team requires *different* members to contribute their unique talents and experiences to the group's work. Also, close and collaborative involvement in the planning and implementation phases of the documentation and evaluation processes can contribute significantly to favourable outcomes.

***Step 2: Describe the programme in detail***

A successful evaluation is more likely when a detailed description and clear statement of the programme's goals, objectives (as shown below), resources and products are outlined from the start. Although a vocational programme was used to illustrate the components required for the evaluation, a similar procedure can be used for any programme in any of the other domains of recovery capital described in Figure III, Chapter I. In fact, a comprehensive assessment of all eight domains of recovery capital is always recommended.

***Step 3: Assess the resources available for conducting an evaluation***

An inventory of necessary resource components includes the following:

- Existing and/or potential financial and material assets;
- Human resources and available expertise; and
- Time availability and allocation.

The following example outlines the steps needed to evaluate a programme. In this case, the focus is on building sustainable livelihoods through vocational skills development.

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[8] Cf. WHO/UNDCP/EMCDDA Evaluation Workbooks Series
http://www.unodc.org/treatment/en/UNODC_documents.html

***Example:*** *A treatment centre plans to set up a clothing and textiles industrial unit as its sustainable livelihoods (vocational) programme. The programme components are:*

***Programme Resources****:*

- *Industrial equipment: Sewing machines (5), embroidery machines (2), weaving looms (2)*
- *Building: To house the equipment*
- *Staff members: (10)*
- *Annual budget: $100,000.00*

***Programme Objectives:***

- *(Number of clients in recovery) trained and assisted in acquiring vocational skills in various aspects of clothing and textile design, production, and marketing;*
- *Short-term employment provided for (number of) recovering drug dependent persons;*
- *(Number of participants) assisted in setting up their own small-scale industrial units (or in securing employment) after completing the training programme;*
- *Basic job interviewing skills taught to (number of clients); and*
- *Evaluation instruments used at various stages of the programme.*

***Short-term Programme Outcomes:***

- *Increase (number of clients') motivation to comply with the treatment centre's after-care plans and reduce attrition rate;*
- *(Number of clients') whose situation after completing the initial treatment programme stabilized;*
- *(Percentage of drug dependent persons) begin the process of rehabilitation and social reintegration after completing the initial treatment programme with the aim of reducing relapse rates; and*
- *(Percentage of clients) reduces risky behaviour that can injure their health.*

**Long-term Programme Outcomes:**

- *Reduced illegal activities among (number of clients);*
- *Improved (number of clients') employability; and*
- *Improved (number of clients') overall health and quality of life.*

### *Step 4: Identify and prioritize areas of evaluation*

After describing the programme in detail, the evaluation team agrees on which aspect(s) of the programme will be evaluated, and why. Using the given example, the group may only be interested in studying the effects or benefits of setting up the clothing and textiles industrial unit as a Sustainable Livelihoods programme among the clients. So, they may be interested in conducting an outcome evaluation rather than a cost or economic one, which would provide additional information for the centre, but would also require a different type of data collection procedure.

Ideally, the evaluation of a programme would start before the programme is actually launched. Evaluations have an important role in the planning and

designing of new programmes or interventions. Also, other types of evaluation can be conducted with existing programmes as follows:

1. **Needs assessment evaluation** needs to be the first step in the design of a programme. This evaluation ideally takes place before the programme is planned. The needs assessment attempts to determine the needs of the substance using community and helps prioritise the necessary services. (See WHO, 2000, Workbook 3.)

2. **Cost evaluation** aims to trace the resources used in treatment. E.g., what is the cost of treatment, and what other approaches are producing equivalent outcomes, if any? How do changes in cost relate to activity levels? (See WHO, 2000, Workbook 5.)

3. **Client satisfaction** evaluation gathers information from client feedback on the programme's services and activities. E.g., has the treatment programme met clients' needs and expectations? (See WHO, 2000, Workbook 6.)

4. **Economic evaluations** can determine the options that give the best value for the resources expended. These evaluations help policy makers decide on resource distribution among different programmes. It involves comparing costs and outcomes of different programmes or alternative interventions .E.g., should investment be made in treatment A or B? (See WHO, 2000, Workbook 8.)

This chapter discusses two types of evaluation that might be implemented on existing programmes: the process and outcome evaluations.

***Process evaluation*** seeks to determine if the treatment programme is operating as planned and, if not, to document and study any deviations. The focus of the process evaluation is on the clients' coverage. Namely, is the programme reaching the intended clients?. Regarding programme operations, the focus is on the manner in which the programme is being delivered. Namely, is the programme being implemented as intended and is it proceeding in an integrated manner?

**Outcome evaluation** measures how clients and their circumstances change following participation in treatment and/or rehabilitation programmes, and whether this experience has been a factor in causing this change (WHO, 2000).

***Step 5: Generate evaluation questions***

Evaluation begins with taking small steps and continuously questioning the relevance and effects of a given intervention and programme. Generating precise questions at the start of the evaluation process helps to narrow its focus. Some of the following questions were applied to the clothing and textiles evaluation, and are presented here as an example:

*Questions on clients' characteristics:*

- *Of the clients completing the initial treatment programme, what proportion goes on to participate in the Sustainable Livelihoods (i.e., clothing and textiles) programme?*
- *What are the characteristics (i.e., social, demographic, health, drug dependence profile) of clients participating in the Sustainable Livelihoods programme?*
- *Are the characteristics of clients participating in the Sustainable Livelihoods programme similar to those of clients entering the treatment programme initially?*
- *Has the treatment admission rate increased since the establishment of the Sustainable Livelihoods programme?*

*Questions on programme processes:*

- *What is the programme retention rate?*
- *Were all training sessions conducted as planned (number and contents)?*
- *Is the programme reaching the targeted clients (e.g., sex, age, primary drug of use, socio-economic situation)?*
- *Are there any significant deviations from the initial plan?*

*Questions on programme outcomes:*

- *What sorts of changes (e.g., related to their substance use, physical and mental health, quality of life, family and social relations) occur in clients during and after they have participated in the Sustainable Livelihoods programme?*

- *What proportion of clients that completed vocational training in the previous year were:*

    1. *Offered full employment in the vocational programme?*
    2. *Employed outside of the centre's programme?*
    3. *Assisted to set up their own vocational programmes?*

- *What proportion of clients have relapsed 6, 12, and 24 months after being discharged from treatment and having entered the Sustainable Livelihoods programme?*

***Step 6: Programme design***

There are typically two possible evaluation designs—randomized controlled design and full-coverage programme evaluations employing time series and pre- and post-comparison methods. The randomized controlled design is more resource intensive and complicated to conduct, and may be extremely

difficult to incorporate into the routine programme of a treatment centre with limited resources and time.

A full-coverage evaluation, using either time series or pre-post designs, can be more realistically incorporated into the routine programme of each treatment centre. These designs enable clients to be assessed on the same outcome domains before, during and after undergoing the programme and at follow-up data collection points. Clients participating in any of the sustainable livelihood projects (e.g., vocational activities) complete several instruments at programme commencement and at pre-determined intervals while in the programme.

The following two methods can be relatively easily conducted in community-based organizations and sustained recovery management programmes by professionals with little or no experience in conducting programme evaluation:

1) **A time series data collection method.** This method uses fixed data collection points through the entire programme implementation. For instance, at three-month intervals, starting at programme commencement, with follow-up at 3, 6, 9 and 12 months. Outcomes differences among the intervals are used as indicators of programme effects over time.
2) **A simple pre- and post-comparison design.** This method assesses the programme impact on the clients' outcome domains before and after completing the programme. Clients participating in any of the Sustainable Livelihood programmes (e.g., vocational activities) are asked to fill in or provide information for relevant data collection instruments upon entry into the programme and at pre-determined intervals during and after its conclusion.

***Step 7: Selecting measures or instruments***

Sustainable Livelihoods programmes aim at assisting clients to develop the supports they need to sustain recovery in the community. Programme evaluation efforts may focus on monitoring the implementation and measuring the extent to which the programme has contributed towards supporting recovery in the community.

Data collection may be performed by examining routine records, using questionnaires and standardized instruments, having focus group discussions or interviews or any combination of these methods. See Appendix II for a list of data collection instruments.
For instance, baseline data could be collected from all clients upon their entrance into treatment using a specially designed intake form or other selected instrument/s such as the Addiction Severity Index (ASI) Treatnet Version - 2.9 (or ASI-5.0 available in different languages). Appendix II

provides an overview of suggested instruments. It is desirable to use well-established instruments with strong validity and reliability properties.

**Process measures** are intended to assess the extent to which the programme has followed a detailed plan such as number of sessions and nature of activities, and if the programme was actually conducted with the specified target population. Process measures include indicators or variables on clients' demographic data (e.g., age, sex, primary drug use, socio-economic situation, health status, drug of primary use), the nature and the number of sessions, if clients actually attended, and the number of products produced in a programme (e.g. number of T-shirts made). Process measures may include instruments to evaluate the degree to which the programme adheres to the model; for instance, when a new evidence-based model is implemented.

Programme measures may include the following qualitative and quantitative methods:

a. Trained staff observations of selected and/or randomized sessions;
b. Audiotape or videotape selected and/or randomized sessions;
c. Reviewing of programme records;
d. Participants' attendance lists and monitoring tables or documents;
e. Demographic data of clients and family members;
f. Clients' satisfaction questionnaires; and
g. Focus groups and interviews with clients, family members (e.g., how would you improve the programme?), therapists and other key informants on the programme processes.

**Outcome measures** are intended to assess the programme's utility. For instance, the extent to which the client has been able to sustain recovery after treatment and other programme results such as physical and mental health, quality of life, economic situation, skills development, and number of patients that found jobs. They may be selected from five broad areas, namely:

1. Maintenance of abstinence or reduction in substance dependence;
2. Improvement in personal and social functioning;
3. Improvement in mental and physical health;
4. Reduction in risky behaviour that could affect health, and
5. Overall improvements in increasing access to livelihoods assets and recovery capital.

Appendix II lists suggested instruments to measure outcomes in these areas. The recovery capital model, including the eight domains, and the Sustainable Livelihoods framework (Figure I, Appendix I) can be used as guides and assessment tools.

*GENDER NOTES ON THE IMPORTANCE OF CONDUCTING GENDER-SPECIFIC ANALYSIS*

*Keeping in mind that women often are a more vulnerable group, conducting a gender analysis is important to reveal gender differences across all recovery capital domains. Therefore, it would be useful to collect and evaluate gender-specific data that provide useful insights on:*

- *The specific needs and vulnerabilities of women, and how their inherent strengths assist them in overcoming their drug dependence;*
- *The barriers (social, personal, and structural) to their gaining access to and control of valuable resources, thereby increasing their recovery capital assets, and making the best use of treatment services;*
- *The livelihoods assets and activities that would most facilitate their recovery, and help them (re)gain a sense of safety, financial security, and social reintegration; and*
- *The social relations and networks that can either hamper and/or facilitate women's recovery.*

*Case studies and lessons provide a more comprehensive outlook at gender-responsive substance dependence treatment services for women and their treatment needs. See UNODC Drug Abuse Treatment Toolkit on Substance Abuse Treatment and Care for Women available at the following link*: http://www.unodc.org/docs/treatment/Case_Studies_E.pdf.

### *Step 8: Managing data*

Data management is a critical component of the evaluation process. Therefore, a staff member or a data management group of two or more needs to be responsible for the coordination of the centre's data management activities. The duties of the data usually include:

- Monitoring the data collection process (handing out forms and questionnaires, supervising dates and procedures;
- Enforcing local data protection laws, good practices and ethics for evaluation studies and research studies;
- Ensuring privacy and security of all collected data; (It is recommended that signed, informed consent be obtained from all participants—clients and a family member—to ensure that they understand the purpose of the evaluation, data collection methods—such as instruments, data collection points—potential benefits and risks of participating in the evaluation process, confidentiality assurance of collected data and their right to withdrawal from the evaluation study at any time, among others.)
- Maintaining proper storage and retrieval of all collected data; and

- Transferring information (data) to a central database

***Step 9: Analysing and interpreting data***

Data analysis does not necessarily entail complex statistical procedures. However, the assistance of a statistician or other technical person is always recommended. Part of the evaluation team set-up plan could be to establish collaboration with universities and research institutes that could ease the burden of data base maintenance and statistical analysis of different degrees of complexity.

Careful discussion and interpretation of data allows a better understanding of the programme's success or limitations, namely:

- Did the programme reach its goals?
- If not, why? How could it be done differently, including redefining unrealistic goals?
- What were the challenges encountered?
- What contributed to the different challenges, and how could they be overcome in future?
- What are other programme effects?

***Step 10: Using the results and lessons learned***

Once results are obtained and interpreted, the following step is to utilize them. Although it is important to share feedback on the outcomes of the evaluation with all stakeholders, and implement lessons on how the programme can be improved, it is also critical to use the results to market the programme in order to directly benefit the clients. Results may be useful to different individuals for different reasons as follows:

a. Programme administrators:
Programme evaluation is critical for most managers to make sure that human resources, such as effort, time, activities, and other material resources such as money are not wasted but are allocated in the most efficient and effective way. Evaluation results could also provide the evidence that would convince policy makers and funding agencies of the need for such treatment programmes and centres.

b. Programme staff
Staff can benefit from the evaluation in many ways, such as making sure that their efforts and services are reported, which, in turn, helps them to justify continuous education, improve their services, and provide an increasingly high quality of care.

c. Programme clients and their families
Clients are the ultimate beneficiaries of the evaluation results. An effective programme evaluation reflects the results of treatment and (if applicable) client satisfaction with the services received. If programme planners, service

providers, and other staff apply the recommendations made from the evaluation, clients quality of care will be directly affected. The results of the evaluation could also encourage drug users and their families to remain in treatment long enough to achieve effectiveness, knowing that they will be provided with adequate care and support to maximise their recovery.

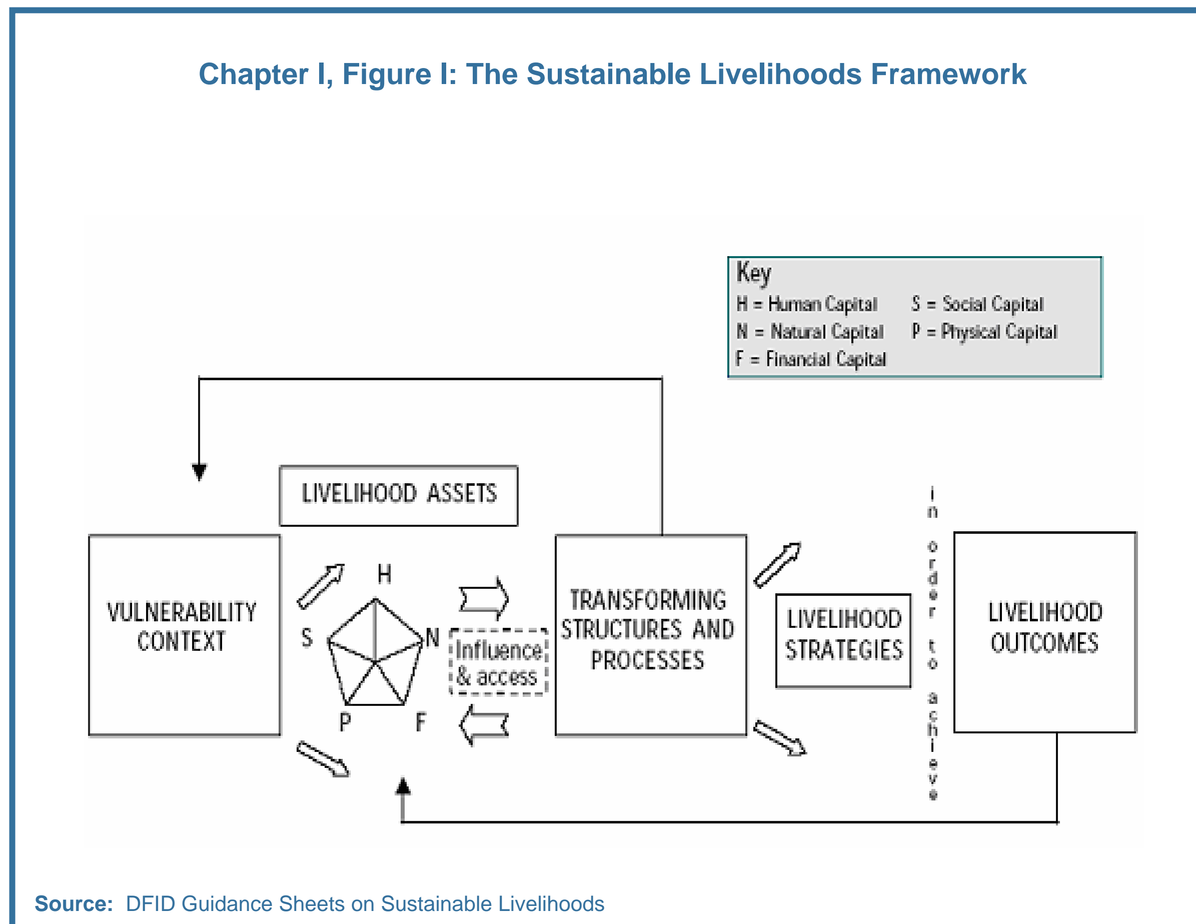
d. Potential employers, businesses and community leaders
Successful programmes can convince business and local employers to provide professional opportunities to people in recovery by hiring graduated clients.. The programme could establish collaboration with diverse local businesses to train individuals and provide funding for sustainability.

**Conclusions and Recommendations**
Sustained recovery management is an emerging approach. There is a need to test programmes and interventions that demonstrate significantly positive effects. Given its broader scope—which focuses on both the individual and the context in which rehabilitation and social reintegration takes place—it is important to promote design evaluation models that reflect the all-inclusive nature of sustained recovery management. Evaluation models need to include assessments of all its essential components, as well as the eight domains of recovery capital.

Sustained recovery management as an integrated, continuum of care approach (which depends on the cooperation and contributions of multi-disciplinary teams across different sets of agencies, organizations, institutions, structures, and processes), needs to have equal attention given to ensuring ongoing institutional assessments and performance management evaluations. As the Sustainable Livelihoods framework emphasizes, facilitating the road to rehabilitation and recovery for drug dependent persons often begins with transforming and improving the institutional context in which recovery supports services take place. Evaluation studies can clearly support institutions by providing the necessary data to demonstrate the benefits of their programmes.

## Appendix I: Figures for Chapters I and III

**Chapter I, Figure I: The Sustainable Livelihoods Framework**




**Source:** DFID Guidance Sheets on Sustainable Livelihoods

### Key Determinants of Livelihoods-Building Blocks:

#### The Vulnerability Context

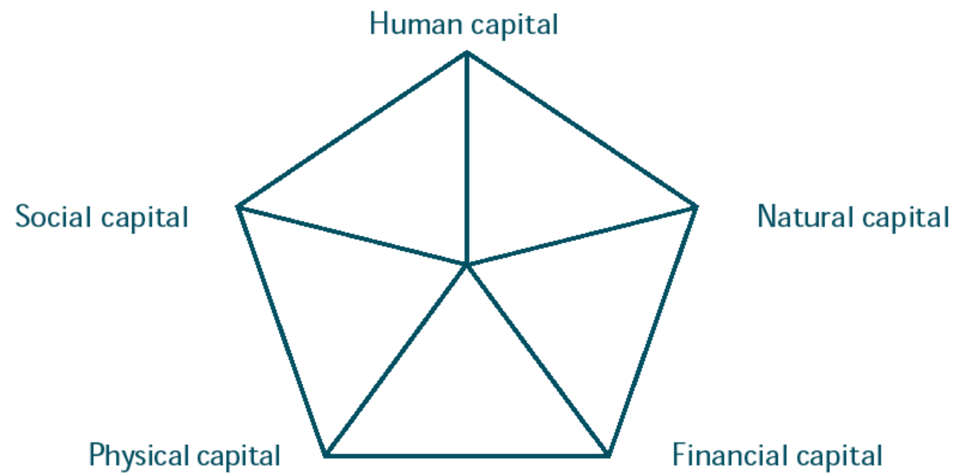
Understanding the nature of vulnerability is a key step in analysing sustainable livelihoods and identifying key factors that have a direct impact upon persons' assets and the options available for them to pursue positive livelihoods outcomes. Vulnerability decreases as people learn to positively influence their immediate and external environment.

#### Transforming Structures and Processes (TSP)

The TSP component of the SL Framework includes the institutions, organizations, policies, legislation and processes that can determine persons' access to capital, the terms of exchanges, and the return to any given livelihoods strategy. It also includes persons' abilities to feel socially and politically included. It helps gain a better understanding of the relationships between the personal and impersonal spheres, and highlights potential opportunities and/or constraints within the two-way governance, "Influence-Access" arrow linking assets and TSP. (Refer to Figure III.)

#### CHAPTER I, FIGURE II: THE SUSTAINABLE LIVELIHOODS ASSET PENTAGON

It identifies appropriate entry points and tracks changes in the accumulation and loss of five core livelihoods building blocks, and also depicts important inter-relationships between them:



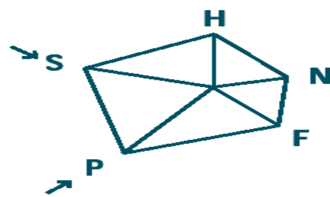

**Human Capital** represents a basic requirement to gaining access to other livelihoods' building blocks. It includes good health, knowledge, skills (e.g., college education and vocational skills), all of which can ease the way to entering the labour market. It is the sum of all personal resources that can be utilized to combat poverty in the context of recovery and substance dependence.

**Social Capital** includes all the resources that can be drawn from social networks, memberships, and relationships of trust and reciprocity that can support the creation of "safety nets." High levels of Social Capital add significantly to Human Capital and positive livelihoods outcomes.

**Natural Capital** consists of natural resources from which livelihoods are derived (e.g., land, trees, key environmental services, and food).

**Financial and Physical Capital** comprise economic and financial assets (e.g., income, property, and investments), basic infrastructure, and producer goods such as tools and equipment) needed to support livelihoods: transport, secure shelter, water supply and sanitation, clean and affordable energy.

The centre of the asset pentagon represents zero access. Maximum access to a single livelihood building block (shown at the outer perimeter) would be insufficient on its own to achieve livelihood outcomes, attesting to the interdependence of each components of the Asset Pentagon.

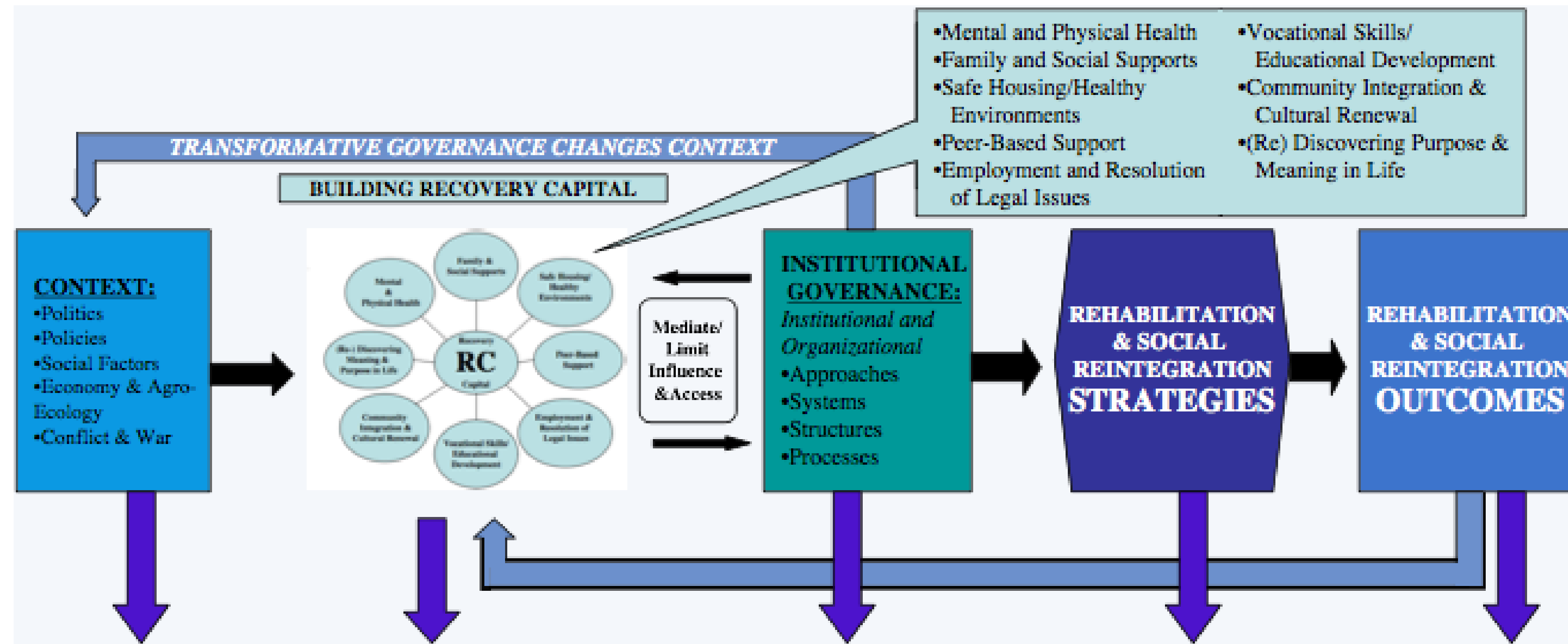



The Pentagon on the left indicates the need for services that could enhance social and physical (financial and infrastructure) assets, shown here in decline.

**Source:** DFID Guidance Sheets on Sustainable Livelihoods

**CHAPTER III, FIGURE IV: SUSTAINED RECOVERY MANAGEMENT FRAMEWORK (SRMF)**

*The SRMF Framework uses both the Sustainable Livelihoods Framework and the recovery capital model, with its eight domains, to better understand and analyse the contextual opportunities and obstacles easing or hampering livelihoods and recovery capital development along the road to rehabilitation and social reintegration. As an assessment tool, it can help practitioners develop a realistic treatment and rehabilitation plan, as well track progress, measure effectiveness, and evaluate outcomes.*




| Contextual and policy analysis: | Analysis of the 8 domains of RC: | Analysis of institutional governance: | Analysis of strategies to achieve substance abuse rehabilitation and social reintegration: | Analysis of substance abuse rehabilitation and social reintegration outcomes: |
|---|---|---|---|---|
| To identify and understand the "Vulnerability Context" limiting drug dependent clients' access to recovery capital:<br><br>Vulnerability decreases as clients increasingly learn to influence their immediate and external environments. Shifting away from punitive policies and measures that consolidate social discrimination and promote social alienation is key. | To provide an understanding of the separate components of resources and assets available to clients, their households, and social groups:<br><br>Using the recovery capital model as an assessment tool helps identify entry points and track changes in the accumulation and loss of any of the eight domains of recovery capital. Building recovery capital is just one component of sustained recovery management, and cannot exist apart from drug dependent persons' relationships to their families and communities. The broader socio-economic, political, environmental, and institutional contexts play an important role, and often limit access to recovery capital resources. | To assess the extent to which institutional approaches, structures, and processes ease or get in the way of the ability of drug dependent persons to achieve recovery capital:<br><br>As indicated in the two-way "influence-access" arrows, transforming the institutional governance set-up have a direct impact on both the external and personal (recovery capital) contexts. | This is based on a comprehensive assessment of all contextual factors and potential barriers, as well as on taking into account individual client's needs and vulnerabilities, while building on their strengths. | Ongoing monitoring of progress and evaluation of outcomes achieved, against clear goals and benchmarks established by each client:<br><br>This process allows for continued adjustments in the treatment plan, and identification of potential barriers that need further addressing. |

**Source:** Adapted from DFID's Sustainable Livelihoods Framework and Shankland's. (2001)

## Appendix II: Screening and Assessment Instruments

**Useful References, Assessment Tools, and Links**

- **Treatnet ASI**

http://www.unodc.org/docs/treatment/asi/Treatnet%20Version%203.0%20050907.pdf

- **Treatnet ASI Supplement**

http://www.unodc.org/docs/treatment/asi/ASI%20Treatnet%20Supplement%20Version%203%20050907.pdf

- **Treatnet Checker's Manual**

http://www.uclaisap.org/InternationalProjects/html/unodc/UN%20September%202007/Volume%20A/Module%202/Supplementary%20Materials/Treatnet%20ASI%20Checker's%20Manual.pdf

- **Treatnet Training Package, Volume D on Programme Evaluation Methods**

(http://www.uclaisap.org/InternationalProjects/html/unodc/UN%20September%202007/Volume%20D/training-package-volD.html

- **The World Health Organization Quality of Life Assessment Instrument**

This is an international, cross-culturally relevant assessment tool. It includes 26 items encompassing such broad domains as physical and mental health, social relationships and the environment. It is aimed at measuring clients' perceptions, personal goals, standards and concerns, in the context of their culture and value systems.

http://www.who.int/substance_abuse/research_tools/en/english_whoqol.pdf

- **WHO/UNODC/EMCDDA Evaluation Workbook Series**

http://www.unodc.org/docs/treatment//framework_workbook.pdf

- **Treatnet Evaluation of Substance Use Treatment Programmes**

See Topic 3: Programme Evaluation Methods, Sample Programme Visual at the following link:

http://www.uclaisap.org/InternationalProjects/html/unodc/UN%20September%202007/Volume%20D/training-package-volD.html

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