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exit

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Theme: Mental Healthcare: Benefits of Addiction Treatment for Individuals, Communities and Governments

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20 YEARS
OF NETWORKING

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DIANOVA'S
VALUES ARE OUR VALUES TOO

COMMITMENT

SOLIDARITY

TOLERANCE

ERNATIONALITY

Rui Martins
Communication Director

Offering treatments based on the scientific evidence is now helping millions of affected individuals to regain control over their lives

It's never too much to reinforce what **UNODC-WHO International Standards for the Treatment of Drug Use Disorders** advocates for: "Drug use disorders are a serious health issue, with a significant burden for individuals affected and their families. There are also significant costs to society including lost productivity, security challenges, crime, increased health care costs, and a myriad of negative social consequences. The social cost of illicit drug use is estimated at up to 1.7% of GDP in some countries (World Drug Report, 2016). Caring for individuals with drug use disorders places a heavy burden on public health systems of Member States and therefore improving treatment systems by making them the best they can be. This would undoubtedly benefit not only the affected individuals, but also their communities and the whole society."

As Professor Susana Henriques states on her latest article "according to Spoth et al. (2006), for each 1 spent on prevention, approximately 10 will be saved from the health, social and criminal burden of addiction". Besides knowing that **Treatment works**, relieving individuals, families, communities and governments suffering and burden on different aspects related with addressing a health, human rights, comprehensive approach to drug addiction and disorders, we also have scientific evidence that correlates a more successful recovery with the longer the duration of the treatment, the much better the treatment evaluation is and capability of reintegration process – such as changing residence to get away from use environments, work, rights of access, social freedom, merit reward.

The internationally benchmarked **Portuguese decriminalised** model, based on a health approach and respecting the UN Drug-Related Treaties, are an undoubtedly outstanding way to tackle the overall drug problem. It's a fact that, due to the 2009 financial crisis that hit Portugal the most, the political decisions made affected negatively the public expenditure on health and social measures and put at risk private/social organizations dealing with treatment working in cooperation with the Ministry of Health. This exemplifies the need of a stronger advocacy activity and sector strengthening both at the international (the new Drug Plan of Action 2019-2029 following UNGASS 2016 is being prepared for the next 62nd CND-UNODC Session next March), regional and national levels to better cope with the work field and collaboration with the public authorities. From which will result gains for all, leaving no one behind.

By bringing together in this EXIT® issue 29 experts public authorities, experts and practitioners from Government, Academia and Civil Society from 22 countries around Europe, Asia, Africa and North & Latin America, we hope their insights, experience and knowledge can contribute to a more enlightening debate on what has been done, the outcomes achieved and what still needs to be done in regard to the drug abuse effects and consequences on individuals, families, communities and governments.

Once again a special thanks to all contributors to this 2018 issue and hope you readers will enjoy.

Have a nice reading!

Note: the Expert opinions that collaborate with Dianova do not necessarily reflect Dianova's corporate positioning.

editorial

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Dianova Portugal partner of new transnational project SMAPP 2018-2019

SMAPP "Tackling Social Media Use with Positive Approach" 2017-2019 focused on Internet Addiction is the new project coordinated by Istanbul Health Directorate – Ministry of Health Turkey, in which Dianova Portugal is a partner, along side with Kairós Cooperative (Spain) and Cassandra Solutions – Consorzio SGS (Italy), financed by European Commission's Erasmus+ program.

Besides the training sessions in each of the Partner's countries – the Portuguese was held the 4-8 June 2018 under the topic "Health Communication and Social Media", the final goal is to create an awareness campaign targeting young adults and adults through a competition on social media (Facebook and Instagram). The project is to be concluded by September of 2019.

Dianova Portugal & International attended the 61st CND – UNODC Session 2018

Took place the 12-16 March in Vienna, Austria, the 61st CND Session UNODC, in which Dianova Portugal attended as participant and speaker at side events on treatment and prevention.

The annual meeting of the CND, UNODC, is an event during which Member States, United Nations Agencies and Civil Society organisations debate and approve international drug policies, share best practices and enhance networking opportunities related to drugs, drug addiction, prevention – treatment – social reintegration, sustainable development, drug trafficking, money laundry and other drug related issues.

Dianova presented as Speaker the Dianova global outcomes and treatment results focused in Portugal, Italy, Spain and Chile at the side event "40 Years of Drugs. Drug Addiction and Recovery" organised by san Patrignano the 12 march. Dianova representative attend a diversity of other side events and special events on prevention (including the Listen First Prevention event), Informal

Dialogues between UNODC and VNGOC Civil Society. And last, attended as member the VNGOC General Assembly in which new Board has been elected, including Lucia Goberna, Institutional Relations at Dianova International, as Vice Chair.

Dianova Portugal is member of the Vienna NGO Committee on Drugs, registered at UN DESA and benefits of the Special Consultative Status of the Social and Economic Council of the United Nations (UN ECOSOC) through Dianova International.

dianova news

Dianova and the Sustainable Development Goals

"A way of development that fulfils the needs of the future generations without compromising their capacity to fulfil their own needs ", is the sustainable development definition supported by Dianova.

In 2015, the United Nations adopted the Agenda 2030 for the Sustainable Development, an initiative to strengthening the cooperation between Member States and other relevant parties in order to erradicate poverrty, protect the planet and guaranteeing prosperity for all. The 17 SDG and its 169 specific goals become a symbol of this ambitious project.

Dianova's mission finds echo in the context of the Agenda 2030. By implementing a diversity of good practices and initiatives both at the international and the local level in the 19 countries in which its 26 members operate, Dianova generates a significant impact in the implementation of the the SDG, adding up to the global efforts to build a better world for all and incorporating the language of the Agenda 2030 on its work.

People, Planet, Prosperity, Peace and Partnerships are the 5 P's of the Agenda 2030 of the United Nations' SDG. Dianova is aligning its activities with these P's in four main areas: Children/ Youngsters and Education; Health / Addictions; Protection / Human Aid; Alliances and Cooperation.

THE GLOBAL GOALS
For Sustainable Development

International Cooperation with Civil Society and Academic World

Between last 4 and 13 June, Dianova Portugal received delegations from Australia, Norway, France and the United States at Quinta das Lapas. This open-door policy aims to benefit professionals, researchers and students with knowledge and practical experience in the areas in which Dianova intervenes.

Civil Society
The exchange of good practices in the area of treatment of dependencies and socio-professional reinsertion on which interventions are based Dianova was the motive for sharing methodologies and results with the 30 representatives of WHOS (Australia) and Fagrådet - Rusfeltets Hovedorganisasjon Norwegian Federation of Dependencies (Norway).

Academia

The Portuguese decriminalization model, the effects of the social and health economic and financial crisis, its impact on Dianova and how it responds to the resulting challenges and constraints, and the exchange of good practices in the areas of prevention and health promotion, and social reintegration were the focus of the visits of 32 teachers and university students from ESTS - Ecole Européenne Supérieure in Travail Social, Saint-Omer (France) and Liberty University - Department of Psychology (USA).

dianova news

Dianova launched the 26 June the campaign "BRINGING ADDICTION STIGMA TO AN END"

#QuitStigmaNow

June 26 marks the third International Day against Drug Abuse and Illicit Trafficking since the adoption of the Sustainable Development Goals (SDG) "Transforming Our World: The 2030 Agenda for Sustainable Development." in 2015, which includes a commitment to leaving no one behind in the implementation of these goals.

Stigmas have the potential to negatively impact various areas of a person's life including employment, housing, social relationships and physical and mental health. They lead to delays in getting treatment, recovering, and ultimately reintegrating into society. Furthermore, they increase the chances of becoming involved in risky behaviour.

As since the past fifteen years, the campaign was launched the 26 June on the occasion of the International Day Against Drug Abuse and Illicit Trafficking of the United Nations #drugabuseday by the ordinary and associate members of the Dianova international network in Canada, Chile, Uruguay, Nicaragua, USA, Spain, Italy, Portugal, Sweden, Slovenia, Kenya, Pakistan and India.

All of these people need our help.
Don't search for a difference, there's none

#QuitStigmaNow

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It aims to raise awareness about the physical and psychological consequences of stigmatizing people facing substance use disorders or behavioural addictions. The campaign aims to emphasize that addiction is not a personal choice but a public health issue that needs to be addressed as such.

"BRINGING ADDICTION STIGMA TO AN END" - "DON'T SEARCH FOR A DIFFERENCE, THERE'S NONE!"

One of these people is now overcoming an addiction problem. Don't search for a difference, there's none

#QuitStigmaNow

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Dianova Portugal awarded with the Honourable Mention of the "Equality is Quality" Award

The jury of the 12th edition of the 2016/2017 Equality Prize awarded last 29 June Dianova Portugal the honourable mention in the category of entity of the social economy sector, awarded the Public Ceremony in Lisbon with the presence of the Secretaries of State for Equality and Citizenship and Employment.

The PIQ aims to distinguish between employers and employers with exemplary policies in the areas of equality between women and men at work, employment, vocational training and reconciliation of family and professional life, as well as good business practices for preventing and combating discrimination. domestic violence and gender.

Dianova International celebrates 20 Years Learning & Networking in Portugal

Last June 27-30, the Dianova International Network celebrated 20 years of partnerships and networking, 20 years of commitment to support the most vulnerable, 20 years of work and dedication to generate key changes in our societies # dianovanetworking20 .

During the General Assembly held on June 28 in Lisbon, under the patronage of the Lisbon City Council, 4 new associate members were integrated: GRADH, Togo (Africa); Karim Khan Afridi Welfare Foundation, Pakistan (Asia); Kothowain Vulnerable People's Development Organization, Bangladesh (Asia) and Izmir Saglik Turizmi Dernergi, Turkey (Eurasia). The International Network now has 26 members present in 19 countries.

On 29 June, with more than 80 delegates, the Symposium "Network Learning - Trends and Challenges of NGOs in the 21st Century" was held, with a diversity of international and national experts. The symposium was opened by Dr. João Goulão, Director General of SICAD - Ministry of Health.

Finally, on June 30th, the "Open Day" was held with a visit to the headquarters of Dianova Portugal in Monte Redondo, Torres Vedras, including a guided tour to the treatment units of the social inclusion and the HQ facilities: Therapeutic Community Quinta das Lapas and Social Reintegration Apartment.

dianova news

Dianova Portugal renewed Quality Certification

Dianova Portugal has successfully completed the transition process of the Quinta das Lapas Therapeutic Community Quality Management System for ISO 9001: 2015 edition, renewing Quality Certification. The continuous improvement of services is reflected in the Customer Satisfaction 94% and Service Recomendation 89% of dependency treatment.
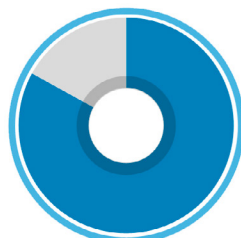
83%
RETENTION RATE
3 MONTHS
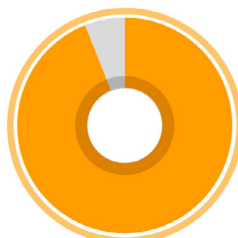
94%
CUSTOMER
SATISFACTION

89%
SERVICE
RECOMMENDATION

Dianova Portugal on behalf of Dianova International attended the first meeting of the newly elected Civil Society Forum on Drugs

The first meeting of the newly formed Civil Society Forum on Drugs (CSFD) took place the 3-4 July in Brussels, Belgium, at the premises of the European Commission. Dianova International, member of the CSFD since 2013 has been re-elected for the period 2018-2020, and was represented by Rui Martins in this inaugural meeting. The CSFD is an expert group to the European Commission, a structured dialogue platform constituted by 45 NGOs between the Commission and the European civil society, which supports policy formulation and implementation through practical advice in the area of drug policy.

This first meeting served to elected the new Board and establish the working groups, which were configured as follows:
- Chair: Laurene Collard, Federation of Addictions (France)

- Vice-Chair: Athanasios Apostolou, Diogenis (Greece), elected Vice-Chair of CSFD

- Working Group 1: EU Drug Strategy and Action Plan - Iga Kender-Jezierska, YODA (Poland)

- Working Group 2: Institutional Relations with the EU and International Structures - Marie Nougier, IPDC (UK)

- Working Group 3: Civil Society Engagement in National drug Policies - Katrin Schiffer, Correlation Network (Netherlands)

- Working Group 4: Quality Standards - Matej Kosir, Institut Utrip (Slovenia)

Given Dianova International's area of expertise and positive experience within the working groups during the previous period, for the upcoming years we will continue to form part of the Working groups 2 and 3. During the meeting, the working groups debated each terms of reference, briefing papers and plan of activities for the new mandate.

Furthermore, the European Commission provided updated information on the organisational and funding novelties for drug-related aspects within the European Union. From Dianova International we value very much the contribution provided by the CSFD and look forward to continuing the good work!

Dianova International continues to be a member of the CSFD for the period 2018-2020

João Goulão
General Director, SICAD – Health Ministry
(Portugal)

Dianova: The innovative model of decriminalization of drug use (Law 30/2000) has been the subject of international benchmarking, evidenced by the recent visits of government official visits to Portugal. What sets this model apart and makes it so attractive to governments in Norway, Canada, Macao or Brazil to name but a few?

João Goulão: Our Model of Decriminalization has, in fact, been the object of great attention and interest on the part of governmental entities and also of professionals of the area and of the media of countries like the ones mentioned, but also of several others. In addition to the visits, during which we explain how this policy was designed and implemented aside the organized field visits, we have been also invited to present it "around the world", from Australia or Macao to Brazil, for example.

In fact, what sets us apart from other types of models, some even in a framework of effective or de facto decriminalization, are two fundamental aspects: the interface of the Justice intervention sphere to Health through the original Commissions for the Dissuasion of Drug Addiction, and the creation of a set of integrated responses (Health and Social) that accompany the individual and try to meet their needs, whether a problem user or an occasional consumer. If, with the former, the great goal is to facilitate access to treatment or harm reduction structures, with the latter, what is wanted is to interrupt, as early as possible, a path that can lead to a more problematic use.

Dianova: The policy decision to "transform" the previous global intervention structure IDT into the current SICAD agency has had less positive effects on a diversity of stakeholders. What steps are being developed to make the intervention process at the level of addictions, particularly at the treatment level, more efficient and effective?

João Goulão: João Goulão: What we have come to realize, since the services have been transformed, is actually the loss of some effectiveness in interventions in the different "mission areas", from prevention to treatment, harm reduction or reintegration. Entropy was introduced into a structure that worked quickly and had easy communication at all levels.

The model to be adopted is still under discussion, with proposals for greater integration into the NHS as a whole, in contrast to the existence of a specialized care network, with a body that coordinates policy-making and has the capacity to implement them with their own resources and in close coordination with partners from the social and private sectors operating in the DAC area. It is also fundamental to articulate with the responses of other ministerial areas, with which we cooperate within the framework of National Coordination structures. I think that a decision will be made by those who will have to take it, which is the Government and, in particular, the Ministry of Health.

Dianova:: In spite of positive results in Portugal's addictions in recent years, shouldn't it be appropriate to carry out a study of the economic and social impact of the consumption and abuse of licit and illicit drugs (and their impact on school dropout, accidents or professional absenteeism, gender-based violence, crime, social and health costs, etc.) in Portugal with the aim to redefine and making decisions about policies and public measures of greater effectiveness in the areas of prevention, treatment and reintegration of addictions?

João Goulão: João Goulão: SICAD has been promoting and conducting studies in the most diverse areas related to addictions, and fortunately this is also an area of growing interest for master's or doctoral studies; there has been some scientific production in the areas that refers to and we have policies increasingly based on this evidence.

We are now completing the mid-term evaluation of the National Plan for the Reduction of Adverse Behaviors and Dependencies 2013-2020 and we will soon launch the international public tender for the final external evaluation of this Plan; of course, all the evidence produced will be taken into account, so that we can introduce the necessary inflections and adjustments into a strategy which, as a whole, we continue to regard as appropriate. If you ask me whether it is pertinent to conduct a global study, I can only give a positive answer:

It is very important to have the most accurate notion of reality so that we can deal pragmatically and truthfully with it.

Given the eminently technical and normative character of SICAD, we have produced guidelines for professionals who deal daily with concrete cases, in the various areas of mission and in different problems. One of the latest productions has to do with a new area of intervention, which is gaming. There's undoubtedly a huge interest in these guidelines for Professionals.

It is also worth noting the very important role that the European Monitoring Center for Drugs and Drug Addiction has played in producing evidence on the best and most effective practices; this very important European agency based in Lisbon, allowing us to interact very intensely and even to develop joint initiatives (such as the Lisbon Addictions Conference, whose third edition we are preparing for 2019) is a tremendous asset for our theoretical framework and for our practices.

And there are other international organizations whose work and reflections we have actively participated in (such as the Pompidou Group of the Council of Europe whose presidency we are about to take on), which have also contributed to the development of progressive policies designed with respect for human rights and in a perspective of great pragmatism.

LISBON ADDICTIONS 2017

Dianova: **The 1975-2017 Longitudinal North American Study "Monitoring the Future" confirms that increased social awareness of risk associated with prevention campaigns / initiatives has a positive impact on reducing illicit drug use and / or abuse. Collaborative Public Health Strategies suh as Community the Care is a cost-effective alternative to positive behavior change. What investment is being made or planned in this area of indicated, selective or universal prevention?**

João Goulão: Of course, a greater perception of the risks associated with the consumption or behaviors potentially generating abuse and addiction is important, along with the development of personal skills and resilience to peer pressure, among others.

We and other partners (ARS DICAD, the Directorate-General for Health, the Directorate-General for Education) have been promoting the development of several preventive programs at the various levels it refers to. At the level of universal prevention, I would like to highlight the "Self and Others" program developed by IDT / SICAD and recognized in the EMCDDA's Good Practice Portal; but there are many good and other preventive programs, some of which are financially supported under the PORI program.

As a corollary, risk perception, according to common trends detected in studies in several groups, has been increasing in the Portuguese population, especially among young people.

Dianova: **The guidelines of the second edition of the International Standards of Prevention of the United Nations and World Health Organization, point out that there must be an evidence-based approach in order to be effective. In view of the lack of technical and financial resources of most of the organizations involved in this area, what is the role of the State - and in particular the Ministry of Health - in ensuring that they are as widespread as possible for the Portuguese Good Practice to become a recognized for benchmarking at the international level?**

João Goulão: As I said earlier, some preventive interventions are already recognized as good practices and begin to be "exported"; is the case of the "I and the Others", which has aroused great interest among the delegations that visit us, and which is already under development, with the necessary adaptations to the local culture and with our technical support in Cape Verde.

We are able to support, in particular under the Integrated Response Operational Plan (PORI) program, preventive intervention projects; however, in the last few years, and given the urgency that the reality resulting from the impacts

of the 2008 economic and social crisis on a particularly fragile population with is the problematic users of drugs, the prioritization resulting from the diagnoses made locally has pointed to a primacy to the reduction projects and minimization of damages and social reintegration.

Dianova: **The evaluation of treatment outcomes, based on for example predictive indicators of success as retention rates at 3, 6 and 9 months for residential programs, should be a national reality in order to ascertain which typologies of the most successful treatment programs and prevention of relapses in the medium and long term? In an economistic and comparative perspective, what other indicators of success should exist for this purpose?**

João Goulão: Residential programs are undoubtedly extremely useful and important in our system. In Portugal we are fortunate to have a system in which there is a complementary complementarity between public responses (predominantly in the outpatient clinic) and those of the social and private sectors (predominantly residential); rather than competing as is the case in most European countries, these types of responses complement each other.

We have established a regulatory system, and with those entities that are in line with the rules and wish to contract services with the State, we have the possibility to conclude conventions. We have a wide range of models, in which we do not interfere, but which end up having different audiences. There are, for example, Therapeutic Communities that run their activity to highly disorganized populations such as homeless people with very compliant admission rules and, at the opposite end, Communities that have admission filters, namely motivational, extreme requirement.

Comparative evaluation of the effectiveness of the various intervention models is greatly hampered by these different starting points and is therefore often skewed and unfair. I think that evaluation should be done from the goals that each institution sets for its typical target population, not from generic goals. And the establishment of "rankings" is, like the one of the schools, very difficult and, perhaps, unjust.

Dianova: **Treatment results. In addition to preventing drug abuse, the goal of treatment is to return people to the productive functioning of the family, workplace / school and community. And to be more effective, it lacks employability measures, access rights, support networks, among others, are crucial for socio-professional reintegration trajectories and reduction of social and health costs in the medium and long term. What measures are currently in place or are they expected to be created in the short term?**

João Goulão: Reintegration policies are complex and very context-dependent. Positive discrimination programs, such as the Vida-Emprego program, became difficult to sustain when unemployment rates in the general population reached 16%; the social base of support for such policies disappears when the ordinary citizen begins to think "I have to get involved in drugs to get a job" ...

Today we are begin to be able to re-measure such measures; however, other aspects, such as housing, are now very difficult due to inflation in this area. Despite this, there are relatively successful projects, such as those developed under the "housing first" philosophy, which require a great deal of commitment from local authorities and which, with rare and rare exceptions, are not easily mobilized. ● ● ●

Dianova: Your role as Ambassador of Portugal at the international level in the area of addictions and addictive behavior is undisputed and widely recognized. In the pursuit of the objectives of Agenda 2030, what would you realistically like to see happen in this sector in the coming years in Portugal?

João Goulão: I am very happy to play the role of Ambassador, but I always resist the role of "architect of Portuguese policies" with which, many times, they present me. I am one of the workers and not the architect, although I ´m truly glad to be the face of the "work".

I do not know if we are exactly a sector. We certainly integrate the health sector in Portugal and in this condition it is important that issues related to addictive behaviors and addictions continue to deserve recognition of the ministry of health. It is important that we can intervene through our own structures, but also integrated in the National Health Service where the eventual users usually move, reducing their effort to access some of our services.

Our performance has been defined over the last decades, precisely, because of this proximity to the citizen and this is the path that I see us go through. The full functioning of a Referral Network that signals any individual that may be at risk is essential in this process, since the sooner we can activate the intervention mechanisms, the more chance we have of success.

The philosophy that underlies our system is the one in which I review myself, but which we must continue to deepen: addiction is a chronic relapsing disease, a health condition with the same dignity of others (especially those caused by other behaviors, such as food disturbs); the combination of these additive behaviors to the concepts of "sin" or "vice", which legitimized their assessment in the light of criminal law, should be added to the list, and include them in the promotion of healthy living habits; and confer on the people who suffer from this disease the same dignity as those suffering from other similar health conditions. There has been significant progress in reducing stigma, but there is still much to be done!

SICAD

Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências
Ministério da Saúde - Portugal

General-Directorate for Intervention on Addictive Behaviours and Dependencies
Ministry of Health - Portugal

GOVERNO DE PORTUGAL
MINISTÉRIO DA SAÚDE

SICAD Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências

. Promover a redução do consumo de substâncias psicoativas.
. Prevenir comportamentos aditivos e diminuição das dependências.
. Promote the reduction of the consumption of psychoactive substances.
. Prevent addictive behaviours and decrease dependencies.

Joaquim Fonseca
Coordinator Division of Intervention on Addictive behaviours and Dependencies (DICAD), ARSLVT, IP – Health Ministry (Portugal)

Dianova: What is the balance of the DICAD mission, ARSLVT, IP, in the last 5 years?

Joaquim Fonseca: In order to be able to make a balance of the 5 years (2013-2017) of integration of DICAD in the ARSLVT – Regional Lisbon Administration of Ministry of Health, it is important to take into account the organic framework and the conditions under which the DICAD activity developed.

At the time of the integration, the first challenge was to overcome the asymmetry of the pre-integration conditions (DRLVT of the former IDT - now SICAD), which had a Regional Coordination structure of five leaders, for a structure in the ARSLVT with only one leader, equivalent to Head of Division, maintaining the Coordinators of the Local Intervention Units, without any equivalent to the Director.

As is well known, technical expertise was assigned to the DICAD only on the assumption that the activity to support the operation of the DAC intervention would be operationalized by the remaining structures of the ARS Central Services (Regional Health Administration). It was therefore necessary to include the activity "care" and "community intervention" in the logic of a structure (Central Services of the ARSLVT), which, of course, was not intended for the provision of care.

This work required a great effort from all DICAD professionals, both at the level of the Coordination and the Technical Teams of the UIL (Local Intervention Units) and an adaptation by the professionals of the Central Services of ARSLVT.

Regarding the Human Resources dimension, a critical success factor for any organization, despite the great difficulties that still remain, some investment was made and no transfer of professionals from the DICAD Teams to other ARS structures was promoted. However, there are still constraints at the level of professionals, such as general practitioners who, as they grow older, have not been able to pass "testimony" to younger colleagues, Operational Assistants to the Internment Units, and nurses in some ETs (Treatment Teams).

Regarding the response capacity in the Treatment area, there have been difficulties in the Internment / Residential Units, however, in general, and despite these constraints, it was possible to maintain the activity of the various Treatment Teams, and there was no decrease in the main indicators of activity.

Regional Clinical meetings, Coordination Meetings and a large training activity were also held. Still in the scope of the Treatment, due to the existence of financial liquidity in the ARS, it was possible to fulfill, without delays, the payments of the convention protocols agreed with the Therapeutic Communities, a reality that must continue to be guaranteed.

Regarding the other areas of intervention, it should be bear in mind that, when RIAs were set up under ITD, sharing of resources between teams was presumed. Over time, it was verified that the majority of these professionals came from the Treatment Teams, and that, in general, they were not allocated 100% to those activities, namely Prevention and RMHR (Risk Minimization and Harm Reduction), situation that led to the answer was always short necessary.

In addition, because of the creation of the Operational Program of Integrated Responses, which presupposes a diagnosis of territory, part of the time of those professionals is invested in the accomplishment of this diagnostic activity.

However, during the last five years, it has been possible to increase the involvement of UIL Technicians in Risk Minimization and Harm Reduction activities, increasing, consequently, the number of actions developed by DICAD professionals, in addition to projects funded and developed by other entities.

There was also an increase in intervention in Prevention, both at the level of professionals involved at the level of actions. In this area, an important partnership was established with the "School Health" of the ACES – Joint Health National Public Centres (Integrated Project for Prevention of DKA), allowing the joint development of actions between DICAD technicians and School Health Teams, as well as training for School Health professionals on the DAC theme, culminating in a Regional Meeting, held in 2016;

It was also possible to guarantee all the territorial diagnostic activity that allowed to verify the continuity of some interventions in the scope of the CRI – Integrated Response Centre (eg the methadone program for the City of Lisbon) and the presentation of proposals for new interventions, for example the discussed "Rooms for Assisted Consumption". As a result of this diagnostic activity, all procedures for the financing of projects, in particular the launching of various competitions, continue to be developed in consultation with SICAD.

It should be noted that all this activity took place in a context of complete technical autonomy that was granted by the ARSLVT Administration Council to the DICAD Coordination. Thus, it was possible to draw up Activity Plans in articulation with UILs and in line with the different national guiding documents issued by SICAD, with whom constant dialogue and institutional cooperation was maintained, as well as by the DGS (Health General Directorate – Ministry of Health).

Despite all the constraints, it is however possible to make a positive balance of these five years. It is now important, and in the face of a reorganization of the various DAC services, to take advantage of this transformative opportunity, taking into account the needs of the people to whom the intervention should respond.

The recent model announced by the Secretary of State of Health, which assumes the maintenance of a regional coordinating structure in the ARS and a strengthening of the national coordination dynamic, brings with it a huge challenge of approaching the rest of the NHS, putting all resources on the National Health Service to compete for the multiple emerging needs in the phenomenon of Additive Behaviors and Addictions. ● ● ●

interview with...

Dianova: As the region with the highest population density in our country, what are the main challenges that Lisbon and Tagus Valley have in the area of mental health, particularly at the level of dependencies?

Joaquim Fonseca: There are several challenges currently facing the intervention in Additive Behaviors and Dependencies, implying, necessarily, an articulated response with the other structures of the National Health Service.

The DICAD Teams, in particular those of Treatment, are confronted with a very aged and very sick population, with several pathologies, both physical and mental. It is a population with a high prevalence of infectious diseases, namely HIV / AIDS, HCV / hepatic disease and Tuberculosis, requiring concerted responses between health care, primary, hospital, continued and / or palliative.

The aging pattern, which has become more pronounced, is evidenced by the percentage of assets with more than 40 years (52% in 2011, to 73% in 2017).

A significant part of this population is followed in the DICAD teams due to problems related to alcohol consumption. In 2017 they accounted for about 25% of the total assets in the Lisbon and Tagus Valley teams, and about 48% of the new cases admitted that year, of which 84% were over 40 years old. It is, therefore, a population that is even older than the rest.

Although Opiates consumers are by far the most treated population in our teams - in 2017 they accounted for 57% of total assets and 22% of new cases, placing them in second position in the new cases - another population group related to Cannabis use should be taken into account. In fact, in 2017, they already represented a total of 10% of the assets and 20% of the new cases, being a very young group, in which about 48% are between the ages of 15 and 24 years. If we consider the age group from 15 to 19 years, we will have about 26% of all new cases.

From the point of view of mental health, knowing that 6 out of 10 people with an addiction to psychoactive substances, whether legal or illegal, suffer from any other mental disorder, it is easy to see that this is a dimension that requires great investment and attention from the entire NHS.

Once the populations have been identified, it is important to find answers to their needs, which is one of the main challenges facing the structures that work in the field of Additive Behaviors and Dependencies. To build the necessary bridges with existing responses, especially with the structures dedicated to mental health in the NHS.

In this context, in Lisbon and Vale do Tejo, several articulations have been developed, both with Pedopsiquiatria, in the framework of the DICAD consultations aimed at Youth and existing in all CRI, as well as with Psychiatric services of several hospitals, in the response to cases of double diagnosis.

Considering also the profile of these populations, it is important to find solutions, both at the level of home support and at the level of care in long-term residential structures / programs.

These and other themes have been the subject of consultation at meetings between the DICAD Coordination and the Regional Coordination of the Mental Health Plan, through articulation with the Technical Support Office and participation in the Regional Mental Health Council.

In future terms, and from the strategic point of view, it is important to continue to consolidate the specialized DICAD response by the DICAD Teams in all areas of Intervention (Prevention, RRMD, Treatment and Reintegration), deepening and strengthening ties with Mental Health of the NHS, since only then will it be possible to respond effectively to the real needs of the people. ●

Suzete Frias
Regional Director for Prevention and Drug Intervention, Regional Health Secretary, Azores Regional Govenrment
(Portugal)

Dianova: What are the main challenges in the context of the addictions currently facing the Azores?

Suzete Frias: The Autonomous Region of the Azores has a higher prevalence of additive consumption than that observed at national level, making it important to understand if there are specific regional variables that justify these differences. Being a region marked by geographical discontinuity, where, although there is some proximity between the islands, these are marked by a specific geographic nature (great distance and insularity). Perhaps this geographic isolation, similar to that observed in other isolated geographic areas, may be contributing to the high prevalence of psychoactive substance use observed in the Azores archipelago.

Parallel to this and in our understanding, the geographical discontinuity and consequent insularity can promote the development of sociocultural particularities in each of the 9 islands, which leads to specificities and constraints on each island, which may translate into differences in factors of risk and protection for the consumption of psychoactive substances.

Thus, the Government of the Azores awarded a Life + Project Study to the University of the Azores, carried out in each of the islands, so that given the specificities found, it can delineate and implement territorial measures. The territorialisation of the answers generates the opportunity to create measures, according to the real needs of the populations.

Dianova: Prevention is an effective investment in the well-being of children, young people, families and entire communities. Studies show that with this type of evidence-based approach, we can save 30 times the amount invested in drug prevention in future social and health costs. What investment has been made, or planned, at the level of targeted, selective or universal prevention campaigns or initiatives in the Azores archipelago?

Yannis Freris: The XII Regional Government of the Azores has assumed the need to consolidate the implementation of the Regional Strategy for the Promotion of Healthy Lifestyles and Prevention of Risk Behaviors as one of the priorities for action in the area of Health.

With this in mind, the Regional Secretariat of Health has understood as vital an intervention that promotes adequate parental skills in "caring" figures of children and young people, in a line of prevention of risk behaviors of younger generations in the area of addictions. In this way, the Government of the Azores will implement the Family and Community Prevention Program in September, a strategy that will focus, among other initiatives, on the implementation of the Family Competencies Program (PCF), adapted to the Portuguese reality.

Thus, and from the constitution of a set of technical teams, formed and supervised by a Technical and Scientific Unit headquartered in the Regional Directorate for Prevention and Fighting Addictions, will implement the Program throughout the archipelago in a double logic - on the one hand, through of a universal prevention for parents and children (involving children between the ages of 6 and 11 years), and on the other by a selective prevention strategy in certain population groups identified with risk factors.

And it is in the structuring and construction phase the Safe Path Project 0, a proposal for universal and selective prevention of early intervention, an initiative that will be operationalized as a pilot project in three vulnerable territories of the Region.

This aims:
Generate adequate prenatal conditions for the parents and promote the healthy development of the child; improving family relationships, promoting an increase in levels of communication, secure links, empathy and intra-aggregate cohesion. At the same time, it intends to increase the levels of planning and family organization, the times of quality cohabitation and to effect a decrease of the conflicts in the system; increase parental skills, providing more knowledge to parents so that they can play their roles more effectively in the family. It also aims is to increase carers' self-esteem and parental effectiveness, by reinforcing an effective positive and disciplinary attitude that contributes to a reduction of parental stress; to intervene in the prevention of psychosocial risks in the prenatal and postnatal periods, both in the parental figures and in the respective "descendants", also investing in the community reality (in terms of coverage of "other" child development needs).

In the Recreativo Noturno (Night Recreational) context, the Giros (Go Round) Program is developed in partnership with the Casa do Povo Santa Bárbara, which aims to selectively prevent and minimize risks in this context.

Dianova: The legalization of therapeutic cannabis is currently being debated in Portugal, taking into account the international experiences of countries such as Uruguay, Holland and the United States, such as Washington, Colorado or California. What is the position of the Regional Secretariat of the Azores in relation to this issue, taking into account the related effects and consequences?

Suzete Frias: It is important to note very clearly in this reflection the separation between the therapeutic use of cannabis and its recreational use, because cannabis can be administered in certain disease situations. It is convenient at this time, and since these countries are experimenting, waiting and realizing the impact of legalization, what effect will it have on consumption among young people, for example. Despite the specificities, these experiences that some countries are carrying out can function as a test laboratory for the Azores. It is important to bear in mind that Cannabis is a disturbing psychoactive substance, it is not innocuous as it is often wanted to be believed, it is important ● ● ●

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to wait for the scientific evidence and to continue to make prevention and work skills in young people for a responsible decision.

Dianova: Is the quality of the services provided and the respective evaluation of results in the treatment of addictions a prerequisite for a partnership between the health services of the Azores and the social organizations that provide them with a proximity logic? What are the main benefits of this cooperation for entities and users / families?

Suzete Frias: The Government of the Azores is creating a regional reference network that aims to optimize the synergies in each territory, based on the knowledge of the reality. In addition to diagnosing the problems, we intend to identify the potentialities for change in the context of intervention, as well as the resources and responses available, with the participation and definition of roles of all.

This network will allow to extend to this scope new agents and new interventions, in order to allow a response that effectively attends to the complexity of the person in all its dimensions. The benefit of cooperation between all actors, and especially the user and family, is the provision of responses that are not only disease-centered but promote the health and well-being of the person, in order to family and social ties giving a sense of belonging, and to promote personal and social skills in the different contexts where they relate.

Dianova: Treatment (of the addictions) results. What measures is available to the Azores Health Region, in articulation with other Regional Government structures, to promote effective and successful socio-professional reintegration after treatment?

and in particular the SDG Quality Health, what measures are being planned or implemented in this sector to achieve this goal in the Azores archipelago?

Suzete Frias: I list below some of the Objectives for Sustainable Development and actions within the Regional Direction of Prevention and Combating Dependencies in order to reach them in the RAA.

• to end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, and to combat hepatitis, waterborne diseases and other communicable diseases

A protocol is being drafted between the Regional Directorate for Prevention and Control of Dependencies with ABRAÇO, which aims to create a network of institutions and professionals trained and able to respond in the context of HIV / AIDS, viral hepatitis and STIs, from screening, linkage to health care and retention in treatment, complying with national and international guidelines and according to the best available scientific knowledge; Increase awareness of the HIV status of the general population and their knowledge of HIV, viral hepatitis and other STIs; Increase adolescents' knowledge about HIV, viral hepatitis and other STIs, with a special focus on modes of transmission, protective methods and emotional resilience work; Increase the awareness of the general population about the theme of sexual and gender rights.

• Reduce premature mortality from non-communicable diseases by prevention and treatment by one third and promote mental health and well-being

• Strengthen prevention and treatment of substance abuse, including drug abuse and harmful use of alcohol

• Strengthen the implementation of the Framework Convention on Tobacco Control in all countries, as appropriate

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Suzete Frias: The Government of the Azores has decided to prioritize and broaden the approach and responses from the scope of Additives Behaviors and Dependencies (DAC) from a cross-cutting, cross-sectoral and integrated perspective. With regard to the Regional Secretariat for Health and regarding the reduction of alcohol-related problems, we have the Action Plan for the Reduction of Alcohol-Related Problems, which involves partnerships with civil society resources and other government departments in two dimensions , demand and supply reduction, and the Regional Alcohol and Health Forum, which involves various partners among the various government departments and civil society, is being set up as an operational instrument.

Dianova: It is an important investment in the field of the policies of this Government, as these problems contain risks and costs to which it is important to face the consequences and impact they have on the life of the person, families and society. In the pursuit of the objectives of the Agenda 2030

- Reinforcement and implementation of smoking cessation consultations in all Island Units;
-Implementation of the 100% Smokeless Homes and Cars Program to all 4th year students in the RAA;
-Implementation of the Regional Plan of Action for the Reduction of Additive Behaviors and Dependencies;
-Implementation of the Action Plan for Reducing Alcohol-Related Problems;
-Implementation of the Regional Plan to Combat Tobacco
- Creation of intervention teams in Admissible Behaviors in all Island Units;
- Strengthening the inclusion of mandatory themes for the promotion of Healthy Lifestyles and Prevention of Additive Behaviors and Dependencies in the School Health Manual.

• Halving, globally, the number of deaths and injuries due to road accidents
-Implementation of the Action Plan for Reducing Alcohol-Related Problems and the Alcohol and Health Regional Forum

Davide Brundu
Vice President, Dianova Chile (Chile)

Dianova: Can you briefly describe the addiction with or without substances situation in Chile in terms of prevention, treatment and social reintegration / recovery?

Davide Brundu: The human being has used drugs since time immemorial, mainly from the natural flora, to alter their psychic and psychic mood. Currently, there are synthetic drugs, which are produced artificially, causing similar effects to the natural ones. Regardless of their origin, these elements can produce addiction, when consumption is based on abuse.

Within the group of legal or psychoactive drugs is alcohol, benzodiazepines, nicotine, among others. On the other hand, marijuana, heroin, cocaine, among others, have been classified as illegal.

Although in the beginning they are used for recreational purposes, it is common to go to abusive and risky consumption, a situation that ends in addiction, a biopsychosocial disease that compromises the whole integrity of the individual.

We understand dependence or addiction as a chronic and irreversible pathology where the interaction between the individual and a given substance causes physical and behavioural changes (such as the irrepressible impulse to consume the drug and the deprivation syndrome, among others), also triggering adverse effects in the social, family, academic, work, etc.

For a person to develop addiction on drugs, various factors come into play, be they individual (belonging to the personality or genetic), family and social. In this sense, the so-called psychosocial adversity plays a decisive role in many people, because poverty, social vulnerability, lack of opportunities, poorly constituted families, intrafamily violence, less access to education and other realities could enhance the appearance of addictions to certain substances.

The person falls into obsessive behaviours where their energy, time and attention revolve around addiction. Among the symptoms that are observed in addiction we can mention:

- Development of tolerance, which implies that the individual progressively increases the amount of the drug to achieve the desired effect.
- Appearance of the withdrawal syndrome (characterized by unpleasant symptoms and intense discomfort when suspending the administration of the substance and disappearing when it returns to consumption).
- Desires and persistent thoughts of using the drug, accompanied by useless efforts to stop or control the administration of it.
- The patient spends a great deal of time for obtaining and consuming the substance.
- Family, social, labour and even economic conflicts, where there is a deterioration and a reduction of the time allocated to the activities pertaining to those areas.
- Consumption of the drug despite the physical and psychological consequences it produces in the individual.

Not all addictions are defined by a drug. There are certain behaviours that can become addictive, in which the individual is not able to control their impulses. The loss of control is compounded by the decline in quality of life as different areas are affected.

Such is the case of gambling, pathological addiction to games, where the individual experiences great difficulty in suppressing their impulses that lead to this type of behaviour. This reality triggers serious consequences in the personal and social life of the patient.

Cyberaddiction could be described as a kind of "relative" of pathological gambling, since it is an addictive behaviour related to pathological gambling, where there is a problematic use of the Internet. The person does not have the capacity to stop the prolonged and repetitive use of the internet, generating an addictive pattern that affects him in the family, social, academic or work area, that is, in the offline life.

On the other hand, we find sex addiction or ● ● ●

hypersexual disorder, a mental health disorder that leads them to pathologically increase their sexual activity, in the face of adverse situations such as stress or depression. Sexual desire manages to dominate all aspects of the individual's life, unleashing family, social, labour and economic problems.

Compulsive shopping is not only a consequence of consumerism, but rather an addiction triggered by psychological problems, frustrations and deep dissatisfactions that seek to be fought with the acquisition of new objects. As in other disorders, the addictive pattern is reflected in the transitory sense of satisfaction caused when buying, followed by guilt and remorse for the expenses incurred. To put an end to these negative feelings, the affected person compulsively returns to buy, which ends up consolidating the vicious circle.

Dianova: What are the 3 to 5 main challenges that Dianova Chile faces in the treatment of addiction at this time?
Davide Brundu: The main challenges that Dianova Chile faces are the quality of the programs versus the sustainability of the organization.

The quality of the treatment implies paying attention to various aspects, such as the accessibility to the treatment and the opportunity of the response; the effectiveness and efficiency of therapeutic interventions; professional skills; respect for the rights of the users, among others.

It is identified in the continuous improvement of quality a way to advance in this way, paying special attention to how the processes are developed and the results obtained; timely detecting errors or areas to be improved, and installing new ways of proceeding that imply the systematic use of methods and strategies to consolidate the necessary changes.

In this way of working, the perception -and opinion- of the user and their family, as well as the participation of the treatment teams, in a public / private care network that shares a common sense oriented to the valuation and commitment to the progressive development of excellence practices.

The delivery of a service of excellence is not valued by the public policies of drugs, in this aspect the State does not economically recognize the real value of a service of professional quality.

Dianova: Redesigning addiction treatment interventions based on evidence, good practices and the evaluation of results and results is a priority request in Chile by health and social authorities and governments to increase public funding for residential programs?
Davide Brundu: The interventions developed based on the scientific and empirical evidence, as well as the conclusions of the evaluations of the programs at the national level, constitute the base that sustains all the actions of all the programs directed to people with problematic drug use. Unfortunately public financing does not correspond to the real costs that are necessary to deliver a quality service that has as objective the continuous improvement and the permanent satisfaction of its beneficiaries.

Due to the economic factor, residential programs are under a latent risk because of their continuity.

Dianova: Predictors of success, such as retention rates or therapeutic discharge, in your general or specific addiction treatment programs, in addition to enhancing a positive image among key stakeholders, can contribute to greater recovery success in his country. From a political decision-making perspective, what measures should be provided to increase social reintegration?
Davide Brundu: The public policies of drugs in Chile aim to: strengthen the quality of care of the programs according to the specific needs of the populations served in the various programs. The health and social care of people with problematic drug and alcohol consumption should be guaranteed, facilitated and coordinated from the very beginning where all programs should be based on the needs of users.

The individualization, the integrality, the incorporation both in the public network of health and the private, the permanent coordination of the attention network and have resolution, as far as possible, at a territorial level. Where there must be diversification of the offer that adapts to the reality of the users.

Strengthening quality means greater effectiveness, efficiency and equity of diagnostic and therapeutic interventions, adequate protocols, clinical guidelines, based on evidence.

The continuous improvement of the public-private network must advance in the design of methodologies that contemplate expedited coordination with the formal systems for the process of reception and motivation to the programs. To achieve full social integration, coordination between social services, the judicial system and health services must improve.

Dianova: SDG 3 - Health and Wellbeing - of the United Nations 2030 Program focuses on ensuring a healthy life and promoting well-being for all ages, including improving the prevention and treatment of abuse of licit or illicit substances. Taking into account the current situation in your country, what are the key triggers to realize that goal until 2030?
Davide Brundu: To fulfil this objective, it is essential to actively promote public commitment through public policies, through the creation of communication channels that allow us to know the sensitivities of these issues, collect and stimulate citizen initiatives in this area and achieve their adhesion to programs, projects and actions.

Social participation gives reality to the voice and initiatives of citizens in a phenomenon of high concern and is essential to address the problems associated with the problematic consumption of drugs and alcohol.

National and international experience indicates that in order to achieve a greater impact on the reduction of demand and the costs associated with problematic consumption, it is more effective and efficient if the community is mobilized, taking advantage of and strengthening its networks and initiatives at the local level and enhancing the resources of civil society itself to face the problem. ●
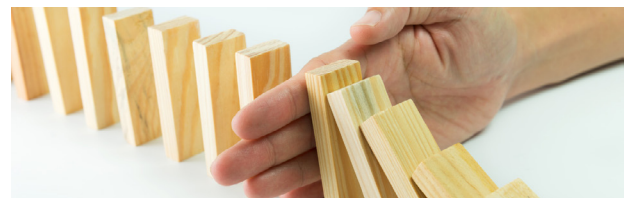
Pierangelo Puppo & Ombretta Garavaglia
Board Directors, Associazione Dianova Onlus
(Italia)

Dianova: Can you briefly describe the addiction with or without substances situation in Italy in terms of prevention, treatment and social reintegration / recovery?

Pierangelo Puppo & Ombretta Garavaglia: Italy is a country of great historical tradition in residential interventions (therapeutic communities) and in the field of compulsory health care for addictions.

The addictions area in Italy in some regions has been merged with psychiatry, while in others it maintains its specific identity.

In Italy the 3 pillars such as prevention, treatment and social reintegration are managed both by the public service and by the accredited social private sector.

The big difference between these two systems is that the national public service performs largely an outpatient job while the private accredited (associations, cooperatives, etc.) do a residential focus. Both within the public and private services, there are services/modules dedicated to prevention, harm reduction and reintegration.

The accredited private individual receives funding from the national health service through the stipulation of specific contracts.

Moreover, even if more and more rarely, experimental projects are financed on various areas of prevention, harm reduction and reintegration, and services for chronicity.

In recent years new forms of dependence have begun to emerge without the use of substances (gambling, cyberdependence, sexaddiction, etc ...) where in particular gambling is becoming an extremely widespread phenomenon in the population even of old age. Also in recent years, intervention models have been created

for this type of dependency, as well as outpatient ones, including residential ones.

Unfortunately, the reference framework law is firmly established in 1990 (309/90) and for some years a political strategy has been lacking at national level.

Dianova: What are the 3 to 5 main challenges that Dianova Italy faces in the treatment of addiction at this time?

Pierangelo Puppo & Ombretta Garavaglia: Over the years, services in general and Dianova with them, record an exponential increase in the average age of users who, at the moment, settles around 41 years with extremes ranging from 20 years to 61 years.

The juvenile audience is not intercepted by the public service and not even by the private one, so it often approaches rehabilitative paths in highly compromised situations.

The increasingly present psychiatric comorbidity and the raising of the average age in the user we welcome has oriented us to personalized paths that rather than exclusively aiming at complete rehabilitation try to achieve the highest degree of autonomy as a primary objective. Flexibility in interventions remains one of the major challenges that both public and private services will have to face in recent years.

Dianova: Redesigning evidence-based addiction treatment interventions, good practices and evaluation of results and results is a prior request in Italy by health and social authorities and governments to increase public funding for residential programs.

Pierangelo Puppo & Ombretta Garavaglia: During the three-year period 2016-2018, the evaluation of the outcome and the social impact produced through our interventions was identified as the primary objective in the Dianova Italia Strategic Plan. During 2016-2017 all the management teams of the centres and services took part in a training program that allowed us to understand all the mechanisms and tools that are used and that are available in the literature.

Subsequently, during the meeting of the Therapeutic Area held in May 2017, the need to identify a common work ● ● ●

interview with...

tool that allowed us to carry out the evaluation of the outcome of the users taken in load.

A working group was created which included all the therapeutic managers of the facilities and the director of the therapeutic area in order to identify the most suitable instrument that could meet the needs of all the services offered. After a long research it was decided to adopt as an instrument the ICF that in addition to the Italian version dedicated to addictions has a version also dedicated to children and teenagers another area in which Dianova Italy has been operating for some years.

Dianova Italia has chosen to use this tool in order to evaluate the outcome at the individual level through different administrations both in the beginning and at the end of the program, whatever it is, as well as for the definition of the individual project.

The future perspective, consistent with the objectives of our strategic plan, is that, through this tool, we can build an outcome on the user group.

Dianova: Predictors of success, such as retention rates or therapeutic discharge, in your general or specific addiction treatment programs, in addition to improving a positive image among key stakeholders, can contribute to greater recovery success in your country . From a political decision-making perspective, what measures should be provided to increase social reintegration?
Pierangelo Puppo & Ombretta Garavaglia: The general economic situation of the country and the personal / family / social resources, do not facilitate the path of social reintegration presenting great difficulties when the users leave residential rehabilitation paths.

It will be necessary to rethink networks and services that work together and can support a range of people who will not be able to stand alone through social housing interventions, work support routes, social housing and dedicated facilities.
In addition to this, the educational and professional training within the rehabilitation paths can be an important card for the successful completion of the work-related reintegration.

In short, think back to a welfare system that takes into account the current situation as it also dates back several years ago.

Dianova: SDG 3 - Health and Wellbeing - of the United Nations 2030 Program focuses on ensuring a healthy life and promoting well-being at all ages, including improving the prevention and treatment of abuse of licit or illicit substances. Taking into account the current situation in your country, what are the key triggers to realize that goal until 2030?
Pierangelo Puppo & Ombretta Garavaglia: Definitely return to invest in prevention and education with a particular focus on those behaviours and attitudes that can bring people closer to addiction, in the broadest sense of the term, and social unease trying to offer tools and empowerment to our young people because they can learn to stand alone.

Supporting families and educational agencies in reviewing and redesigning their role, in the light of all changes, in today's society, promoting listening and dialogue with the new generations so that they can offer us, as well as their point of view, even a another vision of the world.

Ensure public health by trying to ensure that no one is forgotten, reducing inequalities between human beings. ●

interview with...

Antonio Molina
Therapeutic Coordinator, Asociación Dianova España (Spain)

Dianova: Can you briefly describe addiction with or without substances in Spain in terms of prevention, treatment and social reintegration/ recovery?

Antonio Molina: For many years the intervention in addictive behaviors has been based fundamentally on pharmacological intervention on the main substances of abuse. This has led to a very effective network of intervention in drug dependence, which, however, had many more problems to detect and prevent other types of addictive behavior, with and without substance. In the current National Strategy on Drugs this approach is corrected, speaking of development of evidence-based programs on all types of addictive behaviors, prevention and early intervention also with addictions without substance … In short, a great advance in the theoretical approach that has to be accompanied by the corresponding technical evolution.

Dianova: What are the 3 to 5 main challenges Dianova Spain faces in the treatment of addiction at this time?

Antonio Molina: For Dianova Spain it is fundamental to develop quality programs, based on scientific evidence, verifiable and replicable. In that sense, our challenges are related to the development of efficient and sustainable residential and ambulatory services, especially for three groups: women, young people and people with addiction problems without substance.

Dianova: Redesigning addiction treatment interventions based on evidence, good practices and the evaluation of results and results is a prior request in Spain by health and social authorities and governments to increase public funding for residential programs.

Antonio Molina: Yes, and for us it is the ideal strategy. In this way we can demonstrate the validity of the interventions that we develop in a clear and concrete way. For years, for Dianova the evaluation of its interventions and the quality of its intervention services in addictive behaviors, as well as all auxiliary services, is an obligation. On this requirement we build and consolidate our relationships with the agencies and public and private organizations with which we work together.

Dianova: Predictors of success, such as retention rates or therapeutic discharge, in your general or specific addiction treatment programs, in addition to improving a positive image among key stakeholders, can contribute to greater recovery success in your country . From a political decision-making perspective, what measures should be provided to increase social reintegration?

Antonio Molina: In Spain, complementary social integration programs are necessary, due to the difficulties that a certain population with addiction problems presents. Models such as Housing First or experiences such as those we have been able to share with European partners such as Basta (Sweden) or San Patrignano (Italy) show us the importance of working with the labor insertion from the beginning of the interventions, especially with drug-dependent women who usually need greater intervention in this area. Also for young people who have been in a center we think it is necessary to favor a posterior support and facilitate social integration. For this we design specific programs for these young people, and especially for women

Dianova: SDG 3 - Health and Wellbeing - of the United Nations 2030 Program focuses on ensuring a healthy life and promoting well-being at all ages, including improving the prevention and treatment of abuse of licit or illicit substances. Taking into account the current situation in your country, what are the key triggers to realize that goal until 2030?

Antonio Molina: Experiences such as the Recovery Cities show us that we still have to advance not only in prevention but also in health promotion. Emotional health seems basic to us. For this we develop programs to improve personal, family and couple relationships. Food health, habits, sports practice, gender equality … We think that there is still a lot of work to be done and we are going to put our grain of sand in addressing all these problems. ●
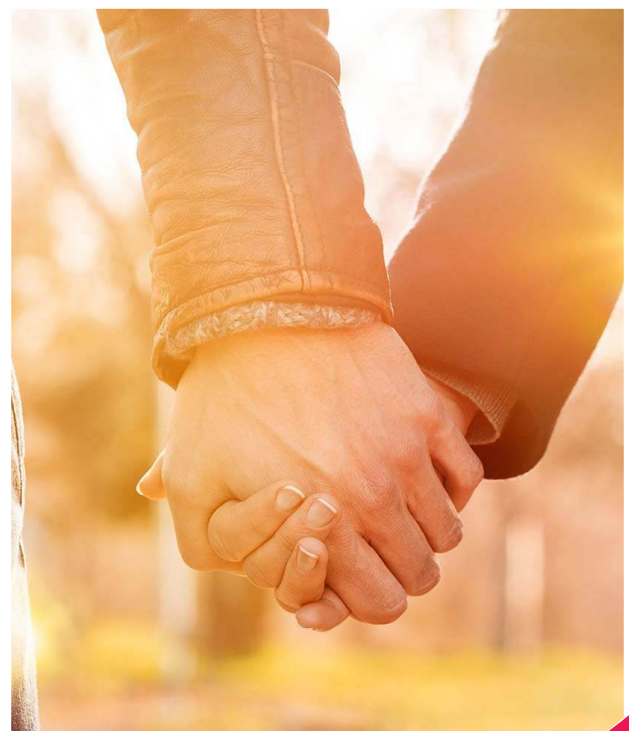
Barbara Ham
President, Društvo Up, Dianova International Network Associated Member (Slovenia)

Dianova: Can you describe briefly the addiction with or without substances situation in Slovenia on what concerns prevention, treatment and social reintegration / recovery?

Barbara Ham: There are numerous programs in Slovenia dealing with various forms of addiction, which are mostly organized in non-governmental organizations co-financed by the ministries (Ministry of labour, Family, Social Affairs and Equal Opportunities, Ministry of Health, ...) and the municipalities in which they are taking place.

In recent years, besides programs in the field of alcohol and illicit drugs, there has been an increasing number of programs that deal with non-chemical addiction (online addiction, social networks, sexual content). Preventive programs for adolescents, especially those who are addicted to marijuana and new synthetic drugs, are developing. In recent years, more and more financial support by government structures have been allocated for low-risk programs and it loks like it will be the same in the next decade (for example: support programs for drug users or people on substitution therapies).

Dianova: What are the 3 to 5 main challenges Drustvo Up is facing on addiction treatment at the present time?

Barbara Ham: The main challenges of the UP Society at this moment are focused on the area of preventive counseling work with adolescents who are addicted to marijuana and new synthetic drugs, counseling work with young adults and elderly people who have a history of addiction (and treatment) from alcohol and illicit drugs, and are sufficiently motivated for counseling, and working with persons who are in various forms of prison sentences - as an additional form of counseling and rehabilitation.

In addition, the Ministry of Labor, Family, Social Affairs and Equal Opportunities, which is the main co-funder of social welfare programs in Slovenia, abolishes the co-financing of residential programs such as communes and therapeutic communities. For our Reintegration program, they demand that we abolishe it and redirect our work to work with adolescents, in the form of Day Care Centers or in the form of outpatient counseling.

Dianova: Redesigning addiction treatment interventions based on evidence, good practices and assessment of results and outcomes is a pre-condition request in Slovenia by health - social authorities and governments in order to increase public financing to residential programs?

Barbara Ham: In Slovenia we have many examples of good practice, especially in therapeutic community programs and reintegration addicted to NGOs, including newer forms of treatment for dual diagnosis, addicted mothers with children, day centers for adolescents, counseling for young people (who experiment with drugs) and their parents.

The "UP" Society makes an important contribution to the latter in preventive and counseling work with young people and families, the reintegration of addicts and counseling for those who have decided to abstain. Unofrtuntely, it is currently demonstrating that the social authorities and governments will not increase public financing for residential programs.

Dianova: The SDG 3 – Health and Well-being – of the 2030 United Nations Agenda focus on guaranting an healthy life and promote the well being on all ages, including enhancing liccit or illict substances abuse prevention and treatment. Considering the present situation in your country, what are the key triggers to make that goal a reality until 2030?

Barbara Ham: As the main guidelines for the next decade, we highlight the idea of a healthy lifestyle, without addiction, more sports activities should be carried out for the groups with which we work, and work on the personal values of the user, which is the main motivational element of progress. In this way, young people could return to the school system or encourage them to persist in it. As an important factor we see the active participation of the family in solving the problem of the individual.

In a wider field, support programs for older users who are on substitution treatment programs will have to be developed; also programs for addicted mothers with children, users with multiple diagnoses / diseases associated with addiction; programs for supporting persons in prisons wishing to establish abstinence; street work with adolescents in more remote locations (from Ljubljana) who experiment with drugs. The main goal is to increase the number of people, especially young people who decide to abstain as a value, and spread positive values in their social environment - among peers. Immediately afterwards, the goals are also to reduce the risks of the development of diseases related to drug use (hepatitis C, HIV, disability), homelessness and social exclusion. ●

interview with...

Rajesh Kumar
Executive Director, SPYM, Dianova International Network Associated Member (India)

Mental health issues among substance users are not addressed as well as only few centers are devoted towards addressing dual diagnosis cases. No. of psychiatrists are very few in the country, and therefore services are limited. Drug addiction is a major problem for many families, communities and law enforcement. Massive numbers of addicts are left to be treated by the families at their own financial costs.

Families can have a powerful influence on shaping the attitudes, values and behavior of children, but how do they compare with peers in terms of influence on drug taking? The influence of peer groups, which is usually strong during formative years of youth, may be stronger than that of parents in some cases. It has been observed that the peer and parental influences are synergistic, children as young as 13 and 14years regularly experiments with intoxicants which is leading to early social, psychological problems as well.

Dianova: Can you describe briefly the addiction with or without substance situation in India on what concerns prevention, treatment and social reintegration/ recovery?
Rajesh Kumar: India has one of the largest proportions of children and adolescents in the world, but the threat posed by child substance use remains under-researched. Only recently a large study, the first of its kind in India, was carried out with a sample of nearly 4000 children using substances (school-going, out-of-school as well as street children) across more than a hundred cities/towns. The problem of substance use among children needs to be addressed from multiple perspectives. The key ministries to be involved in a joint effort to prevent and treat substance use among children are the ministries of Social Justice and Empowerment, Health, Women and Child Development.

The preventive programme needs to focus on children, both in and outside educational institutions. The high-risk groups such as commercial sex workers, the mobile population such as tourists and truck drivers, the children of alcoholics and drug addicts, children of HIV-affected parents, street children, prisoners and school drop-outs, should be specifically addressed. While prevention is a welcome step, provision of treatment services and reducing barriers to treatment among adolescent drug users also need to be prioritized.

Dianova: What are the 3 to 5 challenges of SPYM is facing on addiction treatment at the present time?
Rajesh Kumar: The Main challenges are:
- Linking with new and more organizations is the need of the hour in order to ensure that the treatment services are provided based on the requirement;

- Helping other organizations In capacity building due to scarce resources;

- Child care centers and women centers are very less in numbers as a result lack of attention are given to the particular group;

- Lack of trained manpower and developed infrastructure;

Dianova: Redesigning addiction treatment interventions based on evidence, good practices and assessment of results and outcomes is a pre-condition request in India by health- social authorities and governments in order to increase public financing to residential programs?
Rajesh Kumar: An addiction treatment intervention is a structured, solution oriented process undertaken to persuade someone who has a problem with drug or alcohol abuse to seek help in overcoming the addiction. Some people struggling with substance abuse and addiction can and do recognize the extent of the problems stemming from drug abuse and seek treatment without the need of intervention. Many people however are reluctant or unable to realize that drugs are responsible for problems in their relationship, health and work life

Dianova: Predictors of success, such as retention rates or therapeutic discharge, on your specific or overall addiction treatment programs, besides enhancing a positive image among key stakeholders, can contribute to a higher recovery success in your country? From a decision policy making perspective, what measures should be provided to increase social reintegration?
Rajesh Kumar: The need for social reintegration interventions should be acknowledged in funding provision and national drug policies. Drug treatment alone cannot address the complex needs of problem drug users. Treatment alone is also not sufficient to prevent social exclusion of marginalized individuals, particularly as many problems drug users were already marginalized before they started using drugs. Without social reintegration interventions, there is a serious danger that the gains made during treatment will be undermined.

Social reintegration measures can, and should, be embedded into drug treatment at an early stage in order to ensure that the treatment is effective. It is important to consider social reintegration outcomes as part of individual care planning and make use of multi-sectoral working to address these. Therefore, it is recommended that the monitoring of effectiveness of drug treatment must include data on social reintegration.

Dianova: The SDG 3 – Health and Well-being – of the 2030 United Nations Agenda focus on guaranting a healthy life and promote the well being on all ages, including enhancing licit or illicit substances abuse prevention and treatment. Considering the present situation in your country, what are the key triggers to make that goal a reality until 2030?
Rajesh Kumar: The most aggravating fact is that there is no drug policy in India. India has around 700 districts, and drug rehab centers are less than even half.

Most of the cities have no or limited number of shelter/ observation homes which further exaggerates the situation. ●

Muhammad Ali Mirza
Program Director, Ray of Hope, Dianova International Network Associated Member (Pakistan)

Dianova: Can you describe briefly the addiction with or without substances situation in Pakistan on what concerns prevention, treatment and social reintegration / recovery?

Muhammad Ali Mirza: Drug abuse in Pakistan is rising by an alarming seven percent a year. There are approximately five million drug abusers - 1.5 million of whom are heroin addicts - in the country and between 25 to 30 million people whose lives are adversely affected by the addiction of their relatives. Peer pressure at school, societal taboos, economic frustrations and lack of healthy recreational outlets are among the major reasons why people, especially the youth, are succumbing to the lure of addictive drugs.

Addiction of illicit drug or a medication has materialized into colossal personal, societal and national detriment. It has manifested into problems like:
1. Degradation of physical and mental health;
2. Disintegration of family life;
3. Decaying social relationship;
4. Limitation and sometime total extinction of chance to be employed;
5. Increase in criminal activity law from petty crimes to manslaughter;

According to Pakistani studies, in males addiction is seen at higher side then the females and usually addiction starts between the age of 11- 20. In Pakistan 50.6 % users of the total drug users are married. Among literates the drug usage is 62.6 %.

Friends are the main introducers to drug abuse (62.6%) thus re-establishing peer pressure as a major factor for drug abuse.

Studies shows that teenagers makeup a large segment of drug addicts with male teenagers more susceptible to get addicted than females. Teenagers are found to be more vulnerable to addiction due to peer group pressure, parental attitude and due to many other societal factors.

Among drug users, 22% sustain themselves through casual work, 18% enjoy family support, 16% are beggars, 13% are drug peddlers, and 11% resort to petty thefts and pick-pocketing. Study reveals that the ratio of addiction in poor is more than financially well-off population. Poor predisposition to addiction can be attributed to many social, economic, legal and cultural factors.

According to study conducted in Pakistan there are five million drug addicts and majority of addicts reside in metropolis. "This includes 23,000 addicted children who are living on the streets, and 75,000 women. Some main cities are Lahore, Karachi, Rawalpindi, Peshawar and Faisalabad.

4Cannabis, in one form or the other (marijuana, Charas, etc.), is the most commonly used drug in Pakistan in terms of lifetime use and prevalence, followed by heroin, alcohol and psychotropic substances.

Some drugs are grown in the country (Pakistan) whereas most of the drugs are smuggled into Pakistan. Large amount of drugs sold on Pakistani streets comes from the porous border of Afghanistan. Most of the drugs are smuggled except for few like cannabis and illegal alcohol.

Dianova: What are the 3 to 5 main challenges Ray of Hope is facing on addiction treatment at the present time?

Muhammad Ali Mirza: The challenges faced by ROH are as under:
1. Lack of Financial support;
2. Lack of interest of by major stake holders;
3. ack of interest by volunteers in field of drug abuse;

Redesigning addiction treatment interventions based on evidence, good practices and assessment of results and outcomes is a pre-condition request in Pakistan by health - social authorities and governments in order to increase public financing to residential programs?

Government here regulates rehab service providers but not very deeply. Government is trying to differentiate actual working units from fake ones. But its a hard process it will take time. And we believe things will get better.

Dianova: Predictors of success, such us retention rates or therapeutic discharge, on your specific or overall addiction treatment programs, besides enhancing a positive image among key stakeholders, can contribute to a higher recovery success in your country? From a decision policy making perspective, what measures should be provided to increase social reintegration?

Muhammad Ali Mirza: • Programs starting from grass root level;
• Teaching ills of drugs in school books & making this information part of curriculum;
• Awareness through media i.e. Print, Electronic & Social media;
• Making treatment free for user at certain level;
• Awareness through talks, trainings, seminars etc... will bring positive impact.

Dianova: The SDG 3 – Health and Well-being – of the 2030 United Nations Agenda focus on guaranting an healthy life and promote the wellbeing on all ages, including enhancing liccit or illict substances abuse prevention and treatment. Considering the present situation in your country, what are the key triggers to make that goal a reality until 2030?

Muhammad Ali Mirza: • Strict compliance on implementation of drug Policy made by government.
• Identifying and providing treatment and rehabilitation of drugs addicts in strict environment.
• Grants-in-aid to Non-Governmental Organizations (NGOs) engaged in these fields. ●

interview with...

George Ochieng
Founder and Director, Slum Child Foundation, Dianova International Network Associated Member (Kenya)

Dianova: Can you describe briefly the addiction with or without substances situation in Kenya on what concerns prevention, treatment and social reintegration / recovery?

George Ochieng: According to NACADA the Government coordinating agency on matters related to substance abuse in Kenya, has classified addiction as a disease and they are advocating in partnership with various religious institutions that those affected with addiction should not be punished but treated as sick people, fighting them is not the solution.

This become easy even after going to various rehabilitation centers it becomes easy to reintegrate them back to the society without stigmatization, We believe reintegration is a comprehensive approach that incorporates everyone and they are the one who will help the addicted person to feel they are sick and need care and treatment, if this is done is the right way then recovery becomes something that is possible.

As an organization we advocate for prevention since as a country we have a number of challenges facing us and we need to work on them order of priorities, these include poverty, education, access to health and unemployment, why these priorities? It is because the number of addicts in Kenya is more than 2 million and the resources are not enough.

The situation on the ground now stands that we have four public Hospitals offering treatment to addicts out of the four it is only one that handles female patients and each facility can accommodate 150 persons at a given time, those who opt to go for private rehabilitation is is very expensive, costing more than USD 3000 for the three months that you are at the rehabilitation center, there are people who live under a dollar and cannot afford a meal do you think they will be able to afford rehab? So these are some of the reasons we advocate for prevention.

Dianova: What are the 3 to 5 main challenges Slum Child Foundation is facing on addiction treatment at the present time?
George Ochieng:
1. The cost of treatment is expensive;
2. Access to treatment centers is not an easy thing to the poor people;
3. Female patients need to be given priority since majority do not consider the female;
4. Referrals are not effective (why) because the facilities do not accept more than what they can manage;
5. Inadequate comprehensive support from the members of the family and communities to drug addicts;

Dianova: Redesigning addiction treatment interventions based on evidence, good practices and assessment of results and outcomes is a pre-condition request in Kenya by health – social authorities and governments in order to increase public financing to residential programs?
George Ochieng: Yes, but it is not effective. (Why) the poor who cannot afford are being locked out and not given an opportunity to access these services.

Dianova: Predictors of success, such us retention rates or therapeutic discharge, on your specific or overall addiction treatment programs, besides enhancing a positive image among key stakeholders, can contribute to a higher recovery success in your country? From a decision policy making perspective, what measures should be provided to increase social reintegration?
George Ochieng: Recovery success in Kenya is possible at all levels in Kenya however certain conditions need to be reinforced to ensure that it does not work out in vain. From the policy makers point of view they have advocated for the best policies but poor implementation of such policies has remain a thing of the past and not only to this sector but even other sectors, recovery cuts across all the sectors and they need to be reintegrated by the policy makers, meaning if they do not implement certain part of the policy they will be affecting what related to recovery indirectly.

Dianova: The SDG 3 – Health and Well-being – of the 2030 United Nations Agenda focus on guaranting an healthy life and promote the wellbeing on all ages, including enhancing liccit or illict substances abuse prevention and treatment. Considering the present situation in your country, what are the key triggers to make that goal a reality until 2030?
George Ochieng:
1. Action is needed to ensure the goals and policies domesticated in relation to this SDG goal is achieved
2. Corruption should be stopped since it wil hinder the attainment of this goal
3. Government should ensure that there is enough resources to help achieve this goal
4. Domesticating the goal into the local policies should be key
5. Public participation should be a leading factor since the people are the one directly involved in implementing this, so if they are not part of it, they will not be part of it. ●

slum child foundation

Dianova is an international NGO composed of associations and foundations operating in four continents
Dianova Members contribute to the development of people and communities through a series of programs and interventions in the health, social and humanitarian fields.
It was granted in 2007 the Special Consultative Status at the Economic and Social Council of the United Nations ECOSOC|UN. Since 2010, is an official partner of UNESCO.
Since the last General Assembly 27-30 June in Lisbon hosted by Dianova Portugal, celebrating 20 Years of Networking, it has now 26 Members operating in 19 countries of Americas, Asia, Africa and Europe.

For more information please visit https://dianova.ngo/

Saionara König-Reis
Representative to the UN and Head of NY Office, Dianova International
(USA)

Lucia Goberna
Institutional Relations, Dianova International
(Spain)

Dianova International's Advocacy Work in the Field of Addiction

Dianova International has been operating in the field of addiction treatment and prevention for more than 40 years. The Dianova network member organizations offer in particular recovery services in many countries around the world. During all these years, we have endeavoured to provide efficient responses to the always-changing nature of the problems associated with substance use, including new consumption patterns, new psychoactive substances and the evolution of substance users' profiles.

As of 2017, Dianova network members had 15 residential addiction treatment centres (specialized for adults, minors, women or mental health disorders) and 8 day and outpatient centres for drug addiction problems in Canada, Chile, Italy, Spain, Portugal and Uruguay. The same year, a total of 6.729 beneficiaries have been attended in various addiction treatment and prevention programmes. In addition to this, Dianova associate members in India, Kenya, Slovenia, Norway, Pakistan and Romania also provide prevention, treatment and recovery services in those countries. Due to the diversity of our interventions, we have been able to acquire a vast, diversified experience in the field of prevention, treatment and recovery services at the grassroots level.

Since 2007 Dianova International has had Special Consultative Status to the United Nations Economic and Social Council

(ECOSOC). We have participated in the most important forums where drug policy is discussed and we are part of numerous networks of NGOs that operate in this field.

With time, we have broadened our field of advocacy work to other areas such as promotion of gender equality and women's empowerment, mental health, migrant and refugees' rights, etc. In 2015 we also opened a delegation in New York to be able to have a more active role at the United Nations through a number of New York-based committees and platforms of NGOs that maintain relationships with the UN, and to have a wider geographical scope.

Furthermore, we established in 2017 a network of 'International Ambassadors'. This is a group of representatives from Dianova network organisations around the globe, who supports our advocacy work by representing the network at international, regional and national events.

After 10 years of advocacy work, we have reached a peak in our activities. In 2017, Dianova International attended more than a hundred events in 14 countries and three continents (America, Europe and Asia). That same year, we also organized or sponsored 8 events at international forums, made 12 oral contributions, and sent 26 written contributions to influence relevant policies.

dianova network

What we advocate for in the field of drugs

Dianova advocates the implementation of drug policies based on a public health perspective as well as the development of addiction prevention and treatment initiatives and intervention modalities that are gender-sensitive, evidence-based and person-centred. More specifically, we promote the therapeutic community model of treatment and we call for a wider recognition and attention of concurrent substance addiction and mental health disorders.

We also promote a gender-based approach to mental health issues and to drug policy and programing. We defend to invest in data disaggregated by sex as a way to formulate responses appropriate to the needs of women and girls facing such challenges. In fact, we believe that only by integrating the gender equality perspective into all actions, will we have the chance to achieve a more just and equitable society.

Human rights are also an important chapter of our work in this field. Particularly, we raise awareness to the need of ensuring the full enjoyment and respect of human rights for people with drug addiction problems, their right to enter treatment and recovery programmes, and the need to quit stigma. Furthermore, we advocate the abolishment of death penalty for drug traffic offenses and the end of repressive drug policies while supporting the decriminalization of the use of all psychoactive substances.

With a holistic approach to these issues, Dianova's work advocating for the health and mental health of all persons facing a substance abuse problem impacts a variety of issues of the 2030 Agenda and the Sustainable Development Goals (SDGs). Our work in this field is at the same time influenced by and influence issues related to poverty (SDG 1), gender equality (SDG 5), education (SDG 4), the construction of peaceful societies (SDG 16), social inclusion and the reduction of inequalities (SDG 10), and others.

You can find more information on our Institutional Positioning on Addictions and Drug Policies and in our Manifest.

Where we advocate

At the United Nations level, we attend and monitor the Commission on Narcotic Drugs in Vienna. Being present and active in these meetings has given us the chance to organize side events, meet other civil society organizations and high-level representatives from the UN and Member States and participate in exhibitions.

At the UN level, we are also members of the Vienna NGO Committee on Drugs (VNGOC), which acts as a link between civil society and UN agencies. Currently we hold the vice-presidency position of its Executive Committee. Similarly, Dianova is a member of the New York Committee on Drugs, sister organization of the VNGOC in New York since 2018. It is through this membership that we can be informed about any advancement on drug policy at the two UN headquarters that deal with these issues.

In addition, since 2016 Dianova has been a member of the Executive Committee of the NGO Committee on Mental Health in New York, highlighting the direct and indirect correlation between substance abuse and mental health and advocating putting mental health in the international agenda. We push for the improvement of mental health care standards and for the implementation of essential public health measures in the treatment and rehabilitation of people with substance use disorders and other addictions. Besides, we also advocate for the promotion of a psychosocial well-being in broader contexts of poverty, violence, environment and human rights. We also are active members of the NGO Committee on the Status of Women, the NGO Committee on Migration and the NGO
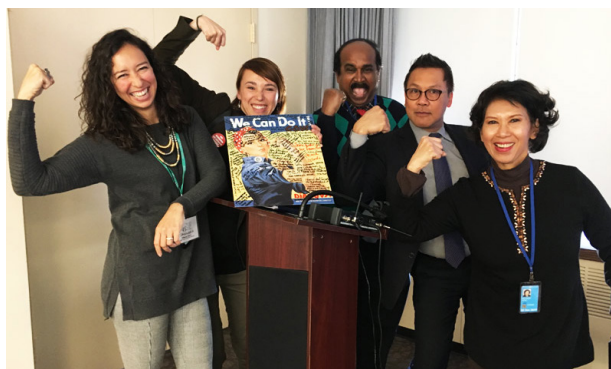
Major Group (the latter specifically concerning the SDGs). Through these platforms we advocate on the interlinkages concerning these different populations and the specific challenges they face in the field of substance use, mental health, and other social or personal challenges.

At the European Union level, Dianova is a member of the Civil Society Forum on Drugs since 2013. This is an expert group of the European Commission where 45 member organizations provide their knowledge and expertise on the European drug policy-making process.

In the American continent, Dianova follows the Organization of American States (OAS) drug policy initiatives. We attend regularly and monitor the Inter-American Drug Abuse Control Commission, providing input to their processes and connecting with civil society in the region to better advocate for a health-based approach to drug policy in the region.

Another way by which we monitor and carry our advocacy work in this continent is via our membership of the Ibero-american Network of NGOs Working in the Addiction Field. This is a non-profit umbrella organization whose main role is to help connect Ibero-american addiction service providers and promote collaborative work through the exchange of best practices.

At the international level, Dianova is a member of the World Federation of Therapeutic Communities (WFTC). The WFTC's objective is to widen the recognition and acceptance of the Therapeutic Community approach among health organizations and health delivery systems of international and national bodies. Dianova is also a member of the WFTC Board of Director. Dianova Uruguay is a member of its regional branch in Latin America (FLACT) and Dianova Portugal and Dianova Sweden are members of the European Federation of Therapeutic Communities.

In addition to these platforms, we regularly participate at experts meetings and events organized by international organizations such as the UN and its agencies, national authorities, and other NGOs or platforms of NGOs that can be of interest to the work developed within our network.

Finally, Dianova International and the Dianova network often conduct awareness campaigns on these issues. In 2017 for instance, we supported the World Health Organization call to promote "Mental health at work". This campaign aimed to reduce risk factors and to implement adequate prevention measures in the workplace.

Since 2017 Dianova has deepened and widened its advocacy work in the field of drugs in order to be present in the most relevant platforms and forums where drug policy is debated. We will continue our efforts in the future following Dianova's motto: Together, Farther! ●

Alfonso Arocena
Dianova Uruguay
(Uruguay)

Introduction to the complexity of the drug field

The different uses of drugs, which the collectives have experienced throughout history, are of such complexity that it is necessary to approach them for their understanding, through the social imaginaries of each space-time (Sachi, 2011). Likewise, in order to give meaning to the contemporary use of psychoactive substances, it is essential to analyze them in the context of social representations and in light of the historical events that sustain them. (Mejías, 2011) In relation to this particular phenomenon, society as a whole is mobilized and tends to give answers to a problem defined from a subjective construction full of morals and contradictions. Social imaginaries explain preconceptions, stereotypes and stigmas regarding psychoactive substances and their consumers, generating invisibility and isolation, instead of providing reflective productions of the phenomenon. (Sachi, 2011)

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The social representations of psychoactive substances in Spain, based on the study carried out by Mejías (Mejías, 2011), highlights the close relationship between the vision of the drug phenomenon (problem, solution, risk perception, effects, plot social, the concept of consumer) and the achieved educational levels, religiosity, political position and age. These social representations do not escape those responsible for the design of strategies at the level of public policies, nor the professionals who approach the problematic use of the different devices. (Gaete, 2008)

The research on "The social representations of psychologists involved in the field of drugs in Chile" shows clearly how they are determined by the current logic, invoking in some way the criminal figure that crosses the consumption of psychoactive substances. Thus, therapeutic strategies are covered by prohibitions and "technical dogmas" validated only by the social imaginary and the social representations of the interveners. (Gaete, 2008)

From these studies, one can better understand how the concepts of "heavy drugs", "escalation of consumption", "addicts" and others,

are treated as "technical" terms when they lack epistemological validity. One of the reasons for these nomenclatures or technical / popular theories is due to Thomas Babor, the lack and dispersion of scientific information that contributed in the last ten years to guide a coherent, solid and well-founded professional response. (Babor et al., 2010).

That is why in Uruguay, based on the National Strategy on Drugs (NDT) 2016/2020, highlights the perspective of Human Rights and comprehensive approaches supported by scientific evidence, which discard models based on reductive disciplinary reductions and linear explanatory models. Thus, the term "addict" is discarded for the description of the table presented by people needing treatment for the problem associated with drug use.

Paradigms, approaches and investigations

Investigations of psychosocial interventions allow less scientific accuracy than research on other treatments (eg, drug-based ones) because of the complexity of intervening variables, the difficulty of isolating them to quantify and qualify, but the data that can be obtained from efficacy of the different strategies can be very valuable to validate some practices and discard others. (Babor et al., 2010)

To be able to take a qualitative step in the restructuring of therapeutic strategies from scientific evidence, it is necessary to determine; which are the paradigms that underlie the therapeutic models; theoretical approaches support clinical strategies and; What are the procedures for the construction of intervention logics?

All services are designed with the clear intention of modifying some patterns of drug user behavior, aiming to improve socio-sanitary indices that provide benefits to the user and their environment. The objectives of these services may be to abstinence drugs, reducing the amount or frequency of use or modifying other behaviors. These three well-differentiated trends are not necessarily exclusive, they can coexist within the same paradigm of health intervention.

But in general, there has been a shift from programs designed exclusively to obtain abstinence (so-called drug-free programs) for a diversification of care provision. Today there is greater flexibility in the proposals, where the individualization of the therapeutic strategy is prioritized, incorporating new programs based on relatively new theoretical approaches, aiming to broaden the spectrum of demand thresholds. For example,

the risk management approach, consisting of a set of socio-sanitary measures, aimed at hierarchically reducing the harmful effects associated with drug use and improving quality of life. (Dell'Acqua, 2011) All sources consulted on published scientific research on the efficacy of medicinal treatment, based on different psychotherapeutic approaches, highlight the cognitive behavioral chain with the highest validity indexes, followed by motivational approaches and systemic interventions. (NIDA 2009a, Pereiro, C. 2010, Secades-Villa, R. and Fernández-Hermida, J. R. (2003).

These quantitative investigations that evaluate the effectiveness of the different approaches, for Becoña without being irrelevant, favor those who, within their operative logics, deal with assimilable languages more easily for quantitative studies. (Becoña, 2010)

This author understands that these results are clearly determined by an abundance of variables that operate in the design of research, in which: a) the selection of approaches studied, b) the difficulty in applying experimental logics to dynamic psychotherapeutic approaches and post- (c) the similarity of some clinical practices with experimental (cognitive) methodologies and their linguistic affinity to expose explanatory parameters of the phenomena (causality, linearity). (Becoña, 2010)

There are many approaches, models and paradigms that have been applied to problematic drug use, and the different experts have classified them as:

• The psychotherapeutic approach: cognitive, dynamic or postmodern: (Becoña, 2010)
• Treatment objectives: Abstentionist, Risk management. (Dell'Aqua, 2011)
• Paradigms: Paradigm of disease, social learning. (Fernández, S. Lapetina, A. 2008).
• The mode of care: Integral, medical, psychological, social. (Babor et al., 2010).

"And while each of them made interesting contributions to the explanation of the phenomenon and managed to help a greater or lesser number of people find a solution to their problem of addition, none of them managed to offer a unique," true "solution to the phenomenon. On the contrary, defenders of some models against defenders of others have tried hard and in many cases have argued that their model is more successful and that "opponents" can not find a clear model of intervention (Becoña, 2010). p.146).

How to know which is the most appropriate therapeutic resource for a given problem? How can one recognize the person's profile, which would be better adapted to a particular line of intervention or vice versa?

In Uruguay, there is a growing tendency to reject approaches based on the epistemic paradigm of simplification, which relies on the total reliability of Aristotelian logic to establish a theoretical truth, establishing with absolute certainty irrefutable scientific theories. It is increasingly prone to discard these premises or paradigms to support research on a broad model of science and an epistemology of complexity. (Morin, 2004)

From this understanding, the following questions are presented: are problematic drug users the center of attention and interdisciplinary scientific projections for the development of therapeutic strategies? The theoretical designs that support existing practices result from a scientific construction based on an epistemology of complexity, as the drug phenomenon demands? How are the social representations of the technicians who design

the intervention strategies integrated to the research practice? Are the functional dimensions of consumption (hedonistic, identifying, attenuating suffering, cosmetics, etc.) integrated into the treatments?

For this reason, the nomenclatures constructed in the technical irresponsibility were demolished, trying to project their professional work from practices and production of knowledge regionally validated through the systematization of qualitative and quantitative experiences and research, that annul the "I". I think "and" it seems to me "along with other expressions that lack precision and validity.

We try to approach the different problems from a multifactorial understanding, guiding any intervention to improve the quality of life of the consumer, based on socio-sanitary indicators. Therefore, the paradigmatic confrontation between "abstentionist" or "risk management" does not make more sense than within value schemes and prejudices that prevent the view of the problem through the particularities of the person. When the person who uses drugs is received as the axis of our eyes and actions, we find that there are no recipes or generalities applicable to all situations.

The approach of the therapeutic strategy to achieve minimum standards of efficiency requires that the technical team take into account the socio-cultural profile of the consumer, his life history, the vital moment by which he is passing, the problematic substance, the pattern, the path, the path and configuration of consumption. In addition, the team should present the necessary technical skills to identify the symptomatology of the biopsychosocial clinical presentation presented by the person, while the demand for the treatment is being constructed. It must give the protagonism to the user to guarantee the relevance and the opportunity of the intervention. It is useless to try to solve a problem from an "abstentionist" approach with a consumer who does not intend to stop consuming, as well as within the risk management approach can address a specific situation that aims at abstinence. (Fernández, Lapetina, 2008).

State of the situation in Uruguay

In Uruguay, the different devices that make up RENADRO (National Network of Drug Attention), receive users of all ages, prioritizing ages between 17 and 30 years. Attention is given in both the public and private spheres, in four modalities; residential, day, outpatient and community. The network has devices for listening, orientation and timely referral distributed throughout the national territory (Ciudadelas). At the same time, the area of social insertion (currently social equity) was positioned as part of the treatment, breaking with the old model of social integration of therapeutic discharge.

RENADRO
red nacional de atención y tratamiento en drogas

Clinically, the presence of polysorbons of psychoactive substance and a high prevalence of associated pathologies (more than 30%) is currently under evaluation, under the assumption that a higher prevalence of associated problems observed is almost 100%. The most frequent combinations of consumption are between tobacco, alcohol, cocaine, cannabis and cocaine paste. ●●●

From the END, problematic drug use is understood as a complex and multidimensional phenomenon, crossed by economic, political, social and historical cultural factors that require interdisciplinary and interinstitutional strategies. In this context, appropriate, flexible and timely intervention strategies are proposed, where the unique characteristics of the people in their context are considered. (END, 2016/2020)

The risk that any psychoactive substance implies, in addition to its typology (experimental, habitual, inveterate or toxic), highlight the management of the risk that the user makes of its use, as a strong clinical correlation for analysis that evidences the resources that the person can put into play. (Dell'Acqua) The END aims to strengthen equity policies aimed at reducing vulnerabilities associated with drug use, improving accessibility to social protection resources (housing solution and primary health care) and developing education-work programs, in the logic of networking intersectoral. (END, 2016/2020)

All network devices have the necessary infrastructure to ensure the adequate development of individual, group and family interventions, both in therapeutic work rooms and at rest, recreation, hospitality, and medical and / or nursing procedures.

Human resources comprise interdisciplinary teams composed of: social workers, psychologists, psychiatrists, social workers and nursing assistants, trained and with clinical skills according to the complexity of the care and the thresholds of the approach requirement.

It includes a set of benefits that technically can not be absent for the accomplishment of the proposed objectives, such as medical consultation, psychiatric consultation, social assistance, psychological counseling, individual psychotherapy, therapeutic groups, think tanks, artistic and recreational workshops, training and occupational activities , therapeutic work with emotional referents, follow-up and support in the socio-educational-labor insertion process.

The treatment is primarily aimed at generating a commitment to work with the user, where personal goals arise in a reinforced construction in realistic and achievable goals in three stages: short, medium and long term, a process supported by resilience. This "therapeutic contract" is essential to maintain the commitment to the construction of the "new".

According to the characteristics of the person and the care device, the most varied strategies are elaborated following the outline of functions described above, integrating the regionally validated tools to work with drug users from a DRR approach.

Monitoring and Evaluation
Monitoring of the behavior of the consumption variables, as well as the variables of the demand for attention and its response are performed from the Observatory of Medicines (OUD). The registration tool for this monitoring is for technical access to all the computers in the network, with partial access for consultation and planning for the attendance record.

Recently, a guideline based on the criteria established in an international specialized production process is being applied to network devices in order to ensure minimum standards of service quality. These are mainly focused on the following evaluation indicators:

• Structural. Infrastructure / Facilities
• Regulations. Functional Organization Process
• HR. Adequacy / induction / permanent practice.
• NETWORK Collaboration / coordination mechanisms
• Information. Documentation Registration
• Human rights of users. Accessibility, Active participation, Consent
• Services: service / assistance protocols
• Evaluation. Systematic recording of interventions. Process evaluation

In line with the common standards of all network devices (traversed by the particularities of different forms of care), together with data collected by monitoring (UDO), quality is assessing the possibility

of developing, based on international agreements , the tools for a validated and validated regional evaluation of therapeutic processes.

The evaluation should go beyond the goals reached by the user in a specific center of attention, directing a broader vision that covers the trajectory of the people through the different nodes of the network of attention to drugs, articulated with the social health network. For this evaluation of therapeutic processes, it will be necessary to develop a network analysis tool, parallel to the development of unique process analysis tools. (Final Document of the United Nations General Assembly Special Session on the World Drug Problem 2016 (UNGASS 2016) and Agenda 2030 for Sustainable Development.)

This extension of the evaluation plan is not restricted to the one-dimensional evaluation of the behavioral indicator of drug use, but aims to provide a multidimensional reading that integrates the different dimensions of the subject. This perspective is aligned with the intersectoral conception of public policy, which understands drug use, as a cross-cutting element of the Sustainable Development Goals (SDG), from efforts to achieve them and face effectively the problems associated with drug use, which are complementary and mutually reinforcing.

Public Policy on Drugs and the Sustainable Development Goals
To understand the relationship between drug use and social development, it should be borne in mind that, like drug use, development is a complex process that challenges the social, political, economic, cultural and environmental dimensions. The great challenge is to propose alternatives for public policies aimed at reducing the problem associated with the field of drugs, while alleviating the effects that hinder development. The United Nations has published a report detailing the impact of drug policies on different dimensions of human development, among which stand out; public health, formal economy, governance, human rights and the environment. (UNDP, 2015).

To understand how these two global agendas synergy (Agenda 2030 and Public Drug Policy), it is necessary to refer to the concept of policy integration, so prominent in the context of ODS. It is a process of policy formulation that takes into account the interdependencies between the dimensions mentioned above and the sectors (UN-DESA, 2015a).

The lack of tools for public policy decision-makers and designers to identify interactions and design strategies that meet goals and objectives are prominent in monitoring the 2030 agenda.

Network analysis allows understanding how SDGs are interconnected. By coding SDG and its objectives, relating goals to objectives, an interaction matrix can be developed, which is used for visualization and analysis of networks (Nooy, Mrvar and Batagelj, 2005). This analysis allowed to visualize the interactions between the SDG and the asymmetry of these connections. This means that some goals join with others through multiple goals, while other goals are poorly connected to the rest of the matrix.

"Networking is considered a tool of the complexity sciences to address complex problems. In the end, the complexity sciences try to observe the order that hides behind the apparent disorder, aim to understand that global and political problems can to be seen through a broader and less reductionist perspective, understanding that the world is constantly changing and requires studying the interaction between different actors or scenarios "(Moncaleano, 2017).

Considering the phenomenon of drugs as a complex problem that has several edges, actors and scenarios, to be effectively addressed, it is essential to analyze the phenomenon using tools of the complexity sciences, such as interaction networks. This approach, applied to the problem of drugs and sustainable social development, is the most efficient and effective way of interventions being reinforced and complemented, rather than parallel, revealing overlaps and contradictions of disjointed policies.

Since 2005, Uruguay has insisted on making explicit the critical eye towards the war approach to public drug policies, promoting initiatives in opposing directions to the "fight against drugs" against harmful evidence in social groups. The Lic. Milton Romani, Secretary General of the SND, before leaving office, made clear statements in favor of the human rights of drug users, denouncing the dramatic social costs that the "fight against drugs" generated and continues to leave behind, victimization of populations that suffer multiple social exclusion and agglomerate penitentiary centers of populations of extreme social vulnerability. (Minutes JND, July 2016). This could be a clear example of efforts to rethink the synergies of actions to the ODS agenda and drug policy.

Regulation of the cannabis market
The following data were taken from report 04/05718 and carried out by the Uruguayan Observatory on Drugs (OUD) in collaboration with the Department of Information Systems and Registries IRCCA (Cannabis Regulation and Control Institute) to communicate the principal monitoring data on the development of mechanisms for the production, distribution and access to cannabis for non-medical use, in accordance with the provisions included in the Uruguayan Cannabis Market Regulation Law No. 19.172.

On 05/04/2018, there were 34,108 persons authorized to access cannabis in a regulated manner. There are 23,161 people who register in pharmacies, 8,418 are registered as self-producers and 2,529 are registered as members of 90 member clubs.

In the VI National Household Survey on Drugs - VI ENHCD (OUD / JND-2014), it is estimated that 147,000 people aged 18-65 consumed marijuana at least once in 12 months. Therefore, the number of people directly involved in the regulated market corresponds to 23% of the population that wants to achieve with the policy. The ENHCD OUD 2014 can be designed so that every buyer in pharmacies shares with another consumer who bought cannabis, while self-producers and cannabis clubs share with two other people. ●●●

Uruguay

NUMBER OF PLANTS ALLOWED 6 (mature female plants)

LEGAL AGE OF CONSUMPTION 18

480 GRAMS POSSESSION LIMIT (per year)

$0 TAXES APPLIED (no retail sales yet)
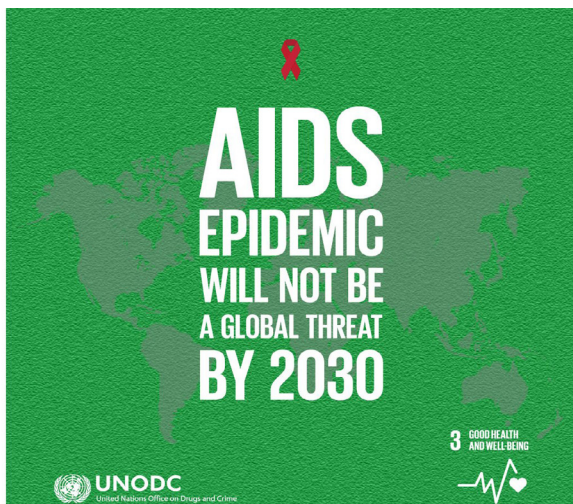
Thus, it is estimated that the regulated market reaches 54% of users. The age distribution shows that the majority of buyers are between 18 and 29 years old (49.5%). While 33.1% are between 30 and 44 years and the remaining 17.4% are over 45 years. Of the total 23,161 people registered to buy in pharmacies, they only bought 17,567 cannabis, which represents 75.8% of the total.

Self-cultivators, the majority male (75%), have an average of 35 years and 60% are 35 years or less. This average age is significantly higher than that found in the distribution of consumers in the last 12 months, according to the VI National Survey on Drug Use, are 28 years old. Since October 30, 2014, when registration began for cannabis clubs, 119 applications have been processed. Of these, there are currently 87 approved and 3 with few pending procedures. There are 2,529 registered and qualified members of the 87 clubs (28 average members).

The assessment of the health impact of cannabis market regulation is still ongoing. So far, with the data surveyed, we have two primary readings. Almost 50% of cannabis users are not buying the drug on the "black market" with two obvious benefits. A) Improvement in the quality of the product consumed by cannabis users and B) reduction of the economic benefits of the trade of this drug in the hands of organized crime. In a cross-reading as discussed above, these two data will benefit positively from the RRDD perspective and the weakening of concentrations of harmful power to our social organizations, which prove to be a powerful brake on social development.

The decrease in the perception of risk of cannabis use was projected from the validity of the cannabis regulation law, by correlational methods of risk perception and "legality". There are preliminary studies that seem to ratify these hypotheses. From the National Drug Board (JND), dissemination campaigns and prevention programs targeted at younger populations have been launched to counteract this potential effect. Likewise, the decrease in the perception of risk in the use of cannabis should not be considered linearly as a harmful effect for the population. This change in the social representation of cannabis use can bring positive impacts. For example, empowering movements of the medicinal and responsible use of the drug, based on scientific evidence.

In order to reduce the perception of risk, it must be based on a homogeneous perception of the risks involved in using a substance, its dose, its standard, path, scenario and purpose. This baseline is utterly illusory in its own right, let alone from populations harboring the same generation of diametrically opposed discourses on the risks and benefits of using the same substance. In order to conduct a consistent assessment of the impact of the Cannabis regulation law, we must start with a complex monitoring, evaluation and analysis framework that transposes the goals and objectives of the drug agenda with the development agenda, in a single context, of a line of action that reinforces each other and does not oppose or overlap lines of intervention.

SUSTAINABLE DEVELOPMENT GOALS

dianova network

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Kenneth Arctander Johansen
Communication Director, RIO Rusmisbrukernes Interesseorganisasjon,
Dianova International Network Associated Member
(Norway)

Norway's Drug Policies - Prevention and Treatment

The situation with regards to prevention of addiction problems as well as treatment and social reintegration for people with addiction problems, are areas of great concern for Norway. In the following I will very briefly describe the situation, the way I see it, on these fronts.

Norwegian drug policies have been characterized by prevention since the 1970s when the government first presented a strategy to combat drug problems (both alcohol and drugs). The aim has been to reduce demand and access. Access reduction through border control and restrictive alcohol policy, and demand reductions through information in schools and by providing alternative activities to drug use (activity services for youth, alternatives to punishment and low threshold services to acquire contact with vulnerable groups).

In Norway, addiction treatment is a specialized health service (cross-disciplinary specialized addiction treatment) consisting of polyclinic treatment, inpatient treatment and opiate replacement therapy (OST). The specialized health service is organized under The Ministry of Health and divided on four health regions: health south-east, health middle, health north and health west.

In 2016, somewhat less than 33 000 people received addiction treatment with the largest bulk being in the south-east. And there has been increased activity on all parametres up until the 1st tertial of 2018, where a slight decrease (approximately 2%) has been observed.

In comparison with Portugal, Norway has a lower estimate of people that are high risk opioid users, and a relatively extensive OST program. A recent study shows that Norway is, together with The Netherlands, Austria and Australia, one of the few countries that have high capacity on needle and syringe programs (NSP) and OST (Larney, et al. 2017). Portugal is different from Norway in the sense that they have fewer people receiving inpatient treatment than Norway (0,05% of the population against Norway's 0,16%). In Portugal, from what I understand from EMCDDA-statistics, there are some more OST-patients, 0,25% of patient population, against Norway's 0,22%. Also, Portugal has somewhat higher use of polyclinic services than Norway (0,40% against 0,36%) (EMCDDA, 2017).

In Norway, most long term inpatient services, such as therapeutic communities, are delivered by non-profit NGOs that have contracts with the health regions. They are expected to have 95% of beds occupied to not have to pay money back to the regional authority. Inpatient prices is approximately 3000 NOK (30 Euro) per day per patient.

In 2013, there was estimated that Norway had 9015 high risk opioid users. The estimate for Portugal is 31858. Divided on population size scores Norway at 2,68 against Portugal's 4,86 (EMCDDA, 2017). Last annual overdose death numbers in Norway was 220 deaths. Seen against Portugal's 16 in 2011, Norway seems to be worse off. A suggested explanation for this, might be that Portugal has better capacity on low threshold methadone substitution, while OST in Norway is a high threshold program. There are some low threshold OST programs in Norway, but not in any comparative capacity. Other probable contributing factors are more rigorous procedures for registration (autopsies) and less competing causes of death (HIV, Hep-C etc.)

Reintegration is a problematic issue in Norway, given that reintegration is the responsibility of 428 municipalities and treatment is the responsibility of four health regions contracted by more than 30 service providers. A central theme in treatment and rehabilitation has been the continuity of services, but in reality this is not working properly and is constantly criticized by almost all stakeholders.

RIO has been focusing on proper activity that prepares the patients for life after addiction treatment to have more focus in treatment. Also, we have been working for achieving a parliamentary decision on establishing a system for integrated aftercare (post inpatient treatment). We have achieved this with a majority vote in June. This decisions consists of giving treatment providers the opportunity to also provide post inpatient follow up treatment. It also consists of efforts to increase affordable housing for people that have been in treatment and of sorting out a financial mechanism that will help municipalities and the specialized health services to cooperate in delivering reintegration programs.

Also, we have been working for a drug policy reform of decriminalization. Yours truly has been appointed by the government to serve on the drug policy reform committee that will present a white paper in december 2019.

However, a problem that gradually has become more dominant is that due to political decisions of increased activity in polyclinic treatment and reduced waiting lists, treatment providers get less patients since they are being referred to short term public clinics and polyclinics. This affects non-profit NGOs that are struggling to meet the demand of 95% coverage, and might actually be lethal to TCs. My suspicion is that this will be a great concern in 2018 and 2019.

To meet the UN goals, it is vital that all people with addiction problems get the proper help they need. In Norway, it has a lot to do with how we organize the services. Perhaps even more so, than the amount of (more) money put into said services. ●

Rowdy Yates
President, European Federation of Therapeutic Communities (Belgium)

Accessing Residential (TC) Treatment: No Easy Way In

It has been long accepted that the fore-runners of the drug-free therapeutic community (TC) movement in Europe were the radical improvements in psychiatric care brought about initially in the UK by Maxwell Jones, David Clarke, Bertram Mandelbrote and others (Kooyman, 2001; Rawlings and Yates, 2001; Yates and Malloch, 2010; Broekaert et al, 2000). Their purpose was to both democratise in-patient care and to encourage appropriate decanting of those with less severe mental health issues into a purposefully supportive wider community. Indeed, Maxwell Jones – often called the founding father of the TC - did not initially use that term himself. He and his colleagues preferred to describe the changes they were making as "community psychiatry" or "social psychiatry" (Kooyman, 2001; Broekaert et al, 2006)). This is not of course to say that the Maxwell Jones-style "democratic" TC was a direct precursor to the American-style "hierarchical" TC. Rather, it is simply to note that many of the underlying principles had already been trialled within mental health treatment (Jones, 1984; Rawlings and Yates, 2001). Indeed, Mandelbrote, who redesigned his "democratic" TC in Littlemore Hospital, Oxford as a "hierarchical" one, saw that change as merely adapting the original model (Broekaert, Vandervelde and Yates, 2005). This familiarity with the basic ethos, along with a long and parallel tradition of partially self-governing communities for at-risk children meant that the psychiatric community was surprisingly open to the introduction of the "hierarchical" TC when a group of young psychiatrists – some of them closely associated with Maxwell Jones – began to champion it (Yates, 2003; Yates, 2011).

Those earlier experiments had struck a chord with many radical psychiatrists across Europe. In the post-war period, the new school of psychiatrists – well schooled in the new "talking therapies" and fully trained in the use of new medications - were anxious to become something more than simply custodians of a medicated arm of the criminal justice system. All across Europe, the work of Mandelbrote and R. D. Laing and others in unlocking the locked wards and providing mental health treatment outside the confines of large psychiatric institutions began to flourish and, in many countries, to form alliances with patient–led mental health campaign and support groups. Perhaps the most radical and far-reaching of these developments was Basaglia's Psychiatrica Democratica in Italy but in many other European countries similar, though less high profile, experiments appeared (Yates and Malloch, 2010). Those early pioneers of the TC movement could scarcely have imagined that the principles of community psychiatry would, years later, be used by right-wing politicians in a cynical and often ruthless pursuit of a monetarist experiment which inserted marketplace economics into health and social care systems all across Europe and moved patients wholesale out of the asylums and into the community: though without any of the corresponding support structures envisaged by Jones and others (Yates, 2002).

The monetarist experiment began in the UK under Margaret Thatcher but it inspired many other right-wing governments across Europe to follow a similar path. The process followed a broadly standard template. Services were systematically under-resourced and in the resulting low-quality provision, the media was encouraged to castigate residential provision as being of poor standard and open too often to abuse. There was little outcry when patients were subsequently decanted into (equally poorly resourced) private rented accommodation in the community with their former home being sold to developers for hotels, supermarkets and even housing (though never housing for the mentally ill). This of course created a general attitude of 'residential bad (and expensive) and community-based good (and cheap)'. Sadly, this is an attitude which remains strong to the present day (Yates, 2011).

The legacy of the monetarist experiment – and we should acknowledge that many would argue, with some justification, that the experiment continues – has resulted in two major barriers for drug-free TCs to overcome: the fiscal barrier to accessing payment for TC residence and the attitudinal barrier that since TC treatment is thought to be demonstrably more expensive than community-based treatment, it must be used as an intervention of last resort (Pitts and Yates, 2010).

Prior to the 1980s, access to residential or inpatient treatment for drug addiction was generally funded in most European countries at the national or quasi-national level. In some countries top-up fees were levied from the local authority where the individual was resident but these were usually small sums and most TCs were able to collect the bulk of these and subsume the cost of those they could not recoup. The monetarist experiment and its marketisation of health and social care demanded that funding flows be redirected from the national level and into local market places where the question of "who pays" could be addressed (Yates, 2002).

In the UK, funds were transferred to local government (rather than local health boards) and the failure to ring-fence these sums meant that those seeking funding for residential addiction treatment were seeking monies from the same fund as those for orphanages, old people's homes and other services generally regarded as more worthy. This process was followed in a largely similar way in other European countries and had a disastrous impact upon TCs and other residential rehabilitation services (Turner, 2005).

Since most TCs worked to regional (or even national) catchment areas they rarely drew their residential community from a single local area. Thus, there was inevitably resistance from the new fund-holders to paying for services outside their area. For the TCs themselves, the changes meant that most services began to have to negotiate with a hugely increased number of fund-holders (often for the first time) and this had serious staffing consequences Yates, 2011).

Moreover, it should be noted that these changes coincided with growing concerns around the spread of HIV/AIDS and a consequent change in priorities away from treatment seekers and

towards those most recovery-resistant (and therefore most likely to continue to inject and to thus be an infection risk). This change in priorities saw a corresponding change in emphasis in treatment provision with methadone prescribing becoming the dominant response in much of Europe. This inevitably further marginalised TCs and other abstinence-based recovery programmes. As a result of these two parallel pressures, many TCs across Europe found it increasingly difficult to continue and a large number closed their doors for the last time (Yates, 2017).

The attitudinal barrier which regards residential rehabilitation as an expensive option and therefore an option of last resort has resulted in significant changes to the resident population in many European TCs. Logically, if only those drug users who have failed at, or otherwise proved resistant to, community-based treatments (mostly long-term methadone), then only the most damaged users with the longest using careers will (eventually) find themselves in residential treatment (Yates, 2010). In the past, this might have not been such a great problem: TCs are generally very good at containing and channelling chaotic and treatment-averse residents. But the pressures on TCs from service commissioners are forcing many to shorten their programmes: often far shorter than research indicates would be appropriate. Of course, inevitably, even with shorter programmes and more difficult clients, funders continue to expect the same results! (De Leon, 2010; Yates, 2010)

All of this has meant that drug users seeking residential rehabilitative treatment will often face significant barriers in achieving their wishes. Many are simply told they are not suitable; particularly if they have appeared to respond well to long-term prescribing. Those whose applications are considered will inevitably be expected to prove their motivation in ways which are not considered necessary for those seeking only a methadone prescription (Bamber et al, 2011).

At the heart of these difficulties lies the mistaken belief that residential treatment is simply too expensive to offer to all drug users. For a detailed discussion of the cost effectiveness, of TCs, readers may want to look at the "Evidence Issue" of the journal Therapeutic Communities which found that the admittedly sparse evidence base suggests that residential TCs are probably no more expensive than community-based interventions (where peripheral costs are generally spread across a range of cost centres and are thus largely hidden) and in terms of long-term recovery outcomes, are significantly cheaper (Yates, 2010).

More worrying than this cost misconception is the fact that two decades of long-term substitute prescribing as the first-choice treatment has resulted in an addiction workforce – treatment commissioners, service providers and their clients – who are often profoundly sceptical of the possibility of recovery. In many community-based drug treatment services, staff will have never seen a recovered addict and simply discount the possibility (Yates et al, 2015).

Certainly, these attitudes are changing but in the aftermath of the 2008 financial crisis and the resulting harsh reductions in funding for drug treatment services in general, that process of change is likely to prove challenging. Top-slicing funding for residential services at the national level would improve the ability of TCs to respond and of clients to access their services but there remains a strong political resistance to what would be a complete reversal of current funding policy. In the meantime, TCs must continue to build their capacity for after-care treatment and support (Yates, 2012); develop initiatives which improve engagement with the programme (since some research suggests that engagement is more important than time in treatment); and encourage the research community to study the comparative cost effectiveness of their services (Vanderplasschen et al, 2017). ●

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Keith Warren
Associate Professor, College of Social Work, The Ohio State University (USA)

My brother's keeper: Recent work on cooperation among therapeutic community residents.

A therapeutic community can only work if the people who live there work together. This ethos of mutual aid is summed up in George De Leon's classic dictum that in TCs the community of residents itself is the method of treatment (De Leon, 2000). This means that TCs are fundamentally different from other forms of treatment. They are not just clinical interventions that are delivered by amateur peers. For TC residents, the daily help, advice and mutual monitoring that peers exchange during constant interactions create an environment that is conducive to profound personal change.

But how exactly do TC residents work together? While there is an extensive literature based on qualitative studies, statistical analysis of resident interactions is a challenge because each of the residents could potentially interact with every peer. This is a both a practical and conceptual challenge. Practically, it's simply hard to keep track of so many interactions. Conceptually, most of the variables that we use in the quantitative analysis of human behavior, from demographic characteristics such as gender to clinical constructs such as motivation, addiction and criminogenic risk predictors, are assumed to be individual characteristics. We seldom attempt to quantify people in relation to others, and when we do it is often simply by asking one member of a group about his or her relationships.

Analysis of TCs as communities requires a shift in mindset away from the individual and toward the connections between individuals. Let's suppose that Bob likes both Tom and Jerry. We can learn about this by asking Bob who he likes, and we can assign a number to it (Bob likes two people) and treat it as a variable. If Bob's outcome depends on the number of people he likes, we're fine. But perhaps Jerry does not like Bob, even though Bob likes Jerry, and this soured relationship could alienate Bob from the TC. Or perhaps it matters if Tom and Jerry like each other. In these cases we will need information about the relationship between every member of the triad. In a TC that may include ninety beds or more, this produces what mathematicians call a combinatorial explosion; there are thousands of possible resident relationships to monitor.

While no one can track all the relationships in TCs, the facilities themselves often track two relational acts of clinical importance. TC residents affirm each other for prosocial behavior and correct each other for behavior contravening TC norms; in the United States the affirmations are generally called "pushups" and the corrections are generally called "pull-ups." It's easy to visualize these affirmations and corrections as a network of helping behavior—if Bob affirms both Tom and Jerry, he has helped both by recognizing and reinforcing prosocial behaviors.

We can treat this as a network simply by drawing arrows from Bob to Tom and Jerry. Thanks to recent developments in social network analysis we can begin to ask what might predict which residents give help and what aspects of this network of helping acts might lead to improved clinical outcomes.

For instance, TC clinical theory claims that residents will react prosocially to peer intervention. One simple measure of a prosocial reaction would be whether TC residents increased the number of affirmations they sent to peers as they received more affirmations themselves. Suppose Bob affirms or corrects Tom. Is Tom more likely to affirm Jerry? Because three TCs in Ohio had kept extensive records of over 400,000 affirmations and corrections that thousands of their residents exchanged over the years, including the sender, the receiver, the date and the content, and because these interactions form a social network, this was a research question that we could answer.

In 2013 we published an article on the way in which TC residents react to affirmations and corrections (Warren, Doogan, De Leon, Phillips, Moody & Hodge, 2013). For each facility we summed the number of affirmations and corrections that each TC resident received in each week. We then used those to predict the number of affirmations that each resident sent in that week and subsequent weeks. We controlled for age, race, gender (two of the TCs had segregated male and female units) and the residents' score on a standardized measure of risk of recidivism.

The results were surprising. Residents who received more affirmations were likely to send more affirmations during the same

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week and from three to six weeks after. Residents who received more corrections were likely to send more affirmations during the same week and for one or two weeks after. As one would expect, affirmations energized the residents, but corrections seemed to as well.

Like any research study, this one left many questions unanswered. Given that residents respond to affirmations that they receive by sending more, to whom do they send them? Are they passing the affirmations forward to third parties, or do they return them to the sender? Do residents also respond to affirmations and corrections which they receive from staff? Are residents of the same race more likely to affirm each other? Are residents more likely to affirm a peer who has just been corrected?

In considering these questions, we drew on two bodies of theory for our next study. One comes from the research that TC clinicians have produced over the last several decades. The other involves work on cooperation in groups that evolutionary biologists and economists have pursued over the same time period (see, for instance, Rand and Nowak, 2013). The question of how people and other organisms cooperate is one of the most important in biology and social science, with ramifications for such pragmatic issues as the global environmental crisis, the pursuit of peace and the way in which bacteria form communities (yes, they really do). Applying the ideas that have arisen as scientists try to answer this question to TCs seemed natural, and so we began work on a second, more detailed study.

In this study (Doogan & Warren, 2017a), rather than looking at the weekly sum of affirmations and corrections that residents gave, we looked at the number of affirmations that residents gave on a daily basis. This allowed us to include a broad set of network predictors. For instance, if Bob affirmed Jerry we could ask whether Jerry would be more likely to reciprocate by affirming Bob, pass it on by affirming Jerry or do both. We also included affirmations and corrections from staff as predictors of the affirmations that

residents sent, so that we could directly compare their reactions to staff and peers. This turned out to be a good idea; while residents were more likely to send an affirmation after receiving one from a peer, they were no more likely to send one after receiving one from staff members. This confirmed the core TC claim that residents respond differently (and more prosocially) to peers. It also replicated the finding of numerous cooperation studies that people have a tendency to pay help forward, a process usually known as generalized reciprocity (see, for instance, Stanca, 2009). On the other hand, after receiving a correction from staff residents were actually less likely to affirm a peer, suggesting that residents might grow discouraged and less active after receiving a staff correction.

Residents interacted with peers in complex ways. There is substantial evidence for the common sense idea that reciprocity fosters cooperation (Rand & Nowak, 2013), and so it was no surprise that residents who affirmed a peer were more likely to subsequently receive an affirmation from that peer. But residents were also more likely to affirm a peer whom they had previously corrected; apparently they were using the affirmations to counterbalance corrections and rebuild relationships after correcting a peer, which De Leon (2000) had suggested would occur. We had expected that white residents would be more likely to affirm other white residents, and that minority residents would be more likely to affirm other minority residents, a phenomenon known as homophily (McPherson, Smith-Lovin & Cook, 2001), and we were correct. But previous research had shown that residents from different ethnic groups receive about the same number of affirmations from peers, so it is not clear that this is harmful in a TC context (Linley, Warren & Davis, 2010). We were pleased to learn that residents who arrived at about the same time were also more likely exchange affirmations, suggesting that residents who arrived at similar times were likely to build trust.

When we applied the same model to the corrections that residents sent (Doogan & Warren, 2017b), we found that residents who arrived at about same time were also more likely ●●●

to exchange corrections. This reinforced the idea that residents who arrived at similar times tended to build trusting relationships, a particularly important issue when correcting a peer. Surprisingly, residents of the same race were no more likely to exchange corrections. Residents were more likely to send a correction after a peer had affirmed them, but not after a staff member had affirmed them, again showing a more prosocial response to a peer affirmation than to a staff affirmation. And the residents tended to send corrections after they had sent affirmations, apparently trying to balance the two.

Our studies of TC network interactions gave us a rich understanding of how TC residents cooperate in building a community. But how does that community lead to positive outcomes? If cooperation is to last, cooperators need to find each other and work together in an ongoing manner, a phenomenon known as spatial selection in evolutionary cooperation theory (Rand & Nowak, 2013). In a TC context, that means that people who are serious about working the program and graduating need to find each other and work together.

In order to test whether cooperators were finding each other, we needed to change our focus from daily and weekly interactions to the way in which TC residents connect with peers over their entire time in treatment. Since TC graduates typically have better outcomes than residents who do not graduate, we analyzed predictors of graduation. Our hypothesis was simple: if cooperative TC residents were working the program together, graduates should cluster together. Therefore, a resident should be more likely to graduate if more peers who graduate have affirmed him. (Our sample for this study was entirely male.)

In Campbell, Cranmer, Harvey & Warren (2018), the analysis found evidence that this was true for both direct contacts and contacts two links away in the network. So, Bob is more likely to graduate if Tom, who will also eventually graduate, affirms him. But he is also more likely to graduate if Jerry (who will graduate) affirms Tom, who then affirms Bob. TC residents who are working the program seriously enough to graduate tend to cluster together, as the spatial selection hypothesis would suggest.

And residents who change in the program are more likely to be successful following graduation. It is possible to treat the content of affirmations as a network by connecting words that co-occur in the same affirmation. A particular connected set of words forms a word combination. Residents whose combinations change more over the course of treatment are less likely to be reincarcerated following discharge (Doogan & Warren, 2016). This strongly suggests that when residents are engaged in the program they learn and change in ways that benefit their lives.

Our research into TC resident interactions is still in its early stages, but it is clear that much of what TC residents do—exchange help, pay help forward, and work with peers who also want to change their lives—is very much like what any group of cooperative people do. TCs have learned to leverage the natural human tendency to work together and use it to build healing communities. It's not surprising when you think about it. But by learning more about how TC residents build communities, we may also learn how to foster more effective TC treatment. ●

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José Florentino dos Santos
Expert Drugs and Alcohol, LH – Training and Business Development
(Brazil)

Mental Health: Benefits of Dependency Treatment for Individuals, Communities and Governments - Brazil

Clock is ticking. More rapidly for the addicts of alcohol and other drugs, aging in the use of psychoactive substances is entering the third age[1]. Even though drugs are the third most prevalent psychiatric condition in this public, second only to depressives and dementia[1], with a focus on the elderly, which may be justified in part, to the related prejudices between the public and this problem[1,12].

If we think about vulnerability, the elderly user has more bulge than young users. Among the factors is the decrease in muscle mass, body water and glomerular filtration of the elderly user, since levels of substances and drugs soluble in water, such as alcohol, increase their level in the blood[1,11]. an increase in the interaction of alcohol and other psychoactive substances with multiple medications[1,11].

Even with more offers of care and treatment, we notice that the dependent ages in use does not believe in long-term recovery[1]. Increase in number of professionals interested in working with the theme[2] and reinforce the belief that it is possible to live in recovery in the long term.

In Brazil there are about two million users of crack, among adolescents and adults[3]. We still have many situations of drug use in scenes of uses which we call *"cracolandias"*, one of the most famous is the City of São Paulo. Good practices are important, actions, projects and programs are carried out all the time in these territories. The Government of the State of São Paulo and the City of São Paulo support the Recomeço[13] and Redenção[4] Programs that provide care, hospitalization for detoxification, opportunities for treatment, listening, feeding, bathing, various care and voluntary participation.

Currently, there are 3,327 vacancies for involuntary, involuntary and compulsory hospitalizations, and the volunteer is the most used[13]. This is done through the Recomeço Program, which has an agreement with Therapeutic Communities[13]. Users are constantly approached by trained agents for the time to accept health care and chemical addiction treatment.

In 2008, professionals specialized in chemical dependency of the Municipality of São Paulo visited some countries, in Lisbon, once SICAD was known to the effectiveness of the work.

This expertise is used to date in São Paulo. User acceptance is proven by the number of hospitalizations. In 2012, a project called Assisted Housing was implemented as a social reintegration for crack and drug addicts, a transition between hospitalization and living in a community[10] was necessary so that the dependent could have the opportunity to resume living with society with just opportunity, learning and practice[10]. ●●●

During one year men and women were followed up at the end of their Therapeutic Communities treatments by case managers10,9 and when at discharge they agreed to be residents of 5 assisted homes with up to 10 in each household, they had only one for women. In a meeting of the residents, they decided, even for the tasks.

They received trainings that adjusted behavior with the new reality (recovery, employment and cultural growth), had relapse prevention, incentive to maintain clinical treatment (comorbidity) and chemical addiction. They went back to work and studied. The Project was inspired by the assisted housing of Portugal, England and America and for women - Berkeley House in Boston10 which are also called Dry House10, the City of São Paulo project practically obtained the same results in the positive outcomes, that is, 58 % 10 than European models.

A Recovery Autonomy Control was used with great success. Unfortunately, the project did not have continuity due to a change in municipal government management10. Social reintegration is a great chance to change the current scenario, giving the chemical dependent an opportunity to build a new life with less frustration and more options for working and living in society without sophistry and prejudice.

Prevention and treatment in the work environment enables care and follow-up in the recovery of the use, abuse and treatment of alcohol and other drugs8. In companies it is ideal to have a Coordinating Committee with multidisciplinary participation5. The creation of a specific internal norm that describes each professional participation, of the adherents and managers in the conduction of the program14. Toxicological exams6 are welcome and should be carried out periodically, also in the other employees of the company. This organization allows the family in the treatment. The company CPTM of rail transport is a reference for results that reach 60% of recovery and 89% of abstinence. ●

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Kevin A. Sabet
President, Smart Approaches to Marijuana
(USA)

Effects, consequences and negative impact of legal cannabis/therapeutic marijuana

Marijuana legalization has been a hot-button issue in the United States, both in Washington D.C. and in state capitols around the country. The movement to legalize marijuana has historically been focused on lobbying policymakers at the national and state level, but after years of little success, the tactics of the monied interests behind the effort shifted to the grassroots level, state ballot initiatives. In 2012, the western states of Colorado and Washington became the first states to legalize recreational use of the drug after massive amounts of money were spent to sell the referendums to the local populations. These two policy changes have indeed accelerated the growth of a multibillion dollar, addiction-for-profit industry and has caused negative impacts both inside and outside of those states. I co-founded Smart Approaches to Marijuana with former United States Congressman Patrick Kennedy in 2013 as a national policy organization to be a check on the pro-marijuana lobby and track data on the harms of marijuana legalization. We now have five years of data, lessons learned, and negative impacts affecting both families and communities. The goals and tactics of the marijuana industry mirrors the playbook and goals of Big Tobacco. That is to successfully convert young, casual users into heavy, more frequent users. Given the United States' addiction epidemic – deaths driven largely by opioids – the rise of lax legalization polices comes at an especially inopportune time. In the time that the opioid epidemic has increased, the percentage of marijuana users who are using the drug frequently has skyrocketed. This is unsurprising as peer-reviewed research has revealed early marijuana use more than doubles the likelihood of opioid use later in life.

Although the full picture resulting from legalization will not be clear for decades, we need not wait that long to understand some key consequences in regards of youth use of the drug. The states that have legalized marijuana have among the highest rates of marijuana use in the country. Worse, since Colorado, Washington, Oregon, Alaska, and the District of Columbia allowed marijuana use, past-month use of the drug has continued to rise above the national average among youth aged 12-17 in all four states and D.C. One of the claims of the pro-marijuana effort was that legalization would not have any effect on young adult and youth use of the drug. The data show quite the opposite as people are radically increasing their rates of consumption. One recent study showed increased use by 14-18-year olds with newer forms of consumption that have become popular such as vaping and edibles. About 62% of 11th grade students in Oregon have reported "very easy" access to marijuana, with many of them reporting marijuana acquisition coming primarily from friends. Another study out of Oregon found that as medical marijuana users and growers increased in a community, marijuana use amongst youth also increased, in part due to the rising social acceptance of it.

One of the most common claims of the pro-legalization effort is that marijuana must be legalized to help crack down on the black-market trade of the drug. The data once again shows the opposite to be true. Criminal activity has only been amplified as highway interdiction seizures and confiscation of illegal marijuana growing operations have become increasingly common. In 2016 alone, Colorado law enforcement confiscated 7,116 pounds, or 3,227 kilograms of marijuana, carried out 252 felony arrests, and made 346 highway interdictions of marijuana headed to 36 different U.S. state. Narcotics officers in Colorado have been slammed responding to a 50% increase in illegal growing operations across rural areas in the state using legal grows as cover. In fact, a recent investigation by NBC, an American media network, found that in legalized states, foreign cartels are using the drug's legal status to hide massive human trafficking and drug smuggling operations.

Oregon has been a hub of black market activity since legalization. A leaked police report revealed that at least 70% of marijuana sales in 2016 in Oregon took place on the black market and around three to five times the amount of marijuana consumed in Oregon leaves the state for illegal sales. The U.S. Attorney in Oregon stated this year that "Oregon has a massive marijuana overproduction problem," with 2,644 pounds of marijuana in outbound postal parcels and over $1.2 million in case seized in 2017 alone. Finally, one of the most concerning developments since legalization has been the subsequent increase in drugged driving and motor vehicle fatalities in the states that have legalized. A recent study by the Washington Traffic Safety Commission found that almost 17% of marijuana users admit to using the substance daily and more than half of daily users ages 15 to 20 believe that marijuana made them a better driver.

The truth is, marijuana intoxication makes it impossible to drive safely. According to the National Institute on Drug Abuse, marijuana can slow a driver's reaction time and impair the ability to judge time and distance. In Colorado, the number of drivers intoxicated with marijuana and involved in fatal traffic crashes increased almost 90% from 2013 to 2015. Further, driving under the influence of drugs (DUIDs) have risen in the state with over 76% of statewide DUIDs involving marijuana. In Washington State, marijuana-impaired driving fatalities have more than doubled following legalization and one in five drivers were under the influence of marijuana, up from one in ten prior to legalization.

When it is all said and done, the data we have compiled over the last five years is clear -- the American experiment of marijuana legalization has been a complete failure. When future generations look back, who will they look fondly on? Will it be those who helped corporate CEO's line their pockets by paving the way for another addiction-for-profit industry, or will it be those of us who stood up to Big Marijuana and advocated for public health and safety? ●

Stig Eric Sørheim
Head of the International Department at Actis – Norwegian Policy Network on Alcohol and Drugs
(Norway)

From substitution to rehabilitation

Improved access to substitution treatment, increased treatment capacity and low threshold services have helped Norway's population of ageing drug users. However, challenges remain to promote recovery, improve quality of life and strengthen meaningful participation.

Like many countries in Europe, Norway experienced a heroin epidemic in the 1980s and 90s. The rapid increase in drug related problems, the emergence of HIV/AIDS and a sharp increase in overdose deaths led to a number of policy innovations.

A health approach

Norway has long had a health approach to drug problems. Needle and syringe programmes were introduced in the 1980s and trials with substitution treatment started in the early 1990s. The methadone programme expanded gradually from 1997 and onwards, and substitution treatment is now the mainstay of the treatment system.

Since 2004 people with drug problems have the same patient rights as other patients. Drug problems qualify for necessary health services in the specialized health care system like any other condition. Prior to 2004 health services for people with substance use problems were a shared responsibility between the municipal and county level. The counties were responsible for treatment services, while municipal social services handled other services for users. The current treatment system is a collaboration between regional health authorities, general practitioners and municipal welfare services. Specialized health care is responsible for the delivery of treatment services. Rehabilitation and care are municipal responsibilities.

In recent years, Norway has expanded harm reduction services. A Lancet article from 2017 shows Norway is among the countries with the highest coverage of substitution treatment and needle and syringe exchange[1]. A number of low threshold and outreach services have been established, and injection rooms have opened in the two biggest cities (Oslo and Bergen). However, the number of overdoses is still high and has been relatively stable over the past ten years.

Substitution successes

In 2017 there were just over 7600 patients in substitution treatment. The most commonly prescribed drugs are Subutex/Subuxone and Methadone.

Evaluations show that substitution treatment has reduced the risk of overdose deaths substantially and improved the quality of life of patients.

Four in five people in substitution treatment had a stable housing situation, and a similar number reported a stable economic situation. However, most are on benefits or other types of support, and only a small minority are employed.

Almost 60 percent of people in substitution treatment report sporadic or no use of illegal substances in the past month. 15 percent continue to use drugs in a way that dominates their lives, according to the latest data collection.

The treatment population still had higher prevalence of crime, non-fatal overdoses and suicide attempts than the rest of the population, but lower than substance users outside of treatment.

A ten year follow up of patients in treatment showed a substantial decrease in use of illicit drugs and crime. More have a stable housing situation and have been integrated in a family without

are outside of the treatment system. Furthermore, around 5000 people combine benzodiazepines, opioids, alcohol and anti-depressants who may not fit neatly into the target group.

In addition to substitution treatment there are also drug free treatment services, ranging from therapeutic communities to out-patient treatment. However, the vast majority of drug free treatment centres also offer substitution treatment. Entry into substitution treatment requires that other treatment forms have been considered, but there is no requirement to try drug free treatment.

Like many other countries in Europe, Norway has seen a shift from residential treatment to out-patient treatment, and from long-term treatment to shorter duration. Recently, critics have argued that access to in-patient treatment has become too restricted to save money, and the Ministry of Health has asked the Regional health authorities to report specifically on this issue.

Ageing users, complex needs

Norway is facing an ageing group of substance users. The average age in substitution treatment is now almost 45 years. Only 1,5 % are under 26 years old and hardly any are under 20.
However, almost one in three is over 50 years, and in the last survey 5 % were over 60 years.

This indicates that recruitment to heavy drug use has slowed down and that the treatment system helps people stay alive. So far, Norway has succeeded in keeping youth use down and is among the countries in Europe with lowest youth use rates. However, the ageing population creates new challenges for the treatment system. The system must adapt to an ageing user group with complex needs.

According to the latest data, a large number of patients have mental health issues such as anxiety and depression, and four in ten have somatic conditions that affect their quality of life. Two out of three deaths in the treatment population has somatic causes. This situation requires greater cooperation between somatic and mental health services and between municipal care services and the health system.

A smart investment

The UNODC describes treatment as "a smart investment", since treatment costs are lower than the costs of untreated drug dependence[3]. Treatment reduces drug-related crime, criminal justice costs, theft and health care costs etc. However, there are also substantial intangible cost savings from recovery.

For the users and their families, recovery is linked to increased connectedness, improved quality of life and greater contributions to the community.

R – for recovery

There are many definitions of recovery. Most emphasize voluntary sustained control of substance use that enables health and wellbeing, as well as participation in the rights, roles and responsibilities of society.

If you ask patients in drug treatment in Norway, nearly three in four (71%) say that their goal is rehabilitation with no drug use. The patients are ambitious on their own behalf, and the treatment system must support their recovery.

One way to do this is to strengthen the resources that are needed to sustain recovery – what some have called "recovery capital".[4] Recovery capital includes personal skills and interpersonal relationships, but also other factors like employment, meaningful activities and communities that support recovery. People who are abstinent and engaged in meaningful activities report higher quality of life.

A survey among patients after treatment showed that loneliness, lack of meaningful activities and difficult relations with family and friends were among the biggest obstacles for sustained recovery.[5]

There is a need for differentiated treatment services adapted to the needs and goals of a diverse group of patients. This includes substitution treatment as well as drug free options, residential and outpatient treatment and short and long-term treatment, but also long term follow up. Economic incentives risk creating one size fits all models with short term goals.

An important question is how we can create more recovery friendly communities. The responsibility for people after treatment is shared between sectors and administrative levels, and there is a risk of gaps in services. The low employment rate among people in substitution treatment is a particular challenge.

A recent Norwegian study showed that drug free networks promote improved quality of life. Social isolation and social networks with extensive drug use led to less improvement and lower quality of life[6]. Peer support structures – "recovery networks" – are among the factors that are related to higher "recovery capital". Recovery networks are important not just for the individual patient and their families, but can also provide support and hope for other people with drug problems. ●

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Susana Henriques
Professor at CIES - IUL Centro de Investigação e Estudos de Sociologia-ISCTE-IUL
(Portugal)

Natalie Broughton
Master Student at Liverpool John Moores University
(United Kingdom)

Substance and non-substance addictions: rethinking prevention

What are we talking about when we speak of substance and non-substance addictions? Why is prevention important to society? What are the impacts of prevention on general health? These questions were the guidelines for structuring this paper, in which the conceptualization of prevention and prevention practices are systematically discussed. Furthermore, some emerging challenges in the development of preventive strategies are raised. The present paper starts with a theoretical debate, supported with empirical evidence and literature. This aims to highlight the complexity of preventive strategies in today's society, is sustained of "...the importance of the involvement of individuals as agents of the construction of (and reflection on) contexts of action" (Abrantes, Henriques, Pereira and Veloso, 2014:2).

Substance and non-substance addictions

In the understanding of addictions as compulsive behaviours, addiction has traditionally been associated with the use of psychoactive substances. However, in recent years, challenges have emerged which have made it necessary to broaden this approach and the subsequent responses. This led to the adoption of the term 'Addictive Behaviours and Dependencies' (SICAD, 2013). Public policies have reflected this trend, with the introduction of the National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020 (SICAD, 2013) and the Guidelines for Health Education (Pereira and Cunha, 2017). In these guidelines, Addictive Behaviours and Dependencies are defined as "...«addiction processes»... impulsively and compulsively characteristic behaviour in relation to different activities or actions" (Pereira and Cunha, 2017: 58).

Psychoactive substances, either naturally or synthetically occurring, are those which change the functioning of the central nervous system when consumed. It can be legal or illegal to consume, grow or manufacture psychoactive substances, depending on the national legal framework and international conventions. "Addition... is the repeated behaviour which produces pleasure and relieves tension, especially in the early stages, can lead to a loss of control, severely disturbing daily life, family, work and social routines, which can exacerbate over time and lead to an addiction" (Pereira and Cunha, 2017: 70). This repeated behaviour may or may not be motivated by a substance, as in the case of gambling or technology dependencies.

Gambling-related issues may arise from gambling itself, which involves betting systems and financial risk, or from gaming, which involves interactivity with others and indicators of success and game progression (Vilar, Duran and Torrado, 2017; Clark, 2014). Problems associated with technology dependence involve the abusive or uncontrolled use of digital platforms and networks, such as social networks and online games.

Importance of prevention in society and its health impacts

Traditionally, prevention relied predominantly on the distribution of information leaflets and on the promotion of play activities. Aimed mostly at young people, such preventive actions aimed to increase the individual's level of information and occupation. Although there is no general evaluation for the efficacy of these strategies, it can be argued that they had little impact (if any) in changing behaviours and attitudes of the target group (UNODC, 2015; EMCDDA, 2011). Thus, the relationship between the cost of such strategies and their benefits and outcomes must be questioned.

In recent years the concept of prevention has evolved; it is now understood as a complex process which is established as part of the educational mission, and is present in areas such as the development of critical thinking, and in preparation of the conscious, autonomous and ethical decision-making process. In order to improve the quality of preventive actions, but also to demonstrate the social and economic impact of such strategic, holistic and integrated approaches, recent decades have seen the development of the science of prevention.

According to Spoth et al. (2006), for each 1 spent on prevention, approximately 10 will be saved from the health, social and criminal burden of addiction. The World Health Organization estimates that non-communicable diseases now account for around 60% of all deaths worldwide. These are deaths that are not due to bacterial or viral infections, or to parasitic diseases; rather, these are deaths resulting from lifestyle decisions (WHO, 2018).

This growing recognition of the health implications of lifestyle choices is the basis, both of and for, public health and welfare policies. Improvements in health not only have direct impacts on wellbeing, but also on the growth of income levels, and consequently on investment in education, training and productivity. As such, the importance of introducing and sustaining science-based prevention interventions is paramount.

A healthy and safe population carries the improvement of their lifestyles. This is the field of science-based prevention, as part of a broader effort to ensure the necessary conditions for the development of those who are less vulnerable and more resilient, acting for the social empowerment of individuals and groups.

Challenges of prevention
The work of evidence-based prevention allows strategies to be developed which are appropriate for the particular vulnerabilities of the target group. This adaptation takes place on two levels: the first is related to the scope of the intervention, and the other is related to the context. In terms of the scope, prevention can be directed at society as a whole (environmental or universal prevention); directed at vulnerable groups at greater risk of developing problems related to addictive behaviours (selective prevention); or it can focus on interventions directed at individuals at risk (indicated prevention). The contexts of interventions are diverse, ranging from families,

schools and communities to workplaces, nightlife settings, and the media.

In each preventive intervention, there are specific issues and challenges relating to the characteristics of the group and the context, but also in relation to the strategies that are used and their scientific support, both theoretical and methodological.

Effective evidence-based interventions should identify and implement policies and practices which are adapted to the needs of targeted individuals, as well as monitor the quality of the intervention and the outcomes for the participants.

In this scenario of increasing complexity and demand, professionals and decision-makers in the field of prevention need specialised training that allows them to develop evidence-based prevention strategies adapted to different groups and their contexts. Such is the case of training programmes based on the Universal Prevention Curriculum (UPC) and the adapted version to the European context (EUPC) .

Information regarding the required skills and responsibilities of prevention professionals is recent and somewhat limited, which has led to poorly-defined and inconsistent descriptions of such expert job roles (Gabrhelik, et al., 2015). The term 'prevention professionals' generally applies to professionals who are responsible for the planning, implementation, and monitoring of prevention interventions and/or policies within a defined geographical area. These individuals may supervise other prevention workers who help to deliver or monitor prevention interventions.

In this context, some of the fundamental skills required for professionals are: i) general, personal and social skills, such as communication and interaction; ii) intervention skills, such as preventive strategies, personal and social development, decision-making processes, and project management (including monitoring and evaluation procedures); iii) multi-disciplinary skills necessary for adapting preventive strategies to the needs of targeted individuals and contexts, including diversity sensitivity (cultural, gender and other diversities). ●●●

Of the competencies presented above, those related to the monitoring and evaluation of preventive interventions are especially important. This is because they are the most directly related to the production of results and scientific evidence, which sustain the balance between the initial design of the intervention and its adaptation. Evaluation is a form of research which allows the short-, medium- and long-term outcomes of prevention to be systematically analysed, in addition to the factors related to these outcomes. "To evaluate is to value and judge rigorously, logically and coherently the state, evolution and effects of problems, actions, devices and organizations upon which we are intervening" (Guerra, 2007: 206). Ideally, all stages of the preventive intervention should be evaluated (i.e. the planning, development, implementation and follow-up), allowing information to be gathered to improve the intervention and its quality.

More specifically, monitoring and evaluation allows: the measurement of results and impact; verification of which segments of the population responded best to the intervention; comparison of costs and benefits; and comparison of the effectiveness between interventions. As evaluation should be based on research, in this paper we stand for several forms of knowledge production – knowledge for action and knowledge in action, in the expression of Guerra (2007). This means that it is necessary to diversify methodologies and approaches in order to evaluate preventive interventions.

This diversity implies not only collating results from several sources, but also the mobilization of less common methodologies which can prove to be very effective in uncovering information that is difficult to access through more traditional methods. The case of visual methods can be used as an example (Henriques and Candeias, 2013).

Here, it is important to mention an additional challenge faced by prevention and prevention professionals at the present moment: the scientific dissemination of results and the knowledge produced. This challenge is particularly pertinent to the Portuguese reality and language, because there are very few publications in this academic field. ●

featured article

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Trevor Hallewell
Program Manager, WHOS, and President at Queensland Network of Alcohol and other Drugs Agencies (Australia)

The Harm Reduction Journey of an Australian Therapeutic Community Organisation

WHOS® (We Help Ourselves) was established 1972 in Sydney, Australia. We have been offering help and support to people with substance use and alcohol problems continuously for over 45 years. Our services are based on the Therapeutic Community (TC) model of care. The service was originally set up and run by ex-users, self funded by people seeking help with their substance use issues. The name We Help Ourselves reflects the self help nature of our programs.

Today WHOS operates with a main campus in Sydney, which houses a Men's program and a Women's program both functioning as abstinence based TCs. We also have the OSTAR (Opioid Substitution To Abstinence Residential) program, where the objective is to provide a modified TC approach, for clients wanting to adopt a lifestyle free from Opioid Substitution dependence. At this site WHOS also runs a modified TC for people on Opioid Substitution Treatment, who want help in stabilising their lifestyle but continue with their OST program. We also run two 26 bed mixed gender programs in regional Australia, one in the Hunter region of New South Wales and the other in the Sunshine Coast region of South East Queensland. Both of these programs provide abstinence based treatment as Therapeutic Communities.

We Help Ourselves has always had a strong focus on abstinence models of treatment. In 1986 it was recognised that many of our clients would not achieve or maintain abstinence post discharge. HIV/AIDS forced us to understand that abstinence and harm reduction are not polar opposites: abstinence is part of harm reduction. It took the terrible HIV/AIDS epidemic to reaffirm to us that our clients don't get better according to the practitioner's timetable. The reality is that relapse happens. It's our responsibility to give them a safe environment to recover in, and the information and a safer means to protect themselves, other users, their partners, and the wider community.

"Are we here to help the drug-dependent or only those who do it our way?" - Executive Director, WHOS, 2005 (Ref: 1) to help our clients protect themselves, including providing access to condoms and sterile needles and syringes. We initially referred to these changes as "common sense", but later found that others called it "harm reduction". Numerous abstinence focused drug treatment centres around the world did not provide the information or the means for drug users to avoid Blood Bourne Virus (BBV) and Sexually Transmitted Infections (STI) or drug overdose, in particular during their stay in treatment.

WHOS staff worried that providing condoms and injecting equipment might send conflicting signals to clients. Some clients indeed said they were confused: sex and drug use within the program were not permitted, but condoms and syringes were available. Therefore it was explained that while there were program guidelines, not everyone followed them all the time. WHOS' position was that if clients did break program guidelines we hope it was done as safely as possible. WHOS wanted the clients to be prepared, to avoid HIV and other infectious diseases. Abstaining from sex and injecting drug use despite the availability of condoms and syringes became a lesson for clients in coping with risky relapse situations. WHOS did not experience a drop in admissions after it introduced harm reduction; rather, as word spread, more Intravenous Drug Users sought treatment at WHOS for ensuring the health and safety of clients.

In 2018, and over 30 years on, WHOS harm reduction strategies are well embedded into its 7 programs across NSW and QLD. Each service has dedicated Harm Reduction Workers who facilitate the education program to the clients. Education groups are provided on BBV, STI"s Overdose Prevention/CPR/administration of Naloxone, Infection Control, Safer Sex and Relapse Prevention. Harm Reduction Workers are overseen by the WHOS Nurse Manager who ensures workers skills are updated and education and resources provided to clients are current and evidence based.

All WHOS services have well established partnerships with harm reduction services in their areas. At the Rozelle site WHOS programs in partnerships with Sydney Local Health District and other community agencies have established an onsite Liver Clinic to induct clients on to hepatitis C treatment whilst in program and an onsite Women's Sexual Health Clinic.

Residential programs for individuals on Opioid Substitution Treatment were introduced in 1999, 2009 and 2012 to offer support for reduction and stabilisation. A day program for OST clients in these programs was also established to further commit

WHOS®
helping people help themselves

WHOS to harm reduction initiatives.

WHOS' journey from an 'abstinence only' based therapeutic community to a therapeutic community based organisation that integrates Harm Reduction initiatives in response to the challenges of the HIV/AIDS epidemic has stood the test of time and new challenges continue to enforce the commitment to harm reduction for WHOS.

The transition illustrated clearly that the process of change, while rarely easy, can be managed and is best achieved by identifying common ground between different viewpoints and taking small steps (World Health Organisation, 2006) Ref: 1. The WHOS Harm Reduction Program was awarded a commendation for the "Excellence in Health Promotion" at the NADA Awards in 2016. ●

Augusto Nogueira
CEO, ARTM – Associação de Reabilitação de Toxicodependentes de Macau
President of the IFNGO – International Federation of Non Governmental
Organizations 2017 - 2019
Macau (RAEM), China

Drug Addiction in Macau

I would like first to share my appreciation and thanks to the DIANOVA to provide me with this opportunity to share the situation and context of drug addiction in Macau.

When it comes to drug addiction, what we need to do as professionals is to comprehend the evidence base and determine the best practices for education, prevention, treatment and harm reduction. This includes understanding what the most effective options are in regard to the individual circumstances of the many people that present for assistance.

One of the perennial questions is the depth of evidence and the benefits that flow from residential settings when compared to other types of treatment. I think this is such a complex issue that it will continue to be debated for many decades yet.

The larger policy debates are also of great importance, particularly regarding whether drug use should be treated as a legal or health issue.

We can see that when we thought that globally we were moving towards a different and more humane approach to people who use drugs such as the decriminalization of drugs, and in some parts even the legalization of some drugs, in Asia we see a different direction. In this region there are often declarations of a full force war on drugs that result in killing people accused of using drugs extra judicially. The developments we see across Europe and the Americas seem to have little to no impact on the drug policies enacted across the Asian Region. The current situation in the Philippines being a perfect example of how many Asian countries ignore the developments and evidence from across the world to pursue harsh and punitive approaches against people who use drugs.

Of course, such policies impact greatly on treatment services. In the Asian region the focus on compulsory treatment centers has resulted in a lack of understanding and support for the therapeutic value of community based residential rehabilitation services. Compulsory treatment centers are often operated by law enforcement agencies (or defense forces) which understandably cannot put in place the health based therapies of centers operated by health professionals.

The death penalty for drug users is another example of how drugs remains a very controversial issue in Asia. As a result, those of us working in Asia are often left wondering just what is the best way to handle this situation.

However, for the purpose of this article I will focus on Macau. Here the NGOs and the Social Welfare of Bureau of the Macau

contributed article

Government work very closely. Luckily, Macau is a small place so it's easier to cooperate, and this co-operation and unity of purpose is no doubt the foundation to our success in Macau.

In Macau, we understand that the recovery in a residential setting such as a therapeutic community has a positive impact on the improvement of the overall life aspects of the person (employment, family, healthy life style) and on their family and community. It also provides significant cost savings to Governments in the long term through the reduction of criminality, social care and health care. All of this is achieved because of very close working relationship between NGOs and several Government Departments, from the beginning of the client's treatment journey until their reintegration into the society.

In ARTM, as residential treatment provider, we give a very strong emphasis to the reintegration of the person. That means building a program where all residents are able to find a job before leave the residential setting. In addition, more recently due to the increase of methamphetamine use among the young people of Macau, and in cooperation with the Social Welfare Bureau and Youth Education Bureau, ARTM has been able to develop opportunities so people can continue their studies during their stay at the residential setting. This is very important for those young people that are sent to our residential services by court order.

But we also understand that not everybody needs residential treatment or its willing to enter a residential setting, therefore Macau offers a range of services that includes community based treatment such as, counselling, methadone programs, needle and syringe programs, and other outpatient services working all together to be able to help the person and their family.

Obviously Macau does not have a perfect system, and we still need significant improvements in some areas. For example, the judicial system needs a far better understanding of how incarceration is not effective in helping people that use drugs. The relapse rate after having been released from prison is high and the treatment of drug dependency inside of the prison cannot offer the same intensity, care, attention, expertise etc. that a specialized NGO can offer. Nevertheless, in Macau we offer methadone programs in the prison setting for the purpose of managing heroin withdrawals, a program we hope will be an example taken into consideration across the region. We also hope that the range of services we have developed will be a guide for others in our Region.

I also would like to share the very good results we have in decreasing of HIV/AIDS among the people who inject drugs in Macau. In 2004 we had an outbreak of HIV among the people who inject drugs and immediately the government created a Commission constituted by different institutions to tackle the problem. After many discussions there was agreement that the only effective measures to fight the problem at that time was to create a needle syringe program and the methadone maintenance program. The needle syringe program in particular was very controversial as no other nearby country in our region was doing this. However, in 2008 with the support of the Drug Commission, Health Services and Social Welfare, ARTM opened the first needle and syringe program in Macau. The innovation of this needle and syringe program is to not only provide clean injecting equipment but to also recover the used syringes. We also created a reward system for clients based on food and beverages that today its responsible for 90% return rate of used syringes and needles. Also, the needle and syringe program was designed to operate as a day center where people who inject drugs can spend their time just reading, watching television, consulting our psychological counselors, social workers or nurse. Immediately we could see from a small study that was undertaken that there was a reduction in drug consumption and criminal activity among clients due to the people who inject drugs spending more time in the Day Center. Today, after 10 years of existence, the needle and syringe program has been so effective we can announce to the world that for three consecutive years we have ZERO NEW HIV INFECTION AMONG THE people who inject drugs (2015, 2016 and 2017).

To conclude, when we talk about drugs, we must always remember that we are talking about our fellow human beings, and they are directly and indirectly affected by the decisions that are made. Therefore, I hope that all politicians, policy makers, frontline workers, police, researchers, educationalists, and drug user advocates, can understand that the most important issue are the people that make up our communities and society. It's time to follow the scientific evidence, it's time to follow what has been successfully applied and its time not to be lost in demagogies.

ARTM

澳 門 戒 毒 康 復 協 會

Associação de Reabilitação de Toxicodependentes de Macau

Association of Rehabilitation of Drug Abuser's of Macau

Savas Yılmaz
CEO/General Manager of Turkish Green Crescent
(Turkey)

98 years of experience in prevention and rehabilitation: Green Crescent

Addiction is the fundamental cause and/or trigger of many economic and social problems we have encountered in recent years. The dimensions of the health problems caused by addiction and the damage caused by criminal events on the social welfare and peace of our society are fixed with statistics.

A great number of our children and teenagers during their most productive ages to contribute to the national economy have become captive to addiction; sources spent on treatment, criminal investigation and prosecution, judicial security measures and rehabilitation studies in addiction field reaches huge budgets. Combating addiction is regarded as a multi-stakeholder combat which is a fundamental task and responsibility of many organizations.

High Commission on Combating Addiction undertakes a highly important mission with its structure providing coordination and representation among stakeholders. Green Crescent is represented in High Commission on Combating Addiction with 98 years of its expertise and experience in prevention and rehabilitation field and it contributes strategies and policies as a widespread non-governmental organization across Turkey.

Green Crescent's prevention programs: TBM and afterwards

Importance of prevention in combating addiction has been approved in all developed countries and prevention studies now have a position as an evidence-based science. Prevention can be defined as non-introduction of teenagers with addictive substances, impediment to substance testing or use age, intervention before turning into negative attitudes and addiction, strengthening public health and peace with a protective approach and interception of potential problems and heavy costs caused by addiction. Prevention is a process which includes all dynamics of community such as school, family, workplace, social life, media, local government and non-governmental organizations. Treatment is a study field which can be implemented with small budgets incomparable with rehabilitation and criminal expenses and which have high social benefits comparing with its cost.

Prevention studies in Turkey, which was signed in 2013 between The Ministry of National Education and The Green Crescent and put into practice in 2014, started within the scope of school-based program TBM "Addiction Prevention Training Program of Turkey". TBM Training Program has already reached 13 million students and 2 million parents through 658 formatters and 32 thousand implementer school counselors with pedagogical approach and training modules tailored to age groups in the areas of healthy life, tobacco, alcohol, substance and technology addiction. TBM Training Program has been registered on the International platform as the world's most prevalent school-based prevention program in terms of reaching the population,

and displayed as ' an example of good implementation' by many foreign organizations which works in the field of addiction.

Awareness raising and informative structure of TBM Training Program is intended to strengthen with programs which upskill and expand adolescents and children's ability (skills) to say no beyond just informing and intervene before harmful habits turn into addiction. Within this framework, Green Crescent prepared "OBM Program on Addiction Intervention in Schools" and "Life Skills Training Program" and planned subsidiary steps after TBM in the field of prevention (OBM and YYBEP Have been developed by the Green Crescent as a complementary action to TBM).

In the upcoming 5 years, OBM and Life Skills Training Programs are expected to be implemented on a school-based basis again through the school counselors. With the protocols signed between the Ministry of National Defense, Ministry of Family and Social Policies, Ministry of Youth and Sports and Presidency of Religious Affairs, TBM continues to reach different target groups and to disseminate adult training. Thus, it is ensured that TBM reaches different layers of the society.

Green Crescent Consultancy Center YEDAM (Life Skills Training Programs) Holds addicted people's hands

In our country, inadequate treatment and counseling dimensions have been identified in the process of combating substance and alcohol addiction and works have been initiated to increase their effectiveness. Primarily short, medium and long-term planning for rehabilitation of people who are addicted to drug and alcohol was completed in order to determine needs and the most appropriate implementation methods. Also, implementations and researches in the world and Turkey were analysed. As a result of these assessments, an outpatient consultancy support service model was developed especially to Turkey. YEDAM which started to service with 444 79 75 Hotline at the first stage, now services with six centers throughout Turkey.

Green Crescent provides free psychological consultancy and rehabilitation support for addicted people and their relatives with YEDAM. The team which includes expert psychologists in the addiction field offers information, proper guidance, advice and consultancy services in drug and alcohol addiction for people who seek for them. Along with psychological consultancy service,

YEDAM provides social support services to reintegrate addicted people into social life, and also it carries out family therapies and consciousness-raising activities.

Rehabilitation Model of the Green Crescent

Addiction is a biopsychosocial disorder which should have a solution containing biopsychosocial elements. Solutions containing these elements should be presented with a unique model appropriate for our addicted profiles. That being the case, Turkey focused mainly on medical treatment, and the treated person was sent back to the same social environment without any support after medical treatment instead of producing a comprehensive mechanism that would provide psychological and social support services in combating addiction. This situation not only caused the success rate of implemented treatments to get low but also built pressure on hospitals because of addicted people who received medical treatment process repeatedly. Hence, it is stated that one of the most important failings is the rehabilitation process along with prevention and Turkey is in need of a distinctive rehabilitation ecosystem. With the law amendment in 2013, rehabilitation was revealed as our fundamental field of activity.

Turkey Rehabilitation Model has been aimed to decrease addiction recurrence rate reaching 50% and to reintegrate addicted people into social life with rehabilitation. The model includes components of effective guidance, treatment for integration into society, social support strengthening integration after treatment and follow-up care. In The Green Crescent Rehabilitation Model, the client journey is discussed from beginning to end and also the roles and responsibilities of appropriate stakeholders are determined. In order to provide integration and maintain rehabilitation process, recovery partner/case manager is involved as a connective element in the model.

In accordance with the reasons which lead individuals to addiction and sociocultural structure of our country, the model is based on therapeutic community. In addition to that, the model based on family, individual and community is framed with "Turkish-Islamic Guild" approach which has been part of our culture for centuries. In the process, an opportunity to rehabilitate and improve their own manners is provided for individuals with integration into social life. The model starts the rehabilitation process with "Welcome House". Addicted people graduated from "Welcome House" pass to the six-month main rehabilitation phase. In this phase, one becomes a part of the therapeutic community and begins to work. Under the guidance of psychiatrists and therapist who evaluate how long an addicted person remains in each phase, the total duration of rehabilitation is determined as a result of one's situation in rehabilitation. Turkey Rehabilitation Centre as part of the rehabilitation model will open with ten models across Turkey at the first stage in cooperation with the government and the first one will be put into practice at the beginning of 2019.

98 years of experience...

With 98 years of experience, Green Crescent has accomplished many important works in the field of prevention and rehabilitation and has been increasing the area of influence and the benefits offered by collecting with each passing day. With its civilizational heritage and historical importance, Green Crescent serves as a model all around the World and it will maintain to shape our ideal to raise healthy generations physically and mentally. ●

Boro Goic
Director, Recovered Users Network RUN
(Bosnia and Herzegovina)

Benefits and challenges of addiction treatment and recovery for individuals, communities and governments in Bosnia and Herzegovina

contributed article

Pre/post war conflict and addiction development in Bosnia&Hezegovina

Reflecting on the situation in the field of drugs in Bosnia and Herzegovina, I cannot talk about this issue without looking back at the period of the 80s of the past century in Yugoslavia, when the addict's pictures were only available on television, and Christiane F.'s book "We children from Bahnhof Zoo" was obligatory book and the only methods of addiction prevention.

Even if there were few addicted individuals, then they belonged to the elites of the famous rock bands who were exposed to these behaviors due to their constant travels abroad. But they also could afford and therefore had access to treatment in one of the Western European clinics. On the one hand, the restrictive socialist system and police enforcement as well as the laws were very harsh with drug related offences, and on the other hand, the stability and limited fluctuation of people across the borders at that time did not allow greater supply and demand for drugs.

With political changes across the Europe, brought by the fall of the "iron curtain" at the end of the 1980s, the territory of Yugoslavia was also severely affected and first cases of heroin overdose deaths were recorded in urban areas in Bosnia and

communities and faith-based rehabs had programmes for people addicted to heroin which lasted between one and three years, and provided necessary tools for further social integration and adaptation to the life after rehab.

It is also very significant to mention relation between addiction and PTSD, which was present in the post war period. Large number of heroin addicts had dual diagnoses, and many were not diagnosed or treated due to the lack of public institution which should have dealt with these issues. Consequently, rehab centers had to address and treat people with these issues, even though they didn't have necessary experience. Even though there are no official data, I have been working in the field for the past 15 years and I can estimate that until 2010, 20% of people with addiction problems have successfully completed programmes in rehab centers, and 80% of those have succeeded in maintaining abstinence.

Addiction treatment has shifted with the establishment of methadone maintenance treatment centers in 2003, which provided opioid substitution treatment - OST, and had standards which included two unsuccessful treatment attempts in resinential rehabs up unitll the 2006. Today, around 20 OST centers exist in Bosnia. From that time, OST treatment has
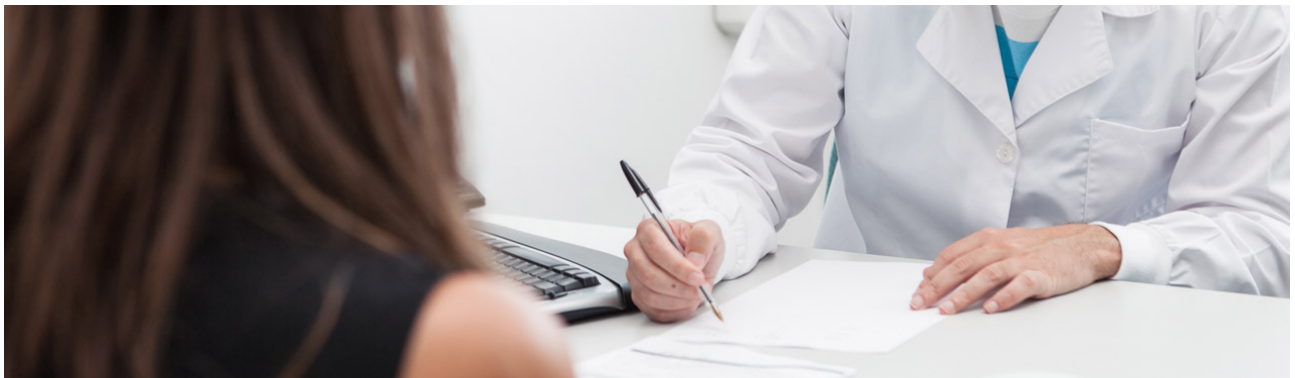
Herzegovina. The war and disintegration of Yugoslavia has brought connections with the west and the east, the Balkan route has been established. From 1995 Bosnia and Herzegovina has been experiencing a constant increase in the number of people addicted to opiates, the establishment of rehabilitation centers and specialized hospitals and treatment facilities that provide treatment etc.

Development and challenges of drug treatment in last 20 years
One specific thing linked to the treatment and the outcomes of treatment, is that the rehab centers were the only available treatment option at the time in 2000's when addicts first started seeking help for their problem drug use. Those therapeutic

become the main treatment option and in 2008 we already have over 1000 people addicted to opioids in treatment, and today over 2000. In the beginnings, OST centers had a clear goal to reintegrate addicts as a main goal of the treatment. Social workers and psychologists had clear share in this goal and NGOs and communes were partners to clients who wanted to continue with recovery process.

OST/ Reducing harm or reducing ability to recover
What has become a problem over time is that all OST centers have lost their clear vision about the necessity of referring people to next phases of recovery and consequently they become institutions that prescribed methadone not only to heroin addicts

but also to people addicted to amphetamine- based substances (which is a wrong approach to treating people addicted to these substances). Today, in Sarajevo, the capital of Bosnia and Herzegovina, there is around 600 addicts on OST, some of them 10 or more years in treatment, and who haven't received adequate follow up treatment, which has proved to be one of the biggest problems within the harm reduction programmes.

Ghettoing patients, poor cooperation over time, the self-sufficiency of OST service providers, and the lack of understanding of a multidisciplinary approach have influenced that now nearly 95% of these patients are still unemployed, marginalized, without social capital, with broken family relationships and absolutely no desire to go further in recovery procces. The information they receive is that they suffer from chronic relapsing disease and that this is their permanent state and the maximum they can achieve.

The future challenges around addiction seen a disorder characterized by relapsing and chronic nature, is the need for different approach to a heroin addict who enters treatment in his 40s after 20 years of addiction and to adolescent of 19 years who is treated for three-year addiction career of mixing heroin, speed and analgesics, and who knows that he can only receive something that will help him with the stabilization. There is a persistent problem with stabilization process, which in this case is not oriented to individual's needs and circumstances, and instead of helping people to move on with recovery process, these adolescents stay parked in this phase for many years, without setting a clear goal, duration or outcomes of the treatment.

After 15 years since establishment of the OST centers in Bosnia and Herzegovina, some conclusion includes that these centers have contributed to improvement of the overall situation and provided services that prevented the spread of grater harms to addicts and society, reduced crime and further spread of HCV and HIV, but at the same time OST centers haven't succeeded to reduce drug use or in any way influenced the motivation of addicts in treatment to improve their status in society, achieve abstinence and integrate into society. So we can conclude that, on the one hand, as much as these OST programs are evidence based and on the medical point of view needed and favorized, in their essence these approaches have led many people to the position that they were not able to see recovery as the ultimate goal of treatment.

Residential rehab – is that a final solution?

The long-lasting benefits of people staying in rehab centers, at the very beginning brought good results. One of the key factors for retention in treatment where recovery capital can grow, and eventually be a tool for successful reintegration, was also the switch from an environment where the person lived and developed addiction to a therapeutic environment. Many recovered users, have become recovery champions and wanted to contribute to spread hope and help others, so back in 2000, these individuals established NGOs across Bosnia and Herzegovina. In spite of being a country with lots of post war problems and also not being part of the EU, many recovered users managed to find an employment, continue with education, resolving housing issues and succeeded to fully integrate and become contributing members of society.

On the other hand, with the progress and further establishment of more OST centers, the residential rehabilitation centers as one of the treatment methods started to be marginalized. Initial successes have become past, so after unsuccessful and short treatment in rehab centers, more and more people addicted to

opiates decided to continue treatment with OST. The decrease in heroin consumption at the beginning of the last five years has contributed to a drop in the number of addicts in rehab centers across the region by around 50%. The clear guidelines of the various residential centers that emerged from a large number of recovered users who are now integrated into society have been lost in their efforts to treat in a similar way individuals addicted to amphetamines and other drugs and who had dual diagnoses. What is now clear is that after many years of competition between the rehab centers and OST centers around abstinence and reducing harm, now has come the time of debates and a joint understanding of these issues which should rely on the research from the field and the aspirations of individuals to recover.

How future can look like without understanding of "new" recovery model

All of these were the reasons that, on the initiative of our organization, which has taken an active role in the Working Group for the development of new National Drugs Strategy, recovery was incorporated as a proposed measure and the main goal within the demand reduction section of the strategy. Recovery as a strategic goal is not new; UK has been successfully implementing its recovery orineted strategy since 2010 and has solid evidence it works. We know that it is necessary to balance the distribution within the actions to reduce the demand. Harm reduction and treatment should not be the only measures that have the priority and support, but also rehabilitation in residential rehabilitation centers and social integration should be supported both through institutions and financial structures.

Within the recovery process, the aim is to provide the services that will enable individuals with drug related problems to achieve their maximum potential, but also to help service providers realize that they should build and develop client oriented approach in which the intervention will not solely be pain-based but rather oriented to hope based interventions which rely on persons' strengths and not their weaknesses and deficits. This requires multidisciplinary and multi-sector approach and understanding of recovery.

In conclusion, it is important to highlight that if we aim to develop better approaches and have benefits in demand reduction field in Bosnia and Herzegovina, we have to follow new trends and acknowledge that building recovery capital brings benefits to individuals and society, and we have to improve the skills and knowledge of the staff, as well as develop cooperation of all actors and with that systematic approach we will consequently help individuals reduce or stop drug use, and integrate as contributing members of society. ●

Karen Biggs
Chief Executive, Phoenix Futures
(United Kingdom)

Helping individuals families and communities recover from drug and alcohol problems – UK

The UK is facing a number of challenges at the moment and whilst our turmoil over Brexit is getting the headlines at home and further afield, other issues are affecting those of us dedicated to helping individuals families and communities recover from drug and alcohol problems.

More people are dying of drug related issues than ever before in England and in Scotland. More people are accessing services without a home. It has become harder to access funding, meaning some people don't get access to the treatment they need, or they don't get it for long enough. What's more, as funders are forced to make difficult decisions about what they can fund, people in addiction and those struggling to maintain their recovery are at greater risk from stigma.

Highest Drug Related Deaths on Record
The UK is reporting the highest drug related death figures ever recorded. In England, there were 2,383 deaths in 2016 - mostly older opiate users, and half of all deaths were amongst people who had not been in treatment for 10 years.

Significant Cuts in Funding
The UK is experiencing the first sustained period of reduced funding to the substance misuse sector it has faced. There has been a 25% cut in funding for treatment services since 2013 and a 32% cut in funding for treatment in prison services.

Increasing complexity in people presenting to treatment
Treatment services in the UK are seeing an increasingly level of complex needs amongst people presenting to treatment
• Higher levels of dual diagnosis and mental health issues
• People who have been in active addiction for long periods of time without treatment
• Older people with worsening physical health issues
• More people experiencing significant and sustained trauma and abuse

Increasing levels of stigma
Whilst we have seen a greater understanding of the causes and consequences of mental health in the UK and increasingly the impact of domestic violence and abuse against women and children, we have arguably seen an increase in the stigma experienced by people with substance misuse issues. This impacts on people's willingness to seek treatment for fear of judgement, and impacts on the treatment people receive. It also stunts people's ability to progress in their recovery.

And this is all in a context of a recovery-orientated Drug Strategy published by the UK Government in 2017 and a recognition by the Government that drug and alcohol treatment saves society £2.4 billion every year, as well as bringing very real benefits to individuals and societies

The charity that is confident about recovery
Phoenix Futures is dedicated to helping individuals, families and communities recover from drug and alcohol problems.
We deliver our purpose through a number of different activities:
• We are a specialist treatment provider of psychosocial services to people with drug and alcohol problems
• We deliver services in prison and the community to individuals experiencing problematic drug and alcohol use
• We are the largest provider of residential rehabilitation services in the UK
• We are the only specialist substance misuse registered housing provider in the UK
• We deliver a number of initiatives across the country that address stigma and demonstrate the impact of treatment and the potential of people in recovery

We have seen much change over the last 50 years but as a charity it is our responsibly to ensure we can effectively respond to that changing need in a changing context.
Charities exist to support people when others can't or won't. So in 2017 we launched our new plan 'Confident About Recovery'. It set out some ambitions for how we could support more people to access treatment and sustain their recovery.
That meant thinking about new ways to support people in prison and in our residential services, it meant speaking out about the stigma and negative attitudes that stop people in the most desperate of circumstances from accessing the help they need. And it meant developing more approaches that supported people in treatment and beyond. Because we know that without good friends, decent housing, high levels of health and wellbeing and a feeling of self-worth, no amount of treatment is going to lead to a successful recovery.

Our Residential Services
Phoenix has delivered Therapeutic Communities for 50 years. We currently have five residential services - three of them run on a Therapeutic Community model and two are specialist services.

One of our specialist services allows mums and dads to access treatment whilst they still have the care of their children. Parents with substance misuse issues are some of the most stigmatized groups in our society which is why it was so important for us to give voice to their experience through our documentary Addicted Parents. The documentary showed peoples experiences before and during treatment and reached 2.4 million viewers.

Our other specialist service Grace House is a small service for women who have experience multiple and complex issues in their life. Many of the women who access Grace House have experienced domestic violence, mental health problems, and periods of custody as well as drug and or alcohol issues. They find their needs exclude them from other services. Women at Grace House tell stories of experiencing prejudice and discrimination from professional agencies because of their experience. Grace House provides women with a safe environment and the care
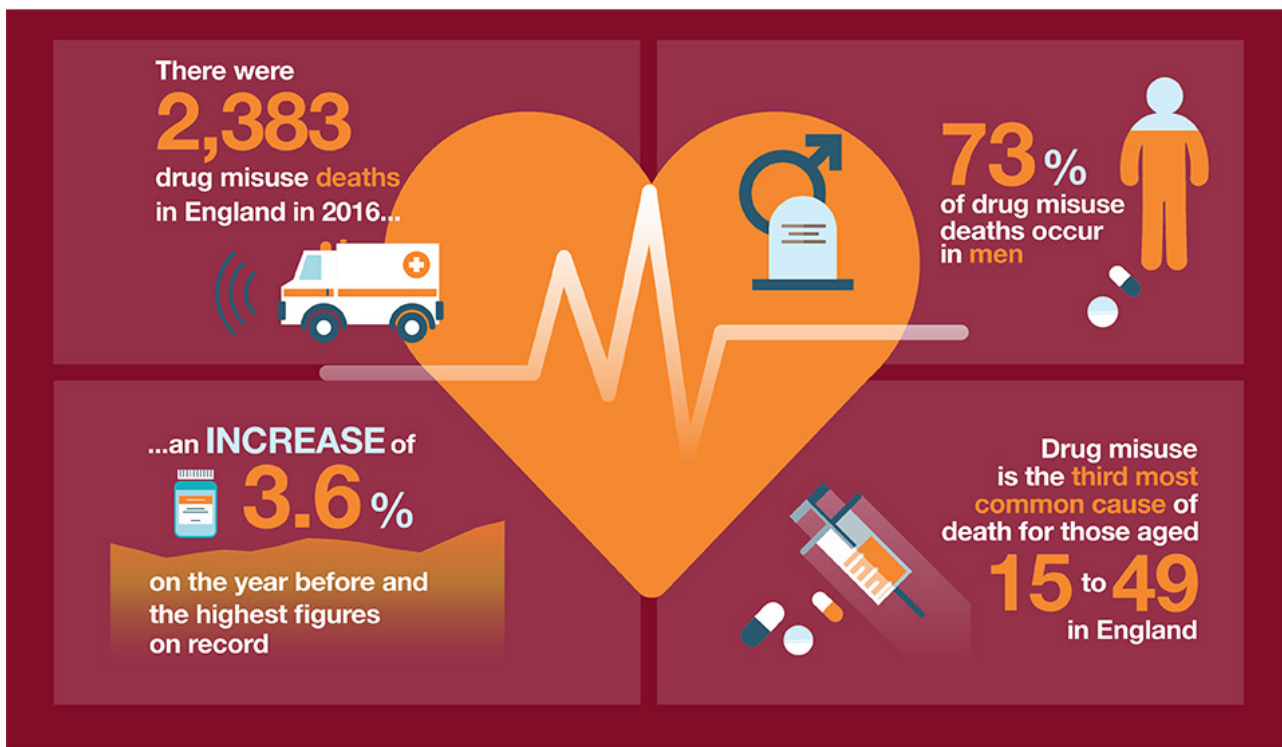
they receive supports the complexity of their needs. With a completion rate of 67% Grace House demonstrates that with the right support women can recover from the most horrendous of life experiences.

In response to the increasing physical health needs of people needing treatment we are moving one of our TCs to a new purpose built registered care home building that allows greater access and support for people with physical health needs. Our new facility for our Scotland service will provide the highest levels of environmental standards to compliment the excellent care and support already delivered in the current building.

Our Prison Services
Phoenix delivers services in 20 secure establishments in England including immigration removal centres and secure facilities for children. We deliver a range of psychosocial interventions including two Therapeutic communities in prison.

We are seeing a changing pattern of drug use across UK prisons, most dramatically a significant level of psychoactive substance (Spice) misuse that presents significant challenges for treatment approaches. 20% of people in one of our services reported using substances for the first time in prison and 72% reported having mental health issues whilst in prison. Spice users are more reluctant to engage in treatment and the methods of use present significant risk. Through multi agency working we have been able to develop unique and innovative approaches to reducing risk that support the efforts of the prison and deliver real and practical help to prisoners using Spice.

In Scotland, our residential service has developed a partnership with two prisons to deliver work placements for longer-term prisoners who are working toward a release date. This brings many benefits but crucially helps with that vital transition from prison to community, which is a period of real risk for many. Phoenix Futures Prison Family service is delivered across three prisons in the North of England. The service runs the visitors centre, supports families of prisoners and provides ongoing support for prisoners and families upon release from custody.

Our Housing Services
Phoenix Futures holds a unique position in being the only specialist treatment provider that holds registered housing provider status. We have developed a unique housing pathway that provides 183 specialist supported housing units for people in recovery that includes three models of recovery housing for people accessing treatment and maintaining their recovery. This provides a vital opportunity for people who need support to sustain their recovery after treatment. The housing services support people in recovery following prison and residential treatment and use strong peer support approaches.

Being Phoenix

Our Values And Beliefis

We are passionate about recovery.
We value our history and use it to inform our future.
We believe in being the best.

When we launched our plan in 2017 we knew it was ambitious. We didn't know how hard the environment would become, how much harder it would be for people to access the help they need. But the progress we have made over the last year is down to the hard work and commitment of the Phoenix staff and volunteers and the contribution of our residents and service users across the country. At Phoenix we have a set of values and beliefs. We use them to guide us on the big decisions and the day to day work because they help us stay true to our purpose and allow us to achieve so much. We know how hard it is to achieve confidence in your recovery. And the times we live in can feel like it is made that little bit harder. But if there is one truth we at Phoenix are convinced of, together we will use our expertise passion and history to help whoever wants to try. ●

Phaedon Kaloterakis
Assistant Director, Kethea
(Greece)

The Evolution of the Greek Therapeutic Communities

The eighties: early beginnings

In the early seventies, throughout Europe, the developments in social psychiatry are radical. In France and Italy new philosophical paradigms and the civil rights movement give birth to antipsychiatry and deinstitutionalisation (Roth and Kroll, 1986).

Few years later, the economic recession, the wide spread of mental health disorders and the use of hard drugs by a comparatively bigger proportion of the population, bring to the surface the first signs of disappointment for these reforms. The ¨open doors¨ policy of the psychiatric establishments is considered goodwilled but romantic (Clark, 1977).

In Greece, the situation was quite different. After World War Two, the country suffered a four year long civil turmoil and then, later on, from 1967 to 1974 a military dictatorship. As a result, the Greek State was very suspicious of any new ideas that seemed to challenge the status quo. Because welfare was also underdeveloped, the traditional extended family came to fill in the gap. Taking into consideration that there were no services designed especially for the people addicted to substances, drug users would end up in psychiatric hospitals or in prison.

Greek psychiatry, having an institutionalised and biological direction became synonymous to neurology (Blue, 1999). An indication of this climate was the fact that the first University departments of psychology and sociology were established after 1982. To this day, there is no Social Work School at a University level.

With the first officially declared deaths by drugs in 1980, the problem of substance use and addiction becomes apparent and takes a central position in the general political discussion about public health.

In 1981, Greece becomes a full member of the European Union. In October of the same year, the Socialist Party was elected to govern for the first time in modern Greek history. Its main election campaign slogan was ¨change¨. Within this new political and social atmosphere, significant changes took place in the welfare and health system. In the context of these changes and due to the increasing phenomenon of drug use and abuse among the young, in 1983 the Ministry of Health entrusted a psychiatrist with the task of organising and setting treatment facilities for drug addicts in Greece.

The psychiatrist, by the name of Phoebus Zafiridis, completed his doctorate in Switzerland and had some experience of drug abuse treatment. Following a visit of Zafiridis to the Dutch TCs during which he was impressed by the way they were operating, he suggested to the Greek Ministry of Health that they should create a similar multiphase programme to combat the drug abuse problem.

In August 1983, the counseling and detoxification centers started their operation and three months later on the 27th of November, ITHACA the first TC in Greece, was created. ITHACA was founded as a part of this specialized programme near the city of Thessaloniki.

The fundamental philosophic principle of ITHACA was that the drug problem is mainly a social problem that relates to the given social structure and familial interpersonal relationships. Addiction is not regarded as an illness in the psychiatric or medical sense of the term but as a psychosocial problem. Consequently, treatment cannot be achieved unless the participation is voluntary and drug-free.

The name ITHACA, a symbolic name, is today a household word in Greek society. Ithaca is the island where Ulysses, a hero of the Trojan war originated. In modern Greek literature and more specifically in Cavafy's poem ITHACA, the name symbolizes the journey home.

During the first period, the Greek government was supportive, as the development of a specialised treatment programme for drug users was one of its priorities. Although its function was not understood, the Therapeutic Community was representing a new direction which was in agreement with the general atmosphere of change.

ITHACA operated as a pilot programme during the first four years (1983-1987) and it belonged to the National Welfare Organization. This status will change drastically with the law 1729/87, when ITHACA becomes a Non Governmental Organization, the Therapy Centre for Dependent Individuals (KETHEA).

The nineties: transition time

In the early nineties the public health agenda is dominated by the fear of infection by the HIV virus and the spread of AIDS. Also in this decade, in Greece we have the appearance of private television where hyperbole becomes the norm. Drug addiction is therefore perceived as an epidemic.

OKANA
ΟΡΓΑΝΙΣΜΟΣ ΚΑΤΑ ΤΩΝ ΝΑΡΚΩΤΙΚΩΝ

In 1993 and under a lot of pressure, the Greek parliament passes a law that promulgates the establishment of a Governmental Organization (OKANA). OKANA was presented as a new solution to the drug addiction problem in Greece. The policy was to promote methadone programmes at the expense of drug free ones. Before, in the eighties, TCs were the panacea; now panacea was substitution and harm reduction.

contributed article

During this period, KETHEA started to focus on the collection of data and the training of professionals, as the need for evaluating the effectiveness of treatment programmes became more obvious.

While the reorganization was difficult, KETHEA adopted new schemes and differentiated its approach, in order to respond to the growing treatment needs of a broader spectrum of drug users with the help of research and practice. Changes included democratic procedures to discuss the policy and the goals of the organization: decentralization of the decision making and the therapeutic programmes, emphasis in parallel supervision and evaluation, both internal and external.

Furthermore, the aim was to increase the number as well as the size of therapeutic interventions and to improve the services offered. Every programme was given the opportunity to organize its own intervention, relevant to geographic location, unique relationships with the local community, available human resources and most importantly, the special needs of the people to whom it was addressed.

A critical dimension of continuous training and education in new methods was introduced. KETHEA also started to examine and assess its services in connection with the population: were they attractive and relevant? As a result of these studies, KETHEA began to provide new services for drug using populations that had not approached its facilities before.

Entering the 21st century : development and integration
The successful effort of KETHEA to adapt to the new external conditions and the ever changing needs of drug users, through internal restructuring and the launching of new services, led the organization into new paths of development.
Having realized that not all drug addicts are the same and that there is a need for adopting different models for different population groups, KETHEA designed and implemented new services such as treatment programmes for ethnic minorities, addicted mothers and their children, an emergency telephone helpline, support centers for discharged prisoners, harm reduction activities, crisis intervention centers. The organization runs counseling centers and TCs in 20 prisons nationwide and provides services to people who are addicted to alcohol, gambling

and the internet. It has a prevention, a research and an education department (the latter cooperates with such institutions as the University of California in San Diego and the Aristotle University of Thessaloniki).

KETHEA's external supervisors include George DeLeon, David Deitch, Martin Cooyman, Thomas Maclellan, Giles Amado and Demetrius Iatridis among others.

In 2003, the National School of Public Health developed and materialized an outcome study; the results were very satisfactory. KETHEA is also a special consultant to the Economic and Social Council (ECOSOC) of the United Nations and with over 110 units across the country is considered one of the largest solid organizations of its kind in Europe.

The model of the therapeutic community is still used by KETHEA, but it has also been evolved in terms of theory and practice and combines self-help, solidarity, active participation, shared responsibility, responsibility, democracy and permissiveness. A distinctive characteristic of this new phase in KETHEA's history is the way in which its relationship with the governmental organization OKANA has progressed: from a competitive interaction to a fruitful collaboration and exchange of know- how and ideas (Poulopoulos, 2005).

Since Greece is facing the most difficult financial and social crisis of its modern history, the challenge for an NGO like KETHEA is a crucial one. With no new hirings since 2006, with less government funding and with more people in need seeking the services offered, the organization has to rediscover in itself, once more, relevant and effective treatment. ●

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Edward C. Carlson
Chief Executive Officer, Odyssey House Louisiana, Inc. (USA)

Crime Reduction through Substance Abuse Treatment: A Plan For New Orleans

contributed article

The Problem

Long before Hurricane Katrina, the city of New Orleans had a well-known history of violence and an even better well-known accessibility to alcohol and drugs. Post-Katrina years saw previously unsurpassed murder records exceeded, while civic leaders excused the violence as a painful reality of rebuilding. However, nearly 12 years later, the city has recorded more than 300 shootings by mid-year 2017. It's evident that this situation is no longer a temporary flare up post-disaster. Right now, our international reputation has become our day-to-day reality:

violence is becoming a permanent state for New Orleans.

New Orleans often prides itself on having a small-town feel in a big city, but it is now vastly outpacing the most violent big cities on a per capita basis. From 2010 to 2015, the five-year homicide rate for New Orleans topped all other cities with populations above 250,000 per capita. While Chicago has the most murders, its per capita rate is only one-third of that of New Orleans.

Compounding this issue, there is another danger that is killing New Orleans citizens at alarming rates: opioids. Today, Americans are more likely to die from a drug overdose than in a car crash, and that probability is growing every day. New data from the Centers for Disease Control and Prevention (CDC) show that opioids—a class of drugs that include prescription pain medications and heroin—were involved in 28,648 deaths nationwide in 2014.

New Orleans' opioid crisis has exceeded what was once already considered an epidemic. New Orleans EMS, which previously responded to two heroin overdoses per day, is now responding to about five. A report released by the New Orleans Coroner revealed that in 2016, opioid-related deaths doubled since 2015 and that drug-related deaths were surpassing homicides in New Orleans.

These two issues—homicides and opioids—are unquestionably related. At the April 2017 New Orleans City Council meeting, New Orleans police chief Michael Harrison stated that the spike in homicides is largely due to the opioid epidemic. He said drugs are at the core of the crime problem in New Orleans and also the reason many homicides remain unsolved. Additionally, a study conducted by the Louisiana Department of Public Safety and Corrections stated that 80 percent of Louisiana inmates have a substance abuse problem that contributes to their criminality.

Historically, legal sanctions have stressed reducing the supply of drugs by punishing the drug seller. Faced with its crime crisis, New Orleans has focused significant attention on increasing police visibility in high-crime areas and mandating overtime for officers in efforts to increase arrest numbers, hoping that these efforts will reduce crime. However, the crux of the drug trade is the demand for drugs. If the demand diminished, there would be no need for a seller or a supplier. To confront the city's substance abuse-related criminality, New Orleans needs to invest into a demand reduction program that promotes community awareness of drug problems, alerts drug users to legal sanctions, and coordinates a bridge between the criminal justice system and access to treatment.

Current System In New Orleans

Currently New Orleans is a city riddled with an aggressive drug trade, widespread opioid abuse, and a lack of a coherent system to effectively manage these issues. With these factors in place, the heightened crime should not be unexpected. There are multiple avenues to eradicate drug abuse: prevention services, treatment programs (including detox, residential treatment and outpatient services), the criminal justice system through police and courts and the larger community as a whole. In New Orleans, almost all of these avenues are largely ignored and underfunded, with the exception of the criminal justice system. However, the criminal justice system is involved once a crime has already taken place.

Leaders must support ways to reduce drug-related crimes before they even happen, but currently, the city is not investing in those avenues. Right now, all action is reactionary, not preventative. Rather than focusing on sanctions for crimes after they are committed, the city should focus on a demand-reduction model with aims to prevent drug-related activities from taking place. It will make the city a safer, healthier and more prosperous place for all New Orleanians to live.

In order to make a noticeable impact, these separate avenues need to: (1) receive more attention and funding; and (2) converge into a coherent system of care that involves prevention, intervention and treatment. Substance abuse issues and the resulting crime will not decrease or become resolved unless these multiple facets are coordinated into comprehensive procedures and structure that involves prevention providers, NOPD and its Crisis Intervention Team (CIT), treatment providers, courts, and the community at-large.

A demand reduction system for dealing with substance abuse issues and related crime is not out-of-reach; it simply requires buy-in from the involved parties. If the prevention providers, treatment programs, criminal justice system and community all consolidated their efforts to thwart drug abuse, the potential results could change the course of New Orleans' persistent and growing crisis in criminality.

Solutions

A three-pronged approach focusing on prevention, intervention and expanding treatment services can help New Orleans address this critical issue.

Prevention

OHL and other providers can work cooperatively to educate policymakers and the community at large as to the severity of the

opioid epidemic. Since most people do not understand the nature of the disease or how to effectively treat it, addiction continues to remain criminalized at enormous cost to the state. Another prevention tactic could be for New Orleans to implement a large-scale public education campaign that could aid in destigmatizing addiction and encourage people to consider treatment.

Intervention

Drug abuse treatment can be incorporated into criminal justice settings in a variety of ways. These include treatment as a condition of probation, drug courts that blend judicial monitoring and sanctions with treatment, treatment in prison followed by community-based treatment after discharge and treatment under parole or probation supervision. Outcomes for substance abusing individuals can be improved by cross-agency coordination and collaboration of criminal justice professionals, substance abuse treatment providers and other social service agencies. By working together, the criminal justice and treatment systems can optimize resources to benefit the health, safety and well-being of individuals and the communities they serve.

Expanding Treatment Services

One of the largest components of this plan is expanding the capacity of New Orleans providers so that they can meet the area's growing need. It is critical that all barriers to treatment be removed. This includes expanding the length of stay in treatment programs payable by Medicaid, securing funding for housing during treatment and establishing significantly more treatment centers in the city that provide a full continuum of care.

Conclusion

Many New Orleans agencies and offices are struggling with the city's crime and addiction issues. These are serious issues that affect every single citizen, even those not engaged in these activities. These problems affect our tourism, our public safety, our public health and our economy. The current approach to minimizing violent crime and addiction simply does not work. A new approach is needed and needed with the full support of the city. A demand-reduction model will not only encourage healthier and more productive citizens, but it also has the potential to realize significant cost-benefits. Only by addressing the correct crux of the crime issue by focusing on demand can New Orleans achieve its full potential. By creating a demand reduction system in New Orleans, Louisiana can set up a model that can be replicated in other cities throughout the State, and possibly the nation. ●

Community and Economic Impact of Odyssey House Louisiana

Overview of Odyssey House Louisiana

Established in 1973, Odyssey House Louisiana (OHL), a behavioral healthcare facility located in New Orleans, Louisiana, puts research and proven approaches into practice to provide comprehensive services and effective support systems to individuals affected by substance abuse.

It is OHL's philosophy to treat the whole person, not just the addiction. OHL recognizes that treatment should include multiple levels of services that can treat clients at their individual level of need. OHL's holistic approach addresses the physical, mental, emotional, and social conditions of each client in treating the illness of addiction. Services and programs include substance abuse treatment, complete health and mental health care, life, skills training, vocational training, individual and group counseling, case management, and housing placement.

Equipped with skills for living and working, and assisted with employment and housing, OHL program graduates return to their communities as contributing members.

In November 2016, OHL retained Tripp Umbach, an independent research company, to conduct a community and economic impact study to determine the financial and social benefits of OHL's operations and services on the State of Louisiana, its communities, and residents. After completing in depth research, gathering financial information on OHL, conducting interviews with internal and external key stakeholders, and generating current and projected economic impact models, Tripp Umbach developed this report to highlight the key community and economic impact findings.

Serving approximately 900 clients each month, OHL fills a needed service gap in a region affected by substance abuse. OHL operates under a nationally recognized integrated care model, providing clients with a breadth of health and social services, including substance addiction treatment, mental and physical health care, counseling and case management, and life skills training. The comprehensive treatment and health care services at OHL give individuals the tools to overcome addiction and take control of their health.

Community Impact of Odyssey House Louisiana

The services of OHL provide significant benefits that impact individuals, families, and communities throughout the State of Louisiana. The services of OHL are increasingly in demand as substance abuse and addiction rates are on the rise, particularly the misuse of opioids in the New Orleans region.

Odyssey House Louisiana provides services and treatments necessary to combat addiction. OHL is working to expand operations to ensure the supply of services are available to meet the need with rising substance addiction in New Orleans and Louisiana. Yet, far too many individuals dealing with substance addiction are not receiving needed ●●●

treatment, and instead, are foregoing care or being funneled through the criminal justice system; this creates significant costs to individuals and society.

Substance abuse treatment serves as a cost effective solution over the alternative of incarceration. Proponents for criminal justice reform recognize the effectiveness and cost savings associated with focusing efforts toward treatment as opposed to incarceration.

In addition to criminal justice costs, health care expenditures and lost employment opportunities also contribute to the cost of substance abuse and addiction. Research shows, however, that investing in treatment services over the alternatives of incarceration or foregoing treatment provides cost savings. For every $1 spent on substance abuse treatment, $7 dollars is saved on average in benefits. These benefits arise from decreased criminal justice costs, decreased health care costs, and increased employment.6 For 2018, OHL has budgeted $11.3 million towards providing comprehensive treatment services. As $7 is saved in benefits for every $1 invested, OHL's expenditures will provide approximately $79.2 million in savings to the State of Louisiana. Growth and continued investment in programming at OHL will provide additional cost savings and benefits to Louisiana.

Treatment programs provide cost savings over the alternative of incarceration; treatment also gives individuals the best chance at successfully overcoming their addictions. Substance abuse treatment is shown to have approximately the same success rate for treating patients as treatment for other chronic illnesses. The relapse rate for those who receive treatment is 40 to 60 percent. As a comparison, the relapse rate for someone who received treatment for asthma is 50 to 70 percent.

Odyssey House Louisiana has helped individuals gain the treatment and tools that allow them to move beyond addiction. The holistic services delivered by OHL provide treatment at every level, from medically supported detox to long term treatment to post treatment housing and job placement. Clients who come to OHL many times are on the brink of incarceration, have previously been incarcerated, have lost employment, or have no positive outlook. Individuals who successfully complete treatment at OHL have the chance to realize opportunities after treatment for reintegrating into their communities and contributing to society.

Interviews with former OHL clients reveal some of the ways that those who have remained sober after treatment have been able to assimilate back into the community. Former clients have furthered their education and received Bachelor's and Master's degrees, have pursued careers in social work, have found employment at OHL and other treatment centers, and have given their time to programs that give back to those less fortunate around Louisiana.

Current and Future Economic Impact of Odyssey House Louisiana

The operations and programming of OHL generates economic impact directly and indirectly in the State of Louisiana by means of organizational spending, employment opportunities, and government revenue generated from spending.

In 2016, the overall economic impact of Odyssey House Louisiana on the State of Louisiana amounted to $14.7 million

annually. This impact is attributed to the direct spending of OHL on goods and services, as well as the indirect/induced impact of spending by suppliers and staff in the state economy.

OHL generated an employment impact of 209 jobs on the State of Louisiana in 2016, including 163 jobs directly employed by OHL and 46 indirect/induced jobs attributed to the spending of OHL, its related suppliers and businesses, and its employees, visitors, and clients.

OHL's local spending and support of jobs, both directly and indirectly generated $453,000 in state and local tax revenue in Louisiana in FY16.

Over the next five years, Odyssey House Louisiana will be expanding operations through the development of a new facility and the renovation of its current site. Development and renovations of these sites will allow OHL to expand its Long Term Residential, Short Term Residential, Detox, and Community Medical Center services. Expansion also will increase the economic, employment, and government impacts of OHL on the State of Louisiana.

- Odyssey House Louisiana is anticipated to generate $29.9 million in economic impact in FY21. This includes $16.0 million in impact from OHL's direct expenditures and $13.9 million in indirect/induced impact due to spending by OHL suppliers, employees, visitors, and clients in Louisiana.

- In 2021, program expansion at OHL will warrant additional job opportunities. OHL is expected to yield an employment impact of 381 jobs in FY21. Of this total employment impact, 277 jobs will be directly employed through OHL, while an additional 104 jobs will stem from the spending of OHL, its industry partners and suppliers, employees, visitors, and clients.

- State and local government revenue attributable to the presence of Odyssey House Louisiana are projected to total over $1 million in FY21.

Summary

Odyssey House Louisiana generates an impact that goes far beyond the organization's spending and associated economic, employment, and government revenue effects. OHL's continuum of services provides a necessary solution to combatting growing drug addiction, alcoholism, and behavioral health issues prevalent across the nation, State of Louisiana, and City of New Orleans. OHL delivers a continuum of care and works with local, state, and national organizations to connect resources and outreach efforts to combat growing substance abuse. Recent reductions in the number of behavioral health programs around the state coupled with rising substance abuse rates warrant the need for OHL's services now more than ever. With continued support, Odyssey House Louisiana will further its role as an economic driver and indispensable resource in the state. ●

OHL LINK OF INVESTMENT TO SAVINGS

$11.3 MILLION INVESTMENT IN COMPREHENSIVE TREATMENT SERVICES

$79.2 MILLION SAVINGS FOR THE STATE

Ivone Patrão
ISPA-IU / Applied Psychology Research Center Capabilities and Inclusion (APPsyCI) (Portugal)

Online games: what do parents need to know and do?

Parents need to know everything and do a lot

This is the current requirement of those who perform parental functions with children and adolescents known as digital natives.

The reality of generations X and Y and of today's parents, has changed. They are different compared to the Z and Alpha generations. The former played and socialized exclusively on the street, the next one have technology as an essential tool for socializing. In this cross-breeding there are those who depend solely and exclusively on being online to live. I call them all the Cord Generation:

1. Generation that does not turn off;
2. Does not financially and emotionally autonomize;
3. Does not develop social skills, essential for entry into the labor market.

In this sense, we have parents who have to be aware that when they are followers of online games, they are giving a model. And for those parents who are not interested in the opposition and do not know the world of online games, they are digging an intergenerational gap.

In the middle of adolescence and belonging to a group of peers is the difficulty of parents to situate themselves. If parents are interested in learning about their children's academic performance, are not they equally interested in learning about and participating in their hobbies?

This is the challenge!

So the question of what parents need to know and do has a clear challenge! Play with your children from a tender age. Learn to play as well. Enjoy that moment. Don't make the game an elephant in the middle of the room, which you can't talk about it! The risks of not relating, of not understanding and getting close to the young are many. In the case of online games, with or without bets, the risk may even be of dependence. We must be aware that DSM 5 and ICD 11, the two manuals that are like a catalog of diseases, recognized by the international scientific community, point to online gambling as a dependency, with defined criteria, and very close to other dependencies with substance.

This dependency can enter the home of each family silently. Once the parents validate the stay of the young person at home, in the bedroom, on the pc, they don't realize that they are validating a single activity in their life, which does not include a face-to-face socialization.

Yes, the players or gamers also socialize with each other but it is only in digital form, which impoverishes their range of emotional and social skills.

How to approach the issue

There can be, in a small percentage, the parents gamers, who will introduce their children to the world of online games. There they have to take into account the vulnerability profile of the children to the risks of dependencies; and other parents who, at another extreme, still believe that their children only use the PC to study. Parents need to know what games there are, the ones that their children play and how they play them. Try them out and from there adjust and restrict games that are not adapted to the age of your children. There are many teenagers playing games that are not suitable for their age, they play more hours than is considered healthy, and so they leave aside many other tasks essential to their healthy development such as socialization. Boredom seems to be missing out on young people's experiences. The ability to make time out, to get frustrated, and to look for other ways of occupying time, which can be, among many, one of the simplest that will stop to reflect on what lived and plan what comes next, is becoming increasingly difficult and infrequent. Parents will be able to analyze the time and type of entertainment they have as a family.

This analysis should make it possible to understand the level of digitalization of the family. A young man never plays or bets online alone - there is always someone in the family to give him that chance. Whether is because of the lack of a rule / limit, or for valuing their digital capabilities, often to the detriment of others equally important to an healthy development. Informed and experienced parents in online games will be parents with the most skill to discern what is appropriate for each of their children's online entertainment level. ●

Pedro Marques
Internet Segura.pt Center, Information Society Department
(Portugal)

From Abusive Use of the Internet to Responsible Use

Almost 60 years ago, when the first e-mail of the story occurred, the world was far from predicting the impact that the Internet would have on the society of the century. XXI. This tool changed not only the way we transmit information, but also served as a platform for the emergence of various services and other associated technologies.

of security and privacy definitions of Information Society platforms and services, and has more recently broadened its scope to issues behavioral issues such as online relationships, digital citizenship and the healthy and balanced use of technologies.

The inescapable presence of the Internet in the life of the Portuguese is one of the factors that can contribute to the abusive or uncontrolled use of this tool. There are also social factors, such as the fact that this technology is part of our work

After more than half a decade, there have been numerous opportunities that the Internet has brought to users, but also the challenges and risks associated with their use. In order to respond to these risks, the Internet Secure Internet Center (CIS), a free public service aimed at sensitizing the population to the adoption of positive strategies in the face of safer and more responsible use of the Internet, emerged in Portugal in 2007. a clearing line for the whole population and a service for reporting illegal online content.

The work carried out by the CIS is carried out through the cooperation and synergies of a consortium comprising the Directorate-General for Education, the Portuguese Institute of Sports and Youth, IP, the Portugal Telecom Foundation, Microsoft Portugal and Foundation for Science and Technology, IP, entity responsible for coordinating this project.

Since the beginning of its activity, the CIS has focused on several more technical issues associated with the optimization

and academic environments and support various services in our society, from consulting schedules to transportation, making appointments online, making bank transfers or simply ordering a pizza.

The pattern of consumption of information and entertainment content has been changing. Newspaper offices and radio and television stations have been gradually losing public to new media such as social networks and content streaming platforms like Youtube, Spotify or Netflix.

And if in the past it was necessary to be at home, or in a public space to have a computer with access to these contents, nowadays, any user can have access to mobile broadband - according to ANACOM data, in the last quarter of 2017 about 7.11 million users in Portugal enjoyed this access, consuming on average 2.6 gigabytes in monthly traffic. According to indicators from January 2018 of the agency "We Are Social", the Portuguese spend an average of 6 hours and a half of

digital media
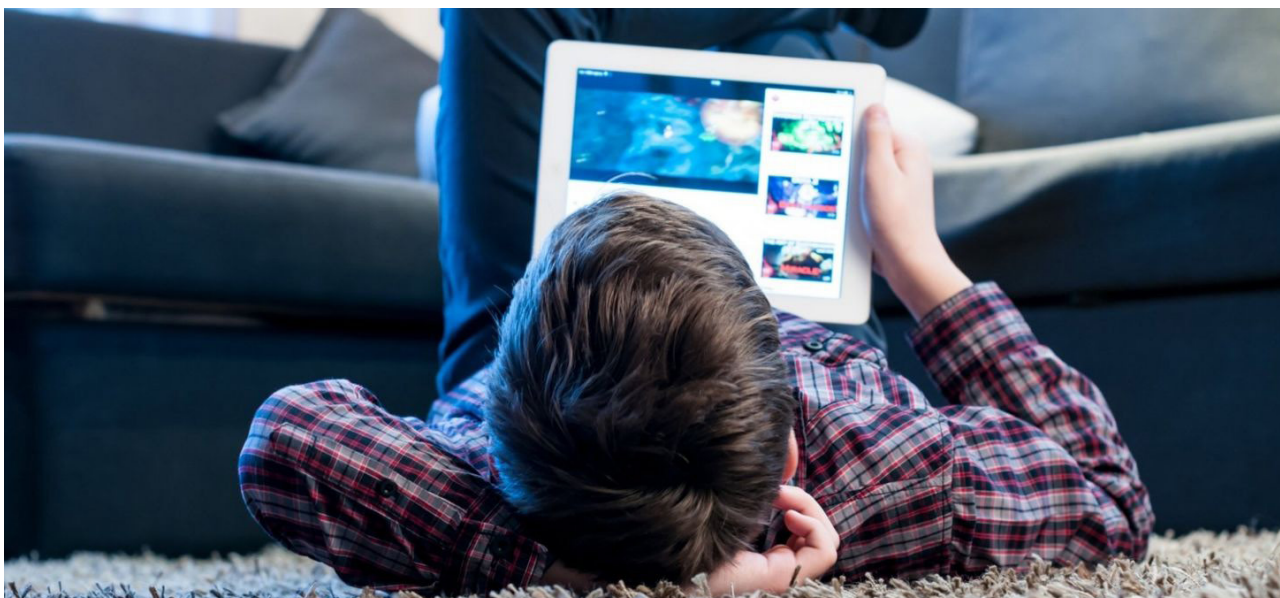
their day, to use the Internet, and about a third of this time corresponds to access through Mobile Internet.

However, Internet usage time should not, by itself, be a criterion for identifying a possible addition to this tool. An abusive use can occur as a result of several factors - the excess of work that requires the consultation of information online, the isolation that contributes to the interaction with other people on the Internet, among others.

However, it must be considered that any behavior that may lead to mood swings has the potential to become an additive behavior. Thus, if the use of the Internet or a particular online service is associated with a pleasurable experience, through the release of dopamine, it can be processed subconsciously as a reward, reinforcing the intention to repeat the behavior. The repetition of this behavior can also contribute to the user becoming less able to tolerate situations of discomfort, resulting from the impossibility of using the Internet.

When these factors are combined with the use of the Internet, it increases the likelihood that the user will overuse this tool, or even develop an associated dependency.

The concept of Internet dependence, proposed by Goldberg (1995), is defined as the inability of the user to control the use of the Internet, resulting in the user's suffering and the commitment of their daily activities as well as the denial of this behavior. According to Block (2008), it is estimated that about 86% of cases of internet addiction may arise associated with other psychiatric disorders.

DSM-V conceptualizes the diagnosis of addiction to the Internet as a disturbance in the compulsive-impulsive spectrum that involves the use of the online and offline computer consisting of at least four components:

1) excessive use associated with loss of notion of time consumed or neglecting basic needs;
2) abstinence, including feelings of anger, tension and / or depression when access to the device is impossible;
3) tolerance, including the need to improve internet access equipment or increase the time of use;
4) negative repercussions, including discussions, lies, poor achievement of goals, social isolation and fatigue.

Focused on this issue, in 2017, Bridges & Griffiths developed the Internet Disorder Scale, a 15-item scale intended to measure and conceptualize addition to the Internet according to four areas: "Escapism and Dysfunctional Emotional Confrontation", "Symptoms abstinence "," Dysfunctional self-regulation "and" Dysfunctional self-control associated with the Internet ".

In fact different forms of online addition are identified, in addition to simple interaction with the device:
- Pornography and Sexting, related to viewing, downloading, sharing and creating pornography;
- Cyber-Relationships, associated with the need to establish online relationships, assigning them greater importance / investment to the detriment of offline relationships;
- Compulsions online, which encompass a set of activities such as Online Gaming, Gambling, Shopping, among others;
- Addition to Information, characterized by the compulsive behavior associated to the research and consumption of online content.

The CIS collaborates to raise the awareness of the excessive use of the Internet, along with other risks arising from the use of this tool, always in a promotion perspective for a safer and more conscious use of this powerful tool.

However, when this use takes on unhealthy contours, professional intervention is important. To this end, the CIS provides a support and clarification service - the Secure Internet Line (800 21 90 90) - which informs on the possibility of these situations being supported by teams of professionals prepared to intervene in the prevention, treatment and reduction and minimization of damages.

In addition, CIS has a regularly updated website (www.internetsegura.pt), where you can consult various information and resources aimed at different target groups such as children, adolescents, adults, parents and teachers. ●

linha
INTERNETSEGURA
800 21 90 90

Valéria Rocha
Clinical Director, Institute of Prevention, Treatment and Education in Psychology and Mental Health
(Brazil)

A systemic view of public policies on drugs in Brazil

This article aims at a systemic reflection on the construction of public policies on drugs in Brazil in recent years, contextualizing the socio-political and economic momentum, as well as its impact on use, abuse and addiction.

Brazil is a country of continental dimensions with 5,570 municipalities and a population of 207.7 million inhabitants, the municipality of São Paulo being the most populous in the country with 12.1 million inhabitants, followed by Rio de Janeiro (6, 5 million inhabitants), Brasília and Salvador with about 3.0 million inhabitants each (IBGE, 2017). Its population history is of extreme miscegenation contemplating, thus, an intense cultural heterogeneity. We live a long period of military dictatorship (from 1964 to 1985), and thirteen years (from 2003 to 2016) of leftist government, and since August 2016 the country has lived a transitional government due to the Impeachment of President Dilma Rousseff. This history, which ranged from political extremes (from right to left), and various corruption scandals leading to political and economic instability, polarized the Nation by bringing the Brazilian people and its institutions to extreme positions and opinions in relation to various issues, impacting directly on public policies on drugs and on the practice of prevention and treatment.

During the military regime, public policies emphasized the prohibition of the use of drugs and the fight against the traffic, like a war without winners as it was verified in the future. This national positioning with Law No. 5,726 of 1971, which followed the Vienna International Convention, restricted the treatment of bribed offenders who were compulsorily hospitalized in psychiatric hospitals. In 1976 a new Law (Law 6,368) maintained the treatment under the "medical domain", considering the drug addict as a patient, but extended the care to the other addicts. It was only after 1980 that a government body was established (FEDERAL COUNCIL OF DRUGS -COFEN), which was responsible for the construction of public policies, defining new guidelines, such as support for scientific research on drug prevention, risk reduction programs directed to HIV prevention among injecting drug users and expanded the forms of treatment, including therapeutic communities and outpatient care units to addicts (Santos JAT, Oliveira MLF, 2012).

It was in 1998 that COFEN was replaced by the National Anti-Drug Council (CONAD), the normative and deliberative body of the national anti-drug secretariat (SENAD), a structure that has been in force until now in Brazil, and the term "antidrug" ". In 2002, although the look and actions regarding the drug phenomenon remain with the inheritance of the policies of the military regime to combat the use, abuse and trafficking of illicit drugs, trying to arrive illusively at a "drug free society", they managed to expand clinical practices introducing multiprofessional teams, involving the family of addicts in the treatment process and strengthening harm reduction strategies, which were then regulated by the Ministry of Health (formerly under the aegis of justice).

In 2006, Law No. 11,343 made significant progress in national public policy, since the difference between users, drug addicts and traffickers was more clearly distinguished, increasing the penalization of individuals linked to trafficking and decriminalizing the took with drugs, had to comply with socio-educational measures applied by special criminal courts. Other innovative aspects include ending compulsory treatment for drug addicts and granting tax benefits for prevention, treatment, social reintegration and trafficking crackdown initiatives. In 2011, the National Policy on Drugs (PNAD) was implemented to date, emphasizing prevention, treatment, social reintegration and harm reduction (Santos JAT, Oliveira MLF, 2012; SENAD, 2011).

Although we have historically observed significant advances in national public policies over the years, the latest statistics have shown a worrying scenario as they evidence increases in the use, abuse and addiction of licit and illicit drugs and adverse consequences for public health in the country.

The first national survey on the use of alcohol, tobacco and other drugs among university students in the 27 Brazilian capitals showed that 89% of university students had used drugs in their lives, 86% of them had used alcohol, 47% had used tobacco and 50% less an illicit drug (Andrade, 2010). 58% of the young people interviewed used two or more psychoactive substances in their lives, with cigarette, marijuana and alcohol being the most used in the last twelve months. Only 11.2% of this population did not use alcohol and other drugs throughout their lives and 30.7% used only one psychoactive substance. The use of marijuana has increased and today is the third most used drug among Brazilian students, and if compared to illegal drugs, becomes the first. Regarding the gender issue, the pattern of alcohol use among women and men is 1: 1, that is, Brazilian university girls are drinking more, to the point that they match the male pattern of ingestion of this population (Andrade et al. al., 2010).

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Other important data collected by the II National Survey of Alcohol and Drugs (II LENAD) and conducted between 2006 and 2012 by the National Institute of Science and Technology for Public Policies of Alcohol and Other Drugs (INPAD) and the Alcohol and Drugs Research Unit (UNIAD) of the Paulista School of Medicine (EPM), Federal University of São Paulo (UNIFESP), pointed out many relevant aspects about the use of drugs in the Brazilian population. It was possible to verify that, from 2006 to 2012, there was not much change in the percentage of Brazilian adults who drink (almost half of the study population), but the increase was significant in frequency and quantity of drink (mainly in the female universe).

In 2012, the observed proportion of those who drank five or more doses on a regular occasion rose to 39%, being 29% in 2006 (approximately ten percentage points difference). As regards frequency, in 2012 the proportion of those who reported drinking at least once per week increased by 11 percentage points (42% in 2006 and 53% in 2012). In the case of the female population, in 2006, 27% of the women interviewed drank at least once a week, and in 2012, that percentage rose to 38% (11 percentage points).

The prevalence of drinking in binge ("binge" means, in the case of men, "drinking five or more servings" and, in the case of women, "four servings or more, at the same time in an interval of up to two hours") 2006 to 2012. In 2006, 45% and in 2012, 58% reported having had a binge drink ever in the last 12 months. This worsening was also more intense in the female population, with an increase of 14 percentage points between 2006 and 2012 (from 34% in 2006 to 48% in 2012). In the 14 to 17 year-old population, the usual pattern of ingestion (five doses or more on a regular occasion) increased among girls from 11% in 2006 to 20% in 2012 (an increase of 9 percentage points) and decreased among boys (from 31% in 2006 to 24% in 2012 - down by seven percentage points) and the age of experimentation remained precocious (between 12 years and 14 years) (II LENAD, Laranjeira et al. ., 2014).

A survey conducted with adolescents aged 11 -18 years, with a questionnaire of Attitudes and Values showed, in comparison with results of 2006, an increase in the high alcohol consumption by both sexes, a decrease in the use of tobacco also in equal proportion by both sexes and a significant increase in marijuana use by both (Macedo RMS et al, 2017).

Given this scenario, how can we explain that, despite the fact that public drug policies have advanced mainly in 2006 and 2011, the main national epidemiological studies have demonstrated a worsening of this phenomenon? I believe that in practice these policies have favored major harm reduction programs, but they are insufficient to meet the demand of a multicultural country and, as already mentioned, of continental dimensions.

At the end of the eighties, the Manicomial Fighting movement takes force in Brazil and directs its efforts to stop hospitalizations by expanding treatment models for outpatient, day hospital and others. This movement was very positive in the sense of deconstructing a traditional, restricted and often inhumane look and actions towards patients with psychiatric disorders, including drug addicts, but this theme went to the opposite extreme (including the political vision of the left radical), stigmatizing important, serious and necessary services such as inpatient clinics and therapeutic communities.

Just as the "fight against drugs" along with the indiscriminate compulsory "incarceration" of drug addicts advocated during the military regime did not cooperate with the solution of drug-related issues, the opposite advocated throughout the leftist government has also failed to address the national demands (as demonstrated in the surveys). In view of this, in 2017 the new Public Policy on Mental Health was implemented by the General Coordinator of mental health, alcohol and other drugs, Dr. Quirino Cordeiro Jr., aimed at seeking a balance of these actions, increasing public support and funding not only for harm reduction policies, but also for other services as therapeutic communities, as well as the strengthening of the Social Psycho Attention Network (RAPS). These actions have received a lot of criticism stating that it would be a setback in the fight against asylum, but I believe that we must reposition ourselves from polarized visions to seek practices that contemplate the different forms of prevention and treatment.

In my clinical practice with drug addicts I have realized over twenty-eight years that I can work with a variety of services and techniques, such as mutual aid groups (eg, anonymous alcoholics, anonymous narcotics, narcotics, demanding communities, etc.), therapeutic communities, day hospitals, specialized inpatient clinics, harm reduction techniques, and the possibilities of co-building with the drug addict and their family members new possibilities of life. What is important is to verify the needs and characteristics of a particular case or population so that it is possible to cross the various forms of prevention and treatment, leaving aside rigid and ideological dogmas.

Brazil has already decriminalized the drug user since 2006, but in order to achieve the decriminalization process, another polemic polemic currently in the country, it is necessary to first structure better in practice and in a more integrated and continuous way the prevention and treatment actions, without allow them to be held hostage to corrupt, partisan, ideological and extremist policies. I believe that only in this way can we effectively advance this issue to the point of positively reflecting the results of the research, thus breaking the contradiction between the numbers expressed epidemiologically and the "admirable" advances of public drug policies in Brazil. ●

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online resources

Therapeutic Communities: International Journal of Therapeutic Communities

https://www.emeraldinsight.com/journal/tc

Established in 1980, Therapeutic Communities (TC) is the only peer-reviewed journal dedicated to publishing international findings related to therapeutic communities, therapeutic and enabling environments and related fields.

Addiction Research & Theory

https://www.tandfonline.com/loi/iart20

Since being founded in 1993, Addiction Research and Theory has been the leading outlet for research and theoretical contributions that view addictive behaviour as arising from psychological processes within the individual and the social context in which the behaviour takes place as much as from the biological effects of the psychoactive substance or activity involved.

Drug and Alcohol Dependence

https://www.journals.elsevier.com/drug-and-alcohol-dependence

Drug and Alcohol Dependence is an international journal devoted to publishing original research, scholarly reviews, commentaries, and policy analyses in the area of drug, alcohol and tobacco use and dependence. Articles range from studies of the chemistry of substances of abuse, their actions at molecular and cellular sites, in vitro and in vivo investigations of their biochemical, pharmacological and behavioural actions, laboratory-based and clinical research in humans, substance abuse treatment and prevention research, and studies employing methods from epidemiology, sociology, and economics.
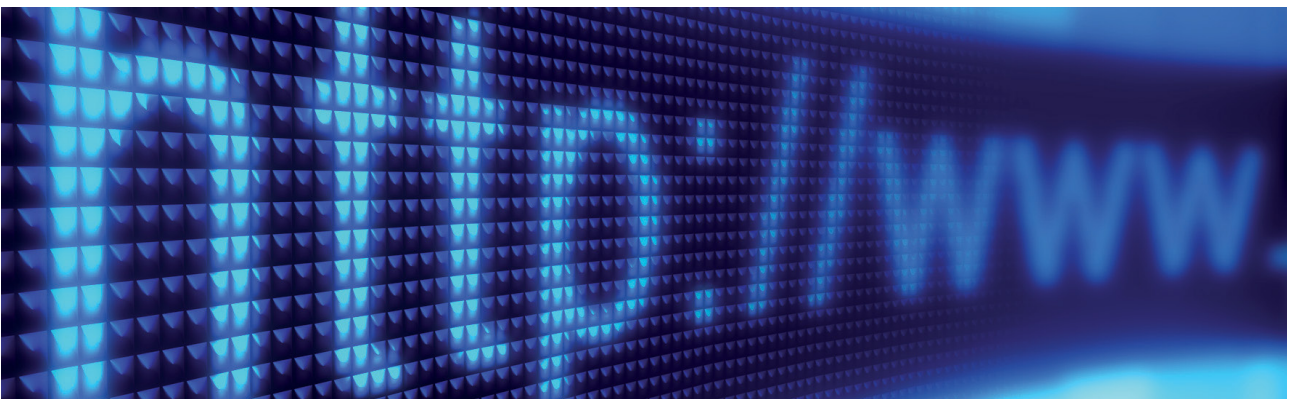
#GeraçãoCordão

Of this generation are the young people who can not disconnect for a second: they are always online, communicate online, spend hours immersed in social networks with friends or in online games, completely unrelated to the rest of the world.

How healthy will it be? As parents are we doing well? How should we manage this desire to be always connected? When to say that enough? Are we giving the best example to our children? What can schools and communities do to better manage technology in the lives of young people?

These are some of the questions that the Psychologist Ivone Patrão answers throughout this book that makes us rethink the education of our children in an era in which everything is digital. A guide that aims to help parents, teachers and society make children happier and better integrated into the community.

Ivone Patrão is a clinical psychologist and family and xasal therapist, intervening for several years in the National Health Service with children, young people and families, particularly in the area of Internet dependencies.

Autor: Ivone Patrão
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Trajectórias da Dependência à Reintegração

The processes of social integration assume a markedly complex and multidimensional character in contemporary societies, in networks, based on information, knowledge and consumption. Some of these dimensions refer to contexts and networks of interaction and support family, professional, sociability.

All these conditions tend to be compromised by situations of dependence on psychoactive substances and their treatment in a therapeutic community, in an inpatient setting. This results in a set of vulnerabilities with impacts that go beyond the individual sphere.

In this book we present the main results of the research project "Trajectories, from dependence to reintegration: study of social trajectories of drug addicts after therapeutic process". The central objectives were to capture regularities and social singularities present in the strategies of reintegration of individuals and associated with social, family, individual, skills acquired during the therapeutic process, or resulting from the appropriation of institutional measures.

To better understand the complexity of the processes of social reintegration of addicts of psychoactive substances is fundamental in the design of policies and intervention programs. In this sense, the study points out some strategic areas of intervention that are necessarily more integrated and with greater attention to the rapid changes that occur in the field of psychoactive substances: the appearance of new licit, illicit and uncontrolled, synthetic and natural substances; the emergence of new consumption patterns and associated lifestyles.
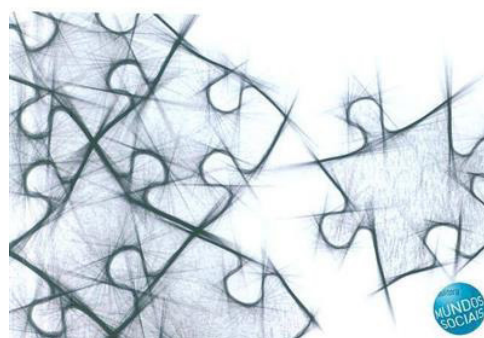
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Ano: Maio 2017
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20 YEARS OF NETWORKING