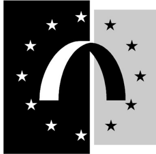

CHAPTER on SI Residential treatment:

Compilation from National Reports 2012
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1. Introduction

In this chapter an overview of residential treatment in Belgium is presented. A describtion is given about the history, policy frameworks and availability and characteristics of residential treatment. Finally we look at the quality management in residential treatment and discuss trends in demand for residential treatment over the past decade.
In the context of this Selected issue "residential treatment" is defined as a range of treatment delivery models or programmes of therapeutic and other activities for drug users, including mid- and long-term medical- psychosocial interventions within the context of residential accommodation. One defining characteristic of such programmes is that they address multiple treatment needs, including but not limited to the following domains: drug use, health, quality of life and wider social functioning. This definition leaves out: residential detoxification only, programmes dedicated to the provision solely of social support (e.g. shelters,…) to drug users, and drug treatment provision in prison.

2. History and policy frameworks

2.1 History of residential treatment

The first specialized residential centres for drug addicts in Belgium arose from youth organizations and a psychiatric hospital. These centres were created in the middle of the seventies as therapeutic communities.

The two oldest therapeutic communities for drug users, De Sleutel and De Kiem, were created respectively in 1974 and 1977 in Flanders. These residential centres were the first being recognized and officially financed. In 1980, the Belgian National Health Insurance Institute (RIZIV-INAMI) launched the convention "rehabilitation for addicts" allowing new therapeutic centres to be created in the whole country. The absence of juridical definition of a rehabilitation program for drug users allowed these new centres to easily adopt new therapeutic programs and to respond to regional discrepancies. Even if the functioning of the centre is not set by the convention, the therapeutic program of each centre has to be described in the convention.

Only since the eighties some psychiatric hospitals included drug addicts into their addiction units and units were created that had a specialized therapeutic offer for drug addicts, in addition to the existing services for alcohol and medication addicts.

For decades residential care was the norm but under the influence of scientific, social and economic arguments this dominant position clearly shifted toward outpatient care.

In addition, the objectives of treatment for drug users has changed. Where once the emphasis was on abstinence only, nowadays in some residential centres the drug free principle is not so absolute anymore and clients can have prolonged substitution medication if indicated.

Substitution therapy in recent years became the standard treatment for heroin addicts.

As a result of more community-based care there is an enhanced cooperation with neighboring areas (welfare, justice, general practitioners, employment and housing organizations). The last decade there is also a trend towards more coordination and networking.

Innovative projects in residential care that have been positively evaluated recently are: units for mothers with children, integrated treatment programs for dual diagnosis clients, implementation of evidence based practice.

The trend in Mental Health Care towards a more community-based care will also affect substance abuse care.

2.2 Strategy and policy frameworks for residential treatment

2.2.1 Current policy frameworks for provision of residential treatment

For almost a decade, the Federal Drug Policy Note of 2001 was the backbone of the Belgian drug policy. At the beginning of 2010, the Inter-ministerial Conference on Drugs approved the Communal Declaration, which was an update of the Federal Drug Policy Note and was prepared by the General Drugs Policy Cell (Van Malderen 2012;Interministeriële Conferentie Drugs 2012a).

On the subject of 'Treatment', the Communal Declaration supports a diversified offer of treatment facilities, integrated in coordinating networks. In order to reach a wider range of drug users, the declaration states that an increase in treatment capacity is needed. The support for the cooperation between the criminal justice system and the drug treatment services continues, with special attention for the necessary conditions. In general, the action points on 'Treatment' are confirmed, as the Communal Declaration promises their continuous optimization and development. The projects that were implemented as part of the Federal Drug Policy Note continue to be supported. The Communal Declaration differs on the subject of risk-reduction. Although it remains an objective of the Belgian drug policy, its confirmation is rather implicit.

In the Joint statement of the inter-ministerial Conference on Drugs named "A global and integrated drug policy in Belgium" from January 2010 some recommendations are made concerning treatment assistance strategy for drug users. It is stated that a global assistance strategy, starting from a health approach and integrating other dimensions (well-being, social integration…) is necessary. It also indicates that assistance for drug users must be developed and diversified to provide treatment as well as care and caring. To achieve this objective, a large choice of facilities is recommended, i.e. facilities specifically dedicated to drug users or global health care and well-being settings. The geographic repartition of these settings must also be balanced based on an estimation of the needs. The statement defines also what kind of treatment has to be available: non pharmacological treatment, withdrawal treatment, maintenance treatment, harm reduction, reintegration and post cure. Complementary, other problems have to be taken into account when treating those clients: dual diagnosis, employment, housing, psychosocial problems. Another important point to be improved is the consultation and the collaboration between all levels of collaborators. This must lead to the development of networks offering general and specific treatment approach. Waiting lists of clients willing to enter centres should be avoided by reducing the lack of field workers and encouraging the training of health care workers. Case management that includes an individualized assistance for an improved follow-up and a complete approach must be spurred, particularly in specific groups.

2.2.2 Financing models and main funders of residential treatment

Due to the political structure different types of statutory regulations and financial rules co-exist. Several authorities are often involved at the same time and this leads sometimes to a lack of clarity in terms of one's authority.

In Belgium, residential care is primarily a federal responsibility and residential care facilities analyzed in this report are those that are solely financed by RIZIV-INAMI or the Federal department of Public Health (for hospitals). However, some residential care facilities may be financed by other means. Thus, in Brussels, there is another structure financed by the Federal Department of Justice. Moreover, it is important to note that residential care is articulated with other types of ambulatory accompaniments (and medical) who are numerous in the territory.

The RIZIV-INAMI subsidizes institutions active in the field of rehabilitation, therefore the RIZIV-INAMI has agreements with different sectors. Within the sector of mental and neurological disorders RIZIV-INAMI provides funds for 'rehabilitation for addicts'. The grants are distributed to crisis intervention centres (CIC), therapeutic communities (TC), day centres (DC) and medical-social care centres (MSOC-MASS). Each setting has a convention concluded with the RIZIV-INAMI for the reimbursement of medical services. The funding is based on the number of treated clients who meet the conditions of reimbursement.

The table below shows the public expenditure of the RIZIV-INAMI for conventions 'rehabilitation for addicts' for residential institutions divided by region. This is an estimate on the basis of the theoretical ‘annual budget envelopes’ that are linked to an occupancy rate of 90%. In practice, the occupancy is sometimes not reached and sometimes exceeded. The theoretical annual envelope of a rehabilitation centre for addicts includes the full annual cost of the staff and the operating costs.

The bulk of this ‘annual budget envelope’ is paid by the RIZIV-INAMI, and a small share is paid by the clients through co-payments.

Table 11. 1: ***Government spending (in €) of RIZIV-INAMI Conventions for 'Rehabilitation for addicts in residential institutions per region’ in 2008***

	Flanders	Wallonia	Brussels	Total
Residential Centres: CIC and TC	13,945,842.15	9,220,915.86	4,298,769.96	27,465,527.97

Source: (Vander Laenen et al. 2011)

RIZIV-INAMI and the Federal Department of Health are jointly responsible for the expenses of psychiatric hospitals (PZ-HP) and psychiatric service in general hospitals (PAAZ-SPHG).

These institutions are given a budget with a flat rate to cover costs. The budget of the Health and Disability Insurance pays 75% of this budget and the remaining 25% is financed by the Federal Department of Health.

Since the hospitals are obliged to register MZG/RHM (Minimum Hospital data), it is possible to multiply the average daycare-price with the number of hospitalization days 'substance abuse'. This can also be used in the context of a House for psychiatric care (PVT-MSP), Initiative of sheltered housing for psychiatric clients (IBW-IHP) or Psychiatric hospital (PZ-HP), and this with the help of the Minimum Psychiatric Data registration (MPD-RPM). The expenditure arising from this methodology is more accurate. Therefore this methodology is only applied.

On the basis of this formula there are two types of estimates, a minimum and maximum (see table 6). The minimum estimate uses the primary diagnoses abuse / dependence on illegal drugs, alcohol and psychoactive medication. The maximum estimate takes into account the primary and / or secondary diagnose by this route, the drug-related costs measured for instance among persons with dual diagnosis.

It should be noted that this is an overestimation since the full daycare price is included, even though the primary diagnosis is drug related. The tables below show the data including the number of hospitalization days for PZ-HP, PAAZ-SPHG, IBW-IHP and PVT-MSP that are available for the year 2008. The MZG-RHM registration produces the same data for general hospitals (AZ-HG), but for the year 2007.

Table 11. 2: Number of hospitalization days for primary and / or secondary diagnosis of abuse / dependence of illicit drugs

Type of institution	Number of hospitalization days
PZ-HP	228,055
PAAZ-SPHG	26,845
PVT-MSP	1,188
IBW-IHP	29,376
AZ-HG	105,807
Total	**391,271**

Note: We take into account the 'primary and / or secondary diagnoses because in this way overlaps are excluded. If the criteria 'primary and secondary diagnosis example is used for admissions of people who have a primary diagnosis of illegal drugs and also for admissions of people with a secondary diagnosis of alcohol, this would be charged twice.

Source: Vander Laenen, F.et al (2011)

Table 11. 3: ***Average daycare-price 2008 per type of institution***

Type of institution	Average daycare-price (€)
PZ-HP	242.04
PAAZ-SPHG	348.21
PVT-MSP	102.10
IBW-IHP	40.46
AZ-HG	348.21

Source: Vander Laenen, F.et al (2011)

Table 11. 4: ***Minimum estimate of government expenditure on the basis of hospitalization days and the average daycare-price (illicit drugs)***

Type of institution	Government expenditure
PZ	28,263,494.88
PAAZ	4,917,073.41
PVT	79,944.30
IBW	612,443.02
AZ	2,142,884.34
Total	**36,015,839.95**

Source: Vander Laenen, F.et al (2011)

Table 11. 5: ***Maximal estimate of government expenditure on the basis of hospitalization days and the average daycare-price (illicit drugs)***

Type of institution	Government expenditure
PZ	55,198,423.20
PAAZ	9,347,697.45
PVT	121,294.80
IBW	1,188,552.96
AZ	36,843,055.47
Total	**102,699,032.9**

Source: Vander Laenen, F.et al (2011)

Table 11. 6: ***Minimum and maximum estimates of government expenditure on the basis of hospitalisation days and the average day-care price of illicit drugs***

Type of institution	Minimum hospitalization days	maximum hospitalization days	Average daycare-price (€)	Minimum Government expenditure	Maximum Government expenditure
PZ-HP	116,772	228,055	242.04	28,263,494.88	55,198,423.20
PAAZ-SPHG	14,121	26,845	348.21	4,917,073.41	9,347,697.45
PVT-MSP	783	1,188	102.10	79,944.30	121,294.80
IBW-IHP	15,137	29,376	40.46	612,443.02	1,188,552.96
AZ-HG	6,154	105,807	348.21	2,142,884.34	36,843,055.47
Total	**152,967**	**391,271**		**36,015,839.95**	**102,699,032.9**

Source: Vander Laenen, F.et al (2011)

After these calculations, the drug-related public expenditure for the hospital sector is not yet fully clear since the budget funding is only a part of the government expenditure. In addition there are costs for honoraria of medical staff and pharmaceutical specialties ... (Sermeus 2006). The technical unit of the RIZIV-INAMI provides financial feedback on general hospitals and in the example of alcohol and drug use, the daycare price is 74.8% of the total amount that is reimbursed by the health services under the mandatory health insurance. In other words, a correction for drug-related spending in general hospitals increases the cost by 33.69%. For psychiatric institutions the average daycare-price is 91% of total government expenditure and the average daycare-price is thus increased by 9.89%.

Availability and characteristics
2.3 National (overall) availability

3.1.1 Availability

In Belgium, a large diversity of treatment settings related to psychoactive substances and addiction exist. They try to help people who cannot deal with their addiction and prevent harmful consumptions by informing them on the effects and risks related to the use of illegal drugs in our society. The main objective of these services is the promotion of quality of life in terms of global health (physical and psychological) as well as in terms of welfare and respect of the autonomy of the drug user (VAD 2012).

As the drug problem is very complex, there is no quick and final solution available to help drug users. It is often a long process with different phases, different from one patient to another. There is no standard treatment available. During a treatment, there are several possible interventions offered by different organizations. Next to specialized or categorical drug centres, informal care and self care as well as primary care play an important role in early detection, care and orientation of people with a drug problem.

Psychiatric hospitals and psychiatric services in general hospitals are most involved in the residential care of drug addicts.

Most of the psychiatric hospitals have a specific section for treatment of people who are using drugs. It is traditionally more oriented towards alcohol and psychotropic drug addicts but more and more of these centres are also treating people addicted to illegal drugs. With medical and psychiatric personnel and a personal approach, they offer a global package of services such as crisis care, screening, detoxification, treatment, social reintegration and after care. Most of the time, clients are encouraged to stop using drugs, this is also a condition during treatment.

In Wallonia and Brussels there are four psychiatric hospitals with a separate unit to provide a specialized program for drug users. There are also specialized units open to alcohol and drug users except “heavy” users such as those addicted to opiates and cocaine. Finally, many hospitals are catering for these clients with helpers specialized in addiction but without separate treatment services.

In Flanders among the 40 psychiatric hospitals and the 38 psychiatric services in general hospitals, 13 have a specialized unit for drug users.

Since 1980 the RIZIV-INAMI convention 'rehabilitation for drug addicts' has been launched. It finances the following treatment programs:

Therapeutic communities are specialized services with a multidisciplinary team oriented to a pedagogic and a group dynamic type of treatment for drug users. The objective of these settings is to detoxificate drug users and to reintegrate them in society. The program is long term oriented. Next to separate units for crisis stay and detoxification, there are also short term therapeutic programs. The reintegration phase often takes place in a separate living situation.

There are 4 therapeutic communities in Wallonia (121 beds), 3 in the Brussels region (50 beds) and 7 in Flanders (135 beds).

Crisis Centres aim to intervene in a crisis situation. These centres try to take care rapidly of the client but also to achieve a detoxification and to prepare and motivate the client for a complementary treatment. There are 2 crisis centres in Wallonia (20 beds), 1 in Brussels (8 beds) and 5 in Flanders (57 beds). Note that crisis units in psychiatric hospitals may also open their door to drug users.

The number of residential clients treated in Belgium can be estimated through different sources, such as TDI and psychiatric hospitals or psychiatric services.

The treatment demand indicator (TDI) gives information about new clients entering specialized treatment centres for their drug problems. Control for doubles can currently only be partially done at the centre or group of centres' level. The indicator does not reflect the total number of clients in treatment but only the new admissions. The coverage of the centres registering this indicator is high and it concerns for 2010, 11 residential units in Flanders, 7 in the Walloon region and 6 in Brussels region.

Table 11. 7: ***Number of new treatments by primary drug in residential treatment centres in 2010 registered via the Belgian TDI register***

Substance	2010			
Primary drug	Men (N)	Women (N)	Total (N)	Proportion (%)
Opiates	667	92	759	52,9
Cocaine	180	42	222	15,5
Stimulants	108	20	128	8,9
Hypnotics and Sedatives	73	24	97	6,8
Cannabis	142	17	159	11,1
Other primary drug or unknown	57	12	69	4,8
Total	**1227**	**207**	**1434**	**100**

Source: Treatment Demand Indicator, Belgium, 2011

In psychiatric hospitals or psychiatric service in general hospitals, the minimal psychiatric register is recording all admissions. For drug problems the DSM-IV codes were used as main diagnosis.

Table 11. 8: Number of clients with a drug related disorder (main diagnosis on As1 DSM IV) in psychiatric facilities in Belgium, by sex, 2008[1]

Substances	Men (N)	Women (N)	Total	
			(N)	(%)
Amphetamine abuse	103	42	145	1.7
Amphetamine dependence	171	80	251	2.9
Cannabis abuse	219	65	284	3.3
Cannabis dependence	435	103	538	6.3
Cocaine abuse	107	41	148	1.7
Cocaine dependence	351	143	494	5.8
Hallucinogen abuse	4	5	9	0.1
Hallucinogen dependence	13	4	17	0.2
Inhalant dependence	6	5	11	0.1
Opioid abuse	63	26	89	1.0
Opioid dependence	1244	414	1658	19.4
Sedative, hypnotic or anxiolytic abuse	95	213	305	3.6
Sedative, hypnotic or anxiolytic dependence	297	489	786	9.2
Other (or unknown) substance abuse[2]	84	47	131	1.5
Other (or unknown) substance dependence	67	64	131	1.5
Polysubstance dependence	1546	613	2159	25.3
Substance induced disorders[3]	314	601	915	10.7
Substance induced mood disorders	19	8	27	0.3
Substance induced persisting amnestic disorders	6	6	12	0.1
Substance induced persisting dementia	3	5	8	0.1
Substance induced psychotic disorders + delusions	136	31	167	2.0
Substance induced psychotic disorders + hallucinations	50	12	62	0.7
Substance intoxicatie delirium	19	24	43	0.5
Substance withdrawal	67	44	111	1.3
Substance induced disorders nos	24	10	34	0.4
Total	**5443**	**3095**	**8535**	**100**

Source: FOD Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu, Minimum Psychiatric Data registration (MPD)

[1]Psychiatric facilities are psychiatric hospitals (PZ), psychiatric services in general hospitals (PAAZ), initiatives of sheltered housing for psychiatric clients (IBW) and houses for psychiatric care (PVT).
[2]Other substance abuse (DSM code 305.90) is other (or unknown) substance abuse, caffeine intoxication, inhalant abuse, other (or unknown) substance abuse or phencyclidine abuse.
[3] Substance induced disorder (DSM code 292.89) are substance induced anxiety disorders, substance induced sleep disorder, substance induced seksual dysfunction or substance intoxication.

3.1.2 Referral pathways

The referral pathways to specialized residential treatment can be evaluated by the TDI where a question concerns the source of referral of each patient entering treatment in 2010.

Table 11. 9: ***Referral pathways to residential treatment***

Referral pathway	
Self-referred	38,7%
General practitioner, another drug treatment centre, hospital, medical source	37,7%
Justice	10,4%
Friends or family	6,3%
Social services	5,5%

Source: Treatment Demand Indicator, Belgium, 2011

More than one third (38,7%) are self-referred, 37,7% are sent by their general practitioner, another drug treatment centre, an hospital or another medical source, 10,4% are sent to treatment on juridical decision. Friends or family represent 6,3% of the referrals and social services 5,5%.

In order to process applications, most of the residential treatment centres have established application procedures organizing the reception of clients. In general the centres provide a pre-admission interview (or more) to analyze the request of the person and set up a hospitalization if necessary. There is no general assessment or triage procedure.

In some regions there is network/circuit meetings where admission requests are discussed and the client is given advice for referral.

2.4 Types and characteristics of residential treatment

2.4.1 Common approaches

The following treatment elements are usually (in a greater or lesser extent) part of a residential treatment program, whether or not in certain combinations:

- Pharmacotherapy withdrawal management: usually a gradual cessation of an opioid agonist (methadone) or a short-term use of a partial agonist (buprenorphine).
- Pharmacotherapy maintenance treatment: opioid maintenance treatment is the administration of thoroughly evaluated opioid agonists by accredited professionals in the framework of recognized medical practice to people with opioid dependence for achieving defined treatment aims (World Health Organisation 2009).
- Pharmacotherapy relapse prevention.
- Motivational interviewing: a collaborative, person-centreed form of guiding to elicit and strengthen motivation for change (Miller and Rollnick 2009). Motivation interviewing is usually part of a broader approach in which one tries to motivate the person to seek help or strengthen its reasons for its drug use to reduce or discontinue (Rigter et al. 2004).
- Cognitive behavioral therapy and variants (including skills training, relapse prevention) is a collective term for an intervention carried out in different ways. Usually starts with motivation increase. The client is trained to resist and to guard against cues/triggers. He learns to say no and in more comprehensive approaches to expand his social network to undertake activities other than drug use. The emphasis is on teaching skills to avoid or reduce relapse (relapse prevention). If one cognitive component - 'learning to think differently' – lacks, we speak of behavioral therapy (Rigter et al. 2004). Relapse prevention is a cognitive-behavioral approach in the treatment of addictive behavior specific to the nature of the relapse process approach and suggests coping strategies useful in the maintenance of change (Marlatt and Gordon 1985).
- Group-oriented psychotherapy: a form of therapy in which 2 or more clients participate under the supervision of one or more psychotherapists with the aim of treating emotional disorders, social maladjustment and increased psychotic modes (MeSH 2006).
- Family-work as a continuum of interventions: from increasing family involvement in treatment to family therapy.
- Psycho-education: education about addiction using video, film, lectures, brochures (Rigter et al. 2004).
- Activities aimed at social integration: housing, employment, daytime activation, leisure, budget and so on.

- Relaxation: activity that reduces stress (MeSH 2006).
- Non-verbal forms of therapy: for example, creative-, occupational-, music- and movement therapy.
- Case management: a form of individualized counseling where one pays attention to different life areas with focus on the coordination and continuity of care.
- Aftercare: ambulatory/polyclinical management of clients / clients after they have completed residential treatment.

2.4.2 Examples of typical mix/integration of services

- Inpatient treatment programs for dually diagnosed clients: a long-term residential integrated treatment program that can be seen as a combination of a specialised assessment, outreaching work, motivational interviewing, individual and group counseling, a pharmacological treatment, psycho education and broadening of the social network.
- Residential treatment with a social workplace to train and integrate low-skilled, unemployed inactive people into employment.
- Residential programs with a structural cooperation with selfhelp-groups.

2.4.3 Integration of OST in residential treatment

As mentioned in 1.1 there is a minor trend that in some psychiatric hospitals the drug-free principle is not so absolute anymore and clients can have prolonged substitution medication if indicated. In other words the application requirements to follow the therapeutic program are not so rigid (drug-free) anymore. This is not the case in TC's, though they sometimes accept clients ending an OST treatment.

2.4.4 Typical levels of collaboration and networking

At the national level

There is a federal pilot project with the aim to implement the function of coordinator of care in the platforms of consultation in mental health care for the treatment of people with substance abuse.

The provincial platforms of consultation should investigate regional mental health needs, as well as describe the programs and channels of care. These platforms should also detect missing features in the provision of care through local consultation. Overlap in the provision of care should also be investigated and remedied.

The task of the care coordinator for each of the platforms of consultation is to facilitate dialogue in a circuit of care for people with a problem related to substances and strive for a maximum participation of stakeholders, so that this consultation leads to creation of cooperative agreements from at least three different types of relevant actors.

The situation of collaboration and networking is very different from one province to another and from one region to another so it is very difficult to make an overall assessment. The number of relevant actors varies from province to province. Moreover, in some provinces the number of specific "drugs" actors is limited because it is principally of general structures (Luxembourg, Brabant, ...).

Some provinces have a tradition of collaboration while others are in the initiation of the process of networking. The level of cooperation between the various services is ranging from consultation and network meetings to a structured formal cooperation agreement.

At the regional level

Since 2007 in French Community, there is a networking project called “Réseau WAB” (shrinking of Bruxelles-Wallonia network) aiming to help clients in difficulties. This network is composed of different stakeholders (psychologist, social worker, nurse…) from residential and outpatient services of Wallonia and Bruxelles helping drug users. Members of the WAB network meet once a month to discuss and elaborate a care pathway for users whom previous treatment trials failed. More generally, they meet to exchange good practices and to elaborate tools to promote networking and facilitate the clinical support to clients. The topic of this network is of course not limited to residential care.

Also, the Walloon government promotes networking between services helping drug users with a recent decree allowing a subvention to create and promote local networks through the whole region. In 2012, 8 local networks can be identified, regrouping mostly services proposing residential and/or outpatient treatment for drug users, but also of services only involved in prevention and harm reduction. The aims of these

networks are: 1) to identify the existing ‘help and care’ supply and demand in collaboration with the platforms of consultation in mental health care; 2) to promote institutional consultation to insure a coherent and complete help and care supply at local level; 3) to help each services at a methodological level to improve their actions (information and harm reduction, psychosocial support, and treatments); 4) to collaborate with the platforms of consultation in mental health care; 5) and to initiate and organize intervision if necessary.

At the international level

Several outpatient and residential services in Belgium participate to the addiction network of the European Companionship in Education (ECEtt-addiction), which regroup more than 700 partners across Europe. The principle of this network is to exchange practice and knowledge of workers during training sessions of several days in another service in Europe. Each institution participating to the network also agrees to host workers from another service.

3. Quality management

3.1 Availability of guidelines and service standards for residential treatment

4.1.1 Clinical guidelines

In Belgium, the implementation of evidence-based practice and guidelines is becoming an important issue for policy makers, researchers and practitioners in substance abuse treatment (Autrique et al., 2007, 2009). Despite this rising interest, almost no guidelines for substance abuse treatment have been developed at a national level and working with evidence-based guidelines is not imposed by the government.
However, some treatment services are using of international guidelines, adapting them to their specific context. This is congruent with the suggestion of some authors that investing in the adaptation of existing evidence-based guidelines and even the development of shareable guidelines at a European level might be preferable over the development of guidelines at a national level, since the evidence underlying guideline recommendations is usually of an international nature (Stiegler et al., 2005). So far, in Belgium no international evidence-based guidelines for substance abuse treatment have been adapted at a national level.
Examples of substance abuse treatment guidelines developed in the Flemish Community:

- Guideline for prescribing benzodiazepines to illicit drug users (2008).
- Guideline for the clinical use of buprenorphine – high dosage – in the treatment of opiate dependency (2005).
- Development of Good Clinical Practice in the assessment and treatment of ADHD in (young) adults with addiction problems (2010).

In 2009, different initiatives were taken within the project ‘Quality improvement in substance abuse treatment’ to inform and sensitize substance abuse treatment practitioners in the Flemish Community concerning the importance of evidence-based guidelines, and to increase the expertise of professionals in substance abuse treatment. An overview of existing evidence-based guidelines was developed and disclosed; it concerns general guidelines for substance related problems, as well as guidelines for specific interventions in substance abuse treatment. Dual diagnosis and HIV related to substance abuse are also included. The quality of the guidelines has been assessed by means of indicators derived from the AGREE instrument (the AGREE Collaboration, 2001) and the GLIA instrument (Shiffman et al., 2005). Based on the results of the needs assessment, one international evidence-based guideline is translated each year. All this information can be found on the VAD website.

Training is an important way to enhance the knowledge, skills and attitudes of the drug care professional in quality improvement in residential care.
In Flanders the VAD (Dutch acronym for Association for Alcohol- and other Drugproblems) has an extensive training program for professionals in the area of residential treatment. There’s an offer of basic and specialized education and training by Werkwijze® (Work director).

Training was developed on evidence-based practice/evidence-based guidelines and is organised annually. By means of a digital newsletter, substance abuse treatment services are informed of interesting weblinks, new initiatives, evidence-based guidelines. For these trainings, VAD can count on a large group of experts.

In 2010, a manual for quality improvement in substance abuse treatment was developed, focusing on the implementation of evidence-based guidelines and outcome management.

In Flanders about half of the residential facilities use a form of outcome management. For this purpose residential centres usually use self-developed or adapted instruments. The focus of the questionnaires is not always on clinical outcomes but also on clients satisfaction, quality of life and other issues.
There is some resistance by health care professionals towards the type of measurements that link results in an economic principle and resistance to measuring devices that interfere in the therapeutic process. A change of mindset is needed before the addiction outcome management will be supported by all drug care professionals, this will be a lengthy process.
In Belgium, standard and formal systems of quality assurance aren't used by common consensus in the field of treatment.
A major opportunity for quality improvement is the start of the process to general application of TDI. As of Jan. 1st 2011, about 750 treatment programs (or more than 300 treatment centres) in Belgium will register the TDI variables for every new patient. The substantial increase of the number of participating programs is due to the first-time registration by the hospitals (general and psychiatric) and in the regular centres for mental health care in the Walloon Region. The raw data will be merged in a "Master TDI database" that will be used for the EMCDDA standard tables in 2012 and for further epidemiological research by the Drugs and Illegal Substances Program and its partners (van Bussel and Antoine 2011).
Recent examples of practice supporting research commissioned by Belgian Federal Science Policy Office that can improve the quality of residential treatment:

- Effectiveness of inpatient treatment programs for dually diagnosted clients.
- Implementation of casemanagement in the substance abuse treatment system, taking into account regional differences (Flanders, Brussels and the Walloon provinces in Belgium) and existing practices.
- Treatment trajectories of drug users from ethnic minority groups
- Evidence-based practice in substance abuse treatment in Belgium: a state of the art

4. Discussion and outlook

Challenges

- There is a lack of crisis beds for illicit-drug users. The existing crisis beds are almost only available for alcohol abusers.
- Pilot projects such as dual diagnosis project, care coordination, case management, crisis centres, which have been favorably evaluated several times, are still waiting for a structural embedding/funding.
- The target groups with poly-drug use and associated psychiatric problems have high drop-out rates and more requests for help come in/after crises. For those target groups, a specific and customized offer should be expanded. There is a need for structured cooperation with other sectors that work with these target groups like social services, outreach, etc. Further implementation and adequate financing of long-term counseling for this group is needed.
- There is a need for Belgian clinical guidelines for substitution treatment and more educational initiatives for physicians who want to work with substitution treatment. Treatment centres that offer training/supervision should have financial compensations.
- The treatment capacity for minors is insufficient for both outpatient and residential care. The environment / context is essential in working with young people. That makes the approach complex and time intensive.
- The guidance and influx of ethnic minorities into care remain a problem, partly because of lack of information about the assistance available, the experience of high-threshold of some categorical services and the different way of dealing with health, illness, request for help, treatment and social and family networks. Language and cultural differences especially complicate the counselor-client relationship. Indigenous workers are educated and trained from 'Western' concepts that are sometimes different to the world of ethnic and cultural minorities. Not all native workers are aware of or manage the gap. There is a need-oriented training of indigenous workers to work with clients from ethnic cultural minorities.
- In both outpatient and residential treatment centres we see a slight downward trend in the number of women in treatment. Some methods are insufficiently geared towards women while newer methods such as online assistance and treatment reach a higher percentage of women than the regular assistance.

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BULGARIA

11. Residential treatment for the drug users in Bulgaria

Within the framework of this section the following main topics will be reviewed:

- History and polity regarding the residential treatment;
- Accessibility and characteristics of the residential treatment;
- Quality management;
- Trends of the future development of the residential treatment.

When reviewing the topic consideration has been taken of the historic development of the residential treatment in Bulgaria, the strategy and policy regarding it, the accessibility and the characteristics of the residential programmes in Bulgaria, the therapeutic approaches used, the levels of interaction and relations with other institutions and therapeutic approaches, the existing trends and standards of good practice in the residential treatment, the tendencies of this type of treatment, its achievements, problems and trends of future development. For this purpose data and information have been used mainly from the National Focal Point for Drugs and Drug Addictions and from the National Center for Addictions.

History and Policy Regarding Residential Treatment

History of the residential treatment in Bulgaria

The residential treatment is based on closed programmes in which to live and they require separation from home and from the usual milieu, i.e, the drug addicted individuals live in a close system with the aim to recover from the addiction.

In April 1964 at the State Psychiatric Hospital- the town of Radnevo "A Club of the Aspiring for Sobriety" was found. This is the first socio-therapeutic club of addicted individuals found in Bulgaria. In 1968 it became the basis for the therapeutic communities in the hospital. Family group psychotherapy was initiated. The patients were actively included in work therapy and art therapy. In 1980 the building of the present Sixth Men's Department was finished with 70 beds and closed profile for patients in severe condition. A wing was also built, which functioned on the principle of protected homes. [1]

After 1990 the prevalence of addictions in Bulgaria acquired epidemic characteristic and became a public problem. Gradually pressing need was recognized to establish therapeutic community as a model of treatment .[2]

In 1994 Dr. Filip Lazarov organized the participation of Bulgaria in a 5-year international project for training in the treatment of addictions. This project was meant for countries from South-East Europe, and the training was conducted in Italy, Slovenia and Bulgaria by David Dache from the California University of San Diego.

Considerable part of the project was practical training in the model of therapeutic community, in which a group of about 50 psychiatrists, psychologists and social workers participated. In this way the transfer of the psycho-technology of the therapeutic community model was transferred to Bulgaria.

In 2001 Dr. Peter Vassilev established the "Phoenix House" in the village of Brakiovtzi, with the support of Assoc. Prof. Toma Tomov, MD- republican psychiatrist and head of the Department of Psychiatry at the Medical Academy in Sofia (at present a Professor). The organization of the therapeutic structure was

[1] Source: Annual Report on the activity of the therapeutic programme for behavioural modification of the patients with addiction to psychoactive substances at the "Dr. Georgi Kissiov" State Psychiatric Hospital– Radnevo in 2011

[2] Source: Vassilev, P. (2008). Therapeutic Communities. Standards for Good Practice, p. 18-19, M-8-M, Sofia.

influenced by the experience gained at the communities Ley Community, England, and Phoenix House, Norway. As a representative of the third generation of the therapeutic communities the therapeutic programme includes cognitive behavioural psychotherapy, which the team of “Phoenix House” managed to integrate in the therapeutic structure. So far the therapeutic centre has participated in three great European projects – Standards for services in the therapeutic centres, SEID, EEA, as well as in more than 5 projects in the country- the project under Phare Programme for re-socialization of drug addicts, projects under the Ministry of Labour and Social Policy and the National Centre for Addictions.

In 2001 selection and training of the staff who would work with the “Debeletz” Therapeutic Community began, which was established under a project of the “Open Society” Foundation. In the same year the team was on training with the “ITAKI” – KETEA therapeutic community in the Republic of Greece. In August 2002 the staff participated in the repair of the building and in the preparation for the admitssion of residents. The training and the work of the community was supervised and supported by the National Centre for Addictions. The capacity of the community is 18 positions, and in February 2003 the first residents were admitted. The community has a structured daily regime, hierarchical structure of the residents, group psychological work is done and other activities, characterizing the specifics of the therapeutic community. In September 2004 financial problems arouse resulting from the fact that the financial funds, provided for the project, had been spent. The leadership of the community introduced taxes for the residents, to cover the financial needs. This however, changed the process and the motivation and the clients, and even a group violation of the prohibition to use alcohol occurred. The financial instability affected also negatively a part of the team, and some of them quit. At the same time the risk of burn-up increased time and again. In February 2005 the therapeutic community discontinued its activity.

At the end of 2004 the State Psychiatric Hospital for Treatment of Addictions and Alcoholism (SPHTAA) was registered as a legal entity. There diagnostic, treatment, stabilization and rehabilitation of persons addicted to alcohol and/or other psychoactive substances began. The real hospital activity of the SPHTAA was done at Suhodol district, where a department of psychosocial rehabilitation was established.

In 2005 the “New Beginning” Centre was established, which was part of the activity of the “Posoki” Foundation. It was based on the approach of the therapeutic communities for the rehabilitation of addicted persons, and its premises were in the village of Bunovo, Municipality of Mirkovo.

On 03rd March 2012 the “Octava” Therapeutic Centre, the first one in Bulgaria for rehabilitation of women, suffering from drug, alcoholic and gambling addiction, opened its doors.

Strategy and policy regarding the residential treatment

The strategy and the policy regarding the residential treatment in Bulgaria is laid down in the National Strategy to Combat Drugs (2009-2013 г.) – Strategic Task 3 „Improvement of the accessibility of the of the patients to various and effective treatment programmes” and Strategic Task 6 „Development of programmes and activities for social rehabilitation and reintegration in the community”. 4 subtasks have been set to them:

1) Developing a system for treatment and psychosocial rehabilitation of the drug users at national and municipal level.
2) Optimizing the information system and referring patients and their relatives to programmes for treatment and psychosocial rehabilitation.
3) Ensuring the quality of the services in the programmes for treatment and psychosocial rehabilitation.
4) Establishing “Protected Homes” for individuals addicted to drugs in the process of treatment and re-socialization.

For the first two subtasks the Minister of Health, the Minister of Labour and Social Policy and the mayors of municipalities (Municipal Boards on Drugs and Prevention and Information Centres) are responsible, and also health establishments and MGOs. For the third subtask only the Minister of Health and the Minister of Labour and Social Policy are responsible, and for the fourth- the Minister of Labour and Social Policy and the mayors of municipalities with partners the Minister of Health and NGOs.

The residential treatment s based on drug-free treatment or on psychological therapeutic approach, directed at complete psycho-social recovery and reintegration of the addicted individual.

In Bulgaria the drug-free treqtment of the addicted individuals is regulated by the Drugs and Precursors Control Act (DPCA). In Regulation № 8 dated 07th September 2011 (about the terms and conditions for implementing programmes for psychosocial rehabilitation of individuals who have been addicted to or have

abused drugs, issued by the Ministry of Health and the Ministry of Labour and Social Policy) the rehabilitation programmes are described as systems of activities and care directed at improving the bio-psycho-social functioning of the individual and his/her social integration in society. These activities and care include psychological interventions and social activities, implemented in the communities and at the health establishments, which assist and extend the options of the individuals to have personal way of life.

The programme for psycho-social rehabilitation is implemented through social services, provided to the community by institutions or persons under Art. 18 from the Social Assistance Act and by health establishments under Art. 89 from the Drugs and Precursors Control Act.

The psycho-social work is done in accordance with the current methods, standards and requirements for social services, regulated by the Social Assistance Act and the regulation for its enforcement.

The psycho-social rehabilitation at the health establishments is implemented in accordance with Regulation № 24 from 2004 for the ratifying of the "Psychiatry" medical standard.

The residential programmes are implemented at health establishments, homes for medical and social care and by social service providers, like centres for accommodation and psycho-social rehabilitation and integration of people with problem drug use – type of protected homes. The target group for this are the individuals diagnosed with psychoactive substance dependence, according to the criteria of the International Classification of Diseases (ICD-10).

The funding of this progranmme is done through:

- annual support through the state budget;
- paying taxes by the residents;
- participation in national and international projects;
- donations.

Accessibility and characteristic of the residential treatment

The residential programmes in Bulgaria may be united in three groups: [3]

1. **Hospital residential programmes.** These are programmes at inpatient healthcare establishments, where specialized medical or psychosocial services are provided to individuals addicted to psychoactive substances. They are suitable for people who need medical or psychiatric monitoring, for life-threatening conditions or for people who are self-threatening or are a threat to other people. These programmes offer psychosocial assistance, including also medical service by a physician or a nurse. The aim is to achieve stability, restoration of skills and abilities which have been lost for the time of use of drugs and alcohol. The hospital programme ensures distancing of the addicted individual from the problematic milieu and also assists his/her social inclusion in the community. The benefit from these social programmes is the enhancement and stabilization of the positive abilities of the personality of the addicted individual. The team, supporting this recovery, consists of a physician, a psychologist, a nurse and a social worker.
2. **"Protected home" programmes.** They are suitable for addicted persons who have completed the rehabilitation programme and are still in the process of recovery and visit the programme with the aim of returning to the community, with the continuing assistance and control of the professionals (social pedagogue/tutor or a nurse, social worker and a manager) and the reduction of the risk of returning to the use of drugs and alcohol. The participants in this type of programmes have an independent way of life in protected space, they help each other in the process of recovery and achievement of full-value life, which are manifestations assisted by milieu, similar to the family one.
3. **Therapeutic community (TC).** These are 24-hour programmes, working 7 days a week and the mean duration of residing in them is 6 months. The therapeutic community is an approach, guided by the understanding of the disease, the personality of the addicted person, the process of recovery and the correct way of life. The main therapist and trainer is the community itself, which consists of the social milieu, the group of the persons participating in the programme and the members of the staff who are the role models and guide the participants in the process of recovery. In this way the community is at the same time the environment of the change and a method facilitating the change. The confrontation by and the positive influence of the group are in this way among the basic means

[3] Source: Mihailova-Petkova, M., Ivanov, Kr., Bogdanova, V. (2011). Drug-free treatment of addictions in Bulgaria. Psychosocial rehabilitation, p. 11-12, NCA, Sofia.

to achieve change of the personality and of behavior. In these programmes the participants do social training through social interaction and this may have therapeutic influence on all the activities of the community. The programme is so arranged that there is a strict hierarchy according to levels, and accordingly the responsibilities of the participants are greater with each level. The therapeutic process in the therapeutic community integrates the work, the professional training, the therapy and the training of skills to prevent relapse. These elements build the 24-hour therapeutic milieu, which by its continuity and intensity is a reflection of the total personality transformation and is the object of the therapeutic work. [4]

Apart from these 3 types of residential treatment programmes, two more have been described: **centre for temporary accommodation** (of addicted individuals in the phase of switching to another treatment or rehabilitation programme, with minimal supervision by the team and providing therapeutic care if needed), and **foster families** (trained volunteers who take the commitment of living together with 1-3 ex-addicted individuals in the phase of rehabilitation, where the natural therapeutic effect of family life is combined with different according to intensity and tendency professional therapeutic interventions). [5] Currently, however, they are not applied in Bulgaria.

On the bases of the studies that the National Focal Point for Drugs and Drug Addictions conducts every year, it can be summarized that by the end of 2011 in Bulgaria there were 20 treatment centres, which were related to the residential treatment. 15 out of them may be numbered among the hospital rehabilitation treatment, 3 – among the treatment of the "protected home" type and 2 – among the therapeutic community. For 14 treatment centres the minimal duration of treatment is less than 3 months, and for 6 – more than 3 months. All the individuals treated in them in 2011 numbered 271. [6] (*see Table 11-1*).

Table11-1

NUMBER OF TREATMENT CENTRES AND NUMBER OF CLIENTS ON RESIDENTIAL TREATMENT IN 2011

Type of residential treatment	Minimal duration of the treatment		Number of clients treated in 2011
	< 3 months	> 3 months	
Hospital rehabilitation treatment	14	1	117
Protected home		3	40
Therapeutic community		2	114
Total	**14**	**6**	**271**

Source: National Focal Point for Drugs and Drug Addictions

Those state psychiatric hospitals, centres for psychic health and multiprofile hospitals for active treatment which provide specialized services like psychotherapy and psychosocial rehabilitation to individuals addicted to psychoactive substances belong to the inpatient rehabilitation treatment.

At the building for the inpatients of the **State Psychiatric Hospital for the treatment of addictions and alcoholism – Suhodol district** there is a ward for psychosocial rehabilitation with 10 beds. To the ward men and women addicted to alcohol and psychoactive substances are admitted, needing medium intensity care. The patients with high degree of addiction, who have successfully completed the two-week detoxification programme on the inpatients' premises or at another health establishment, are included in clinical programme of medium-term duration.

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Within the framework of **Protected Home at the State Psychiatric Hospital (SPH) – the town of Radnevo** services are provided for ex patients of the hospital, aimed at their re-integration in society or at prevention of relapses.

Since 2004 at the hospital group therapy began for addicted individuals and models and instruments were used reciprocated from the therapeutic communities. The meetings were five times a week. The groups were guided by a psychiatrist and a psychologist. The group therapy complemented the therapeutic programmes available, giving the patients the option to educate themselves about issues, related to their condition, to behavioural change, to assuming responsibility and commitments, experimenting new

[4] Source: Raicheva, Tzv., Groshkova, T., Vassilev, P,. Nikolova, E., Naslednikova-Rainova, R. (2009). Guidelines for the good practice of the psychosocial rehabilitation of addictions, p. 15, NCA, Sofia.

[5] Source: Georgiev, R., Vassivev, G., Belchev, Al., Grashnov, E., Angelov, Al., Vassilev, P. (2005). Consensus opinion about recommended approach for rehabilitation of addictions, p. 13, NCA, Sofia

[6] Patients were not treated in all of the rehabilitation centres of residential treatment, providing psychotherapy and psychosocial rehabilitation, in 2011

behaviour. In the group the addicted individuals can contact people suffering from the same problems, can share their thoughts and experiences, they can watch and participate in the others' success and can share their own success.

Since February 2007 at Sixth's Men's Department of the SPH-Radnevo, a 12-step programme began functioning – a group for self-assistance and mutual assistance. The number of the meetings gradually increased from once a week to five times a week.

In the last years the hospital was in successful partnership with organizations and institutions having similar activity, such as: "Stefan Batori" Foundation in Poland, "Mothers against Drugs" association in Plovdiv, The National Centre for Addictions, "Solidarity" Day Centre – the city of Sofia, Probation Service – the town of Stara Zagora, The Prison- the town of Stara Zagora, The Regional Inspection of Preserving and Control of Public Health- (RIPCPH) – Stara Zagora, etc.[7]

Protected Home at the "Decisions" Centre- Rousse functions as public service in the community and has a capacity of 8 positions. Daily at the home clients aged between 18 and 65 years and using psychoactive substances who want to work for their skills of independent life and social inclusion, and who have risky dysfunctional behavior are cared for.[8]

At the "**Phoenix House" TC** the typical behavioural instruments and methods for the therapeutic centres are used, including psychoanalysis and cognitive behaviuoral consulting. The long-term residential programme operates as a 24-hour programme and provides systematic therapeutic approach, where the basic therapist and trainer is the community itself. It consists of a social milieu, the group of the residents and the staff members, who are role models of a successful personality change and guide the residents in the process of recovery form the psychoactive substance dependence.[9]

At the therapeutic centre 11 specialists aged from 25 to 54 years work. Those are 2 psychiatrists, 6 psychologists, 2 social workers and a health manager. Three ex-addicted individuals work as volunteers. The clients are aged between 18 to 50 years – male and female, abusing heroin, amphetamines, marijuana, alcohol and methadone.

The programme is in partnership with "Institute of Ecology of Thinking" Foundation, with the National Centre for Addictions and the Bulgarian Association for Prophylaxis of Addictions.

The residential long-term programme at the **"New Beginning" TC** is a 24-hour programme based on the model of the therapeutic communities for the recovery from the addiction to psychoactive substances, approaches, based on the 12-step and recovery philosophy. The main goal is to cover the main educational and psychological and emotional deficits, enhancing the feeling of security and belonging. The medical and legal problems are solved in a systematic way, and the team provides complete support, if necessary.

The team of the programme includes 11 people, most of them on part-time work – 2 psychologists, 2 psychotherapists, 1 clinical social worker, 1 social worker, 4 ex-addicted to drugs individuals and 1 psychiatrist as a consultant. 50% of the clients are addicted to amphetamines, and the rest – to heroin and methadone, and there are also individuals abusing more than one substance. The therapy is done in most of the cases in groups (psychodrama, group analysis, cognitive behavoiural approach, crisis prevention).[10]

The therapeutic centre is in partnership with:

- "New Society Alternative" NGO – on the basis of the mutual experience and intervision on cases from the work with addicted individuals and their families.
- The Bulgarian Association of the Social Workers- in the line of the development of social work with the addicted individuals in Bulgaria.
- Medical Centres- for referring clients with severe form of addiction for detoxification, as well as consultations regarding co-morbidities of the patients.
- The Bulgarian Red Cross – regarding the re-socialization phase of youths who have successfully completed the programme and who participate in teams, as well as joint projects regarding prevention of risk use of psychoactive substances among the adolescents.
- The regional probation service, the town of Pirdop- regarding probation practices in addicted individuals.
- "Mothers against Drugs" Association, the town of Plovdiv – for enhancing the level of awareness among the adolescents and their parents, assisting and coordination of all the NGOs in the region.

[7] Source: National Centre for Addictions.
[8] For further information: http://www.solutions-centre-rousse-bulgaria.org/index.php?option=com_content&task=view&id=55&Itemid=76.
[9] Source: Maya Michailov-Petkova, Description and Analysis of the Situation in the Sphere of Psycho-Social Rehabilitation and Integration of the Addicted Individuals in the Country in 2011
[10] Source: Kalotherakis, F., Kalabalikis, V.(2012), Monitoring report of "Ketea" .

- Metropolitan municipality – uniting the efforts to assist the organizations established and working in the sphere of treatment and rehabilitation of addictions and assistance at institutional level, providing the municipal premises for the development and extension of the activity of the organization.
- Anonymous addicted individuals (AAI) – evening groups for personal experience. [11]

The long-term residential programme under the model of the "Octava" Association therapeutic communities is addressed to women with addiction to psychoactive substances, to alcohol, gambling, internet and bulimia. The programme includes all-day groups and work activity. The groups are for preventing relapse, coming to know the addiction, self-knowledge. The methods used are positive psychotherapy, cognitive-behavioural psychotherapy, neuro-linguistic programing (NLP)-techniques, art-groups, hippotherapy (work with horses).

The team consists mainly of psychotherapists from different therapeutic directions (cognitive-behavioural therapy; psychodrama; Jungian psychoanalytic psychotherapy; positive psychotherapy; art therapy) and of two consultants with personal experience. The programme has 5 positions, and till the end of August 2012 two addicted individuals were included in it. The therapeutic process is of total duration 14 months.

In Bulgaria there **is no clear practice of the maintenance programmes referring their clients to centres for residential treatment.** They apply within the framework of their programmes different psychosocial interventions, these mainly being: individual and family consulting, cognitive-behavioural therapy, motivation interviewing. Psychodrama techniques, Neo-Reichian therapy art therapy, as well as systemic psychotherapy and psychoanalytic psychotherapy, family therapy groups for parents, therapy for couples, crisis interventions, trans-theoretical approach, positive psychotherapy and prevention of relapse are less frequently applied. The psychotherapy is done by the psychiatrists, the clinical psychologists and the psychotherapists, working for the programmes. With the patients from most of the programmes work is done for their re-socialization to their families and to society and for the acquisition of living skills and techniques to improve their social communication. [12]

There are also 4 daily rehabilitation programmes at the centres of psychic health in the towns of Vratsa, Dobrich, Plovdiv and Rousse under the structured in these health establishments substitution and maintenance programmes, but they are not included in the residential treatment.

More often the residential programmes refer their clients for treatment to the substitution and maintenance programmes. This is most often related to the normatively enforced requirement, namely that till 2011 in order to be admitted to the substitution maintenance programs (SMP) the patients must have had at least three documented courses of treatment without having discontinued drug abuse.

Quality management of the residential treatment

In 2003 a team of specialists from the National Centre for Addictions, on grounds of the Bulgarian and foreign experience prepared a suggestion for **Consensus Opinion about recommended approach to rehabilitation of addictions.** This professional Consensus was adopted at the Annual Conference of the Bulgarian Psychiatric Association in Varna in October 2003 and it is an important step to introducing professionalism in the sphere of rehabilitation. [13]

In 2009 **guidelines for good practice in the psychosocial rehabilitation of addictions** were prepared, and they were aimed at improving the quality and efficacy of the work in the sphere of psychosocial rehabilitation in Bulgaria. In them the basic conceptions, definitions, aims and normative framework of the psychosocial rehabilitation, the stages of the rehabilitation process (including the types of the residential programmes) for addicted patients, the standards of the good practice of the rehabilitation of addictions, the monitoring and the assessment of the efficacy of the rehabilitation programmes, the basic ethic principles in the treatment and rehabilitation of addictions are described, and so is the ethic card of the staff.

The current standards of the good practice of rehabilitation of addictions in Bulgaria have been worked out on the basis of the Standards of Good Practice in the therapeutic communities for addictions, the regulating document for monitoring the quality of the implementation of these programmes, worked out by the Royal College of Psychiatrists, 2006. After consultations by a group of experts and by a group of those

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[11] Source: Annual report of the activity of the "New Beginning" therapeutic community in 2011

[12] Source: Dr. Tomova, B., Yoneva, K. Summarized data from the annual reports of the substitution and maintenance programmes, functioning on the territory of the Republic of Bulgaria in 2011

[13] Source: Georgiev, R., Vassilev, G., Belchev, Al., Grashnov, E., Angelov, Al., Vassilev, P. (2005). Consensus opinion about recommended approach to rehabilitation of addictions, NCA, Sofia.

working in this sphere at national level, the standards were modified, so that they could meet the requirements of different types of programmes for psychosocial rehabilitation in Bulgaria. [14]

The qualification which the leaders of the programmes for psychosocial rehabilitation must have is specified in Art. 4, Para. 2 of Regulation № 8 from 7 September 2011 about the terms and conditions for implementing programmes of psychosocial rehabilitation of individuals who have been addicted to or have abused drugs, issued by the Ministry of Health and by the Ministry of Labour and Social Policy.

Art. 9, Para. 1 of Regulation № 8 regulated the terms and conditions under which the individuals with personal experience in the recovery from drug abuse, and who have successfully undergone treatment, psychosocial rehabilitation and/or groups for mutual assistance, may participate in the implementation of programmes for psychosocial rehabilitation:

- they must not have abused drugs over the last 2 years;
- they must have completed a course of training on the programme, approved by the National Centre for Addictions.

Appointing the staff, the requirements to the staff of the programme and the requirements for the number of positions allowed for the programmes, are all regulated in item 7.13.2. of the Regulation to Amend Regulation 24 from 2004 for endorsing "Psychiatry" medical standard, issued by the Ministry of Health.

Pursuant to Section IV (Monitoring and Accountability of the programmes for psychosocial rehabilitation) and to Regulation № 8 **the managers of the programmes for psychosocial rehabilitation report on the activity, done under the programme, by presenting An Annual Report to the National Centre for Addictions (NCA), i**ncluding the results, the main trends, conclusions and problems that have occurred**.**

The activities done under the programmes for psychosocial rehabilitation are a subject of control by the National Centre for Addictions and by the Social Assistance Agency pursuant to Art. 86, ParA. 2 from the Drugs and Precursors Control Act and under Art. 31,Para. 2 from the Social Assistance Act.

The National Centre for Addictions monitors the activities of the programmes for psychosocial rehabilitation (particularly the residential programmes), and external experts may be involved with this, as well as representatives of the patient rights protection organizations which have been acknowledged as representative.

In February 2012 monitoring was done by Vasilis Kalabalakis (director of KETEA ITAKI - the biggest organization for rehabilitation and social reintegration in Greece) and by Fedon Kalotherakis (deputy director of KETEA) of four rehabilitation programmes, among which two residential - "Phoenix House" TC and "New Beginning" TC. The monitoring was commissioned by the National Centre for Addictions.

To assess the quality of the activity and the organization of the residential programmes in Bulgaria the following indices are used:

- satisfaction of the clients of the programmes - it is measured with surveys, client satisfaction questionnaire (SCQ 8), written balance, interviews;
- satisfaction of the programme teams-it is measured by subjective self-assessment and the microclimate of the respective programme;
- supervision of the clinical and organizational work – external (by external supervisors) and internal (administrative and organizational supervision, team meetings).

The on-going training of the teams, and the maintenance of high qualification of the staff is of considerable significance for the quality of the activity and for the organization of the residential programmes.

Trends and future development of the residential treatment

In Bulgaria the residential treatment is reviewed as part of the psychosocial rehabilitation and integration of addicted individuals and specific studies regarding it have not been conducted. There is no registry of the programmes, nor of their clients. The national system of treatment still does not encompass all the programmes in which residential treatment is offered. All this hampers the drawing of tendencies in relation to the demand of such treatment.

Nevertheless, we can assess that over the last 5 years the clients, treated in the residential programmes, numbered between 200-300 per year.

"Phoenix" TC reports, that over the 11 years they have existed they have cured more than 200 addicted to narcotic substances individuals. At the same time in 2011 there was a reduction registered of the number of positions at the therapeutic communities ("Phoenx"TC and "New Beginning" TC). There withdrawal of

[14] Source: Raicheva, Tzv., Racheva, R., Groshkova, T., Vassilev, P., Nikolova, E., Naslednikova-Rainova, R. (2009). Guidelines for good practice in the psychosocial rehabilitation of addictions, p. 21, NCA, Sofia.

patients is reported who are in the process of change, for financial reasons, because the programmes are self-supported by the taxes paid by those who participate in them. This causes lack of stability regarding systematically provided funding of the services, the activities and the maintenance of a qualified team. Regular upkeep of the premises is also necessary - extension of the space where the residents live, investments for building (constructing sewerage, repair of the premises), providing heating and other basic necessities of life.

The necessity of additional support and funding is one of the most serious problems for which the residential problems seek a solution. For this they rely on the support of the state institutions, on participation in national and international projects, and also on donations.

The phase of the re-socialization of clients with drug addictions remains problematic. Therefore the efforts of the residential programmes should be directed at the relation with institutions, at improvement of the skills of the clients in regard to the labour market (rules for applying for work, preparing a CV, etc.). The closer relationship with the local communities can also be beneficial for the residents.

The development, the stability and the efficacy of the residential programmes is related to the continuation of the implementation of the Action Plan of the National Strategy to Combat Drugs (2009-2013 г.) – Strategic Task 3 „Improving the accessibility to various and effective treatment programmes for patients", Strategic Task 6 „Development of programmes and activities for social rehabilitation and re-integration in society" and more specifically with the solving of some basic tasks:

- Extending the residential basis for admission of drug dependent individuals– establishing new departments at the health establishments for addictions with providing specialized services like psychotherapy and psychosocial rehabilitation; maintenance and development of programmes of the "Protected Home" type; increasing the number of existing therapeutic communities and support for the establishment of new ones.
- Maintaining and enhancing the qualification of the teams, working for the residential programmes – trainings and exchange of staff and residents between the residential centres in Bulgaria, as well as abroad.
- Maintaining the quality of the treatment offered and enhancing its efficacy- if possible, more residential programmes should use external supervision and regularly measure their clients' and staff satisfaction.
- Improving the interaction and the relations between the residential programmes and the other institutions in the sphere of treatment - programmes for detoxification, referral of addicted individuals in psychotic condition, etc.; as well as institutions, supporting the re-socialization of the clients- labour services, employers, etc.
- Pursuit of services, corresponding to the needs of the clients treated on the part of the residential programmes.

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CZECH REPUBLIC

PART B: SELECTED ISSUES

Selected issues are included in the Annual Report every year. The topics are set by the EMCDDA in cooperation with the focal points in the individual Reitox countries with regard to the topics' relevance and the research needs. Since last year all the countries have been required to prepare chapters on at least two selected issues, one of which is mandatory (this year it is the chapter on residential treatment for drug users), and one is selected from two options offered. The Czech National Focal Point has chosen to cover all three selected issues.

Residential Treatment for Drug Users

For the purposes of this Selected Issue, "residential treatment" is defined as treatment delivery programmes of 12 weeks or more in duration which are provided by inpatient or residential facilities and involve therapeutic and other activities for drug users. A distinctive feature of these programmes is that they address a wide range of their clients' treatment needs, including, but not limited to, the following domains: drug use, health, quality of life, and wider social functioning.

In the Czech Republic, two models of residential treatment match this definition: (1) treatment in specialised units of inpatient healthcare facilities, i.e. psychiatric hospitals and general hospitals, and (2) treatment in therapeutic communities.

In general, these two models overlap in certain aspects of their treatment philosophy, characterised by the terms "abstinence-oriented" or "drug-free" treatment (in comparison to substitution treatment), and provide their patients and clients with a basically similar range of services and professional interventions. An important common feature lies in the concept of a "structured programme", which involves not only a fixed timetable within which the services and interventions are incorporated, but also a set of rules that the treatment follows. Another converging characteristic may be seen in the principles of a therapeutic community, which are also applied to a greater or lesser extent by the specialised units of treatment institutions and hospitals.

The differences between these two models are mainly determined by their respective historical development, which, to a great degree, influenced their position within the current system of drug services, the ways in which they are funded and their quality is assured, and the structure of their patients/clients.

More detailed quantitative data about the network of facilities providing residential treatment and the clients of these services are also presented in the chapter **Error! Reference source not found.** (p. **Error! Bookmark not defined.**).

Specialised Addiction Treatment Units – the Apolinar Model

Historical Background

In the Czech Republic, the first specialised inpatient unit for the treatment of alcoholism, known as Apolinar,[15] was established in 1948 as part of the Department of Psychiatry of what is now the First Faculty of Medicine of Charles University and the General University Hospital in Prague. The unit was founded and headed until 1982 (i.e. for 34 years) by Professor Jaroslav Skála. The addiction treatment model (the Apolinar or Skála model) he conceived and developed combines the principles of collective treatment and education or a therapeutic community[16] with behavioural approaches characterised, in particular, by a strict treatment regimen featuring a system of scoring points. The Apolinar model underlines abstinence and patients' responsibilities, both individual and collective. Other core elements include regular community meetings, group therapy, working with the family, an emphasis on psychoeducation, and the enhancement of physical fitness.

With the benefit of hindsight, we can conclude that Prof. Skála created a largely independent and original approach that further developed and incorporated new ideas for over three decades of his active involvement in the field while retaining its own distinctive nature. Skála's approach inspired the establishment of addiction treatment units in a number of psychiatric hospitals (including Prague-Bohnice, Červený Dvůr,

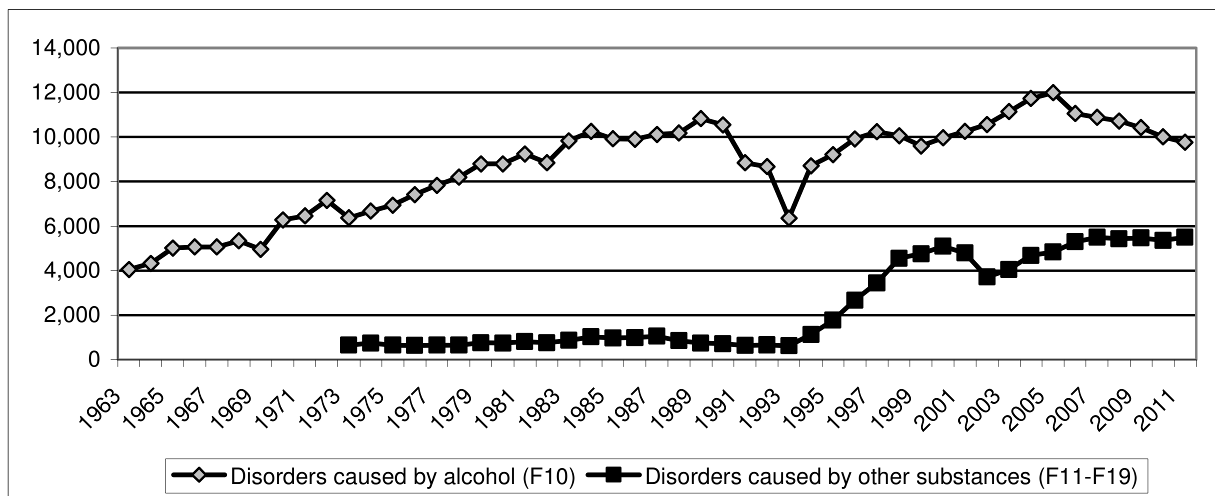
[15] The name was derived from the unit being placed in the former monastery affiliated with the Gothic church of Saint Apollinaris ("Apolinář" in Czech) situated on the outskirts of the Prague quarter known as the New Town.

[16] Skála's concept of "collective treatment and education", pursued in the early years of the Apolinar project, referred to the educational communes championed by the Soviet/Ukrainian educator A.S. Makarenko. In the 1960s Skála adopted the therapeutic community model of British provenance associated with Jones and Main. It is not really clear whether he had been acquainted with this model before or, perhaps, from the beginning (Kalina, 2008b).

Dobřany, Horní Beřkovice, Havlíčkův Brod, Jihlava, Brno-Černovice, Šternberk, and Opava) during the period from the 1950s to the 1980s.

The Apolinar model was originally designed for the treatment of alcohol dependency. Until the 1990s patients falling within this diagnostic category made up a substantial percentage of the clients of inpatient facilities of this type; patients dependent on medication (such as hypnotics, analgesics, and anxiolytics) were also admitted. A growing number of patients addicted to illegal drugs (especially opiates and methamphetamine) emerged in the early 1990s. At the beginning, this new group of clients posed considerable difficulties and provoked discussions as to whether it was appropriate to mix illicit drug users with "traditional" patients in treatment. However, the Apolinar model finally proved to be quite flexible and adaptable. Patients dependent on illicit drugs continue to account for about one third of all the clients of these units in recent years; see Graph 0-1.

Graph 0-1: Development of the number of hospitalisations for substance use disorders in psychiatric inpatient facilities according to diagnostic categories, 1963-2011 (Mravčík et al. 2011a; Nechanská, 2012c)



There were 1305 beds available to the users of both legal and illegal drugs in psychiatric hospitals in 2011; see the chapter **Error! Reference source not found.** (p. **Error! Bookmark not defined.**). However, this number should not be identified with the real capacity of specialised treatment wards. In addition to units dedicated to institutional detoxification, there are inpatient departments providing treatment programmes that are not fully structured. The people admitted to the latter include chronic users, patients who are not motivated or suited to undergoing the full treatment programme for various reasons, patients who are waiting for enrolment in such a programme, and those who were excluded from it. In the Czech Republic, there are 10 to 12 specialised therapeutic units (with the exception of the Apolinar centre at the General University Hospital in Prague, they are all parts of psychiatric hospitals) that provide treatment based on the philosophy of the Apolinar model, with a total capacity of approximately 800 beds.

While operating in a largely unified manner until 1990, these units currently show certain divergent tendencies. Some of these facilities continue to adhere to the Apolinar model (Dr. Petr Popov, Apolinar's present-day head physician, describes it as "regimen-based treatment following the principles of a therapeutic community"[17]) or place more emphasis on the regimen rather than the principles of a therapeutic community, while others seem to be more inclined to pursue the therapeutic community model. Nevertheless, the Apolinar approach may still be considered one of the two principal modalities of residential treatment in the Czech Republic, despite the fact that such a distinction may not always be perfectly accurate.

[17] Popov, personal communication, 2009. Its founder, however, regarded *Apolinar* as a therapeutic community with no further attributes needed (Skála et al., 1987). In the 1990s *Apolinar* separated from the Psychiatric Department to become an independent addiction treatment unit of the General University Hospital in Prague. Since 2012 it has been a clinical base for the Department of Addictology of the First Faculty of Medicine of Charles University and the General University Hospital.

Latest Developments

The Apolinar approach basically follows the *medical, bio-behavioural* model. Institutionally, it stems from health care; almost all the specialised units are parts of psychiatric hospitals directly administered by the Ministry of Health.[18] Treatment is covered by the public health insurance system.
According to the ASAM criteria (American Society for Addiction Medicine, 2006), this type of treatment should be managed by a physician. The physician in charge is usually a psychiatrist with a specialisation in addiction medicine. Given its nature, treatment should be provided by a multidisciplinary team comprised mostly of health professionals. In addition to physicians, mid-level health staff, and clinical psychologists, the therapeutic team may include other mental health practitioners with relevant expertise, social workers, labour therapists, and addictologists (Dvořáček, 2003; Společnost pro návykové nemoci ČLS JEP and Klinika adiktologie 1. LF UK a VFN v Praze, 2012).
As regards duration, it is referred to as *medium-term institutional treatment* lasting 3-6 months[19] (Dvořáček, 2003; Kalina, 2003). Some facilities apply the 3-month period to dependency on legal drugs, while a longer period is allowed for illicit drug addiction; it is not a general rule, though. In practice, the length of treatment is flexible. According to Dvořáček, it results from the assessment of multiple factors, such as the quality of the client's collaboration with treatment, the progress of the treatment process, the presence of any physical or psychological complications and the need for special care, the results of any previous therapeutic attempts, a premorbid personality, the level of seriousness of social and health consequences, the possibility of aftercare in the patient's original environment, and the quality of their social setting. Although some of these factors may be expressed in objective terms, there is no specific matter-of-fact clue as to how to determine the ideal length of the treatment.
The terms "rehabilitation" or "abstinence treatment" are used to refer to the nature and focus of the treatment. The principal goals of the treatment are to achieve and maintain abstinence, stabilise the patients' psychological and physical conditions, and reintegrate them into the community to the greatest degree possible (Společnost pro návykové nemoci ČLS JEP and Klinika adiktologie 1. LF UK a VFN v Praze, 2012). The comprehensive structured programme[20] encompasses therapeutic activities involving medical care (including pharmacotherapy), psychotherapy, education, and social reintegration-related and leisure activities. Work with the family, an important legacy of the Apolinar model, is also incorporated.
As mentioned earlier, alcohol users account for two thirds of the patients, while one third comprises users of drugs other than alcohol, among which methamphetamine continues to predominate over opiates/opioids; polydrug use (dg. 19) is also diagnosed very often (whether correctly or not). Patients diagnosed with pathological gambling (dg. F63.0) are admitted too. An increase in the number of psychiatric comorbidities (dual diagnoses) has been observed, although more specific data are not available; see also the chapter **Error! Reference source not found.** (p. **Error! Bookmark not defined.**).

Treatment Goals

The goals should reflect the length of the programme and the patient's needs. The goal that has been formulated the most frequently (especially with respect to the original Apolinar model) is sustained and consistent abstinence from all addictive substances. Dvořáček (2003) suggests that it takes great therapeutic skills to find an ideal balance between this recommendation, which presents the safest way while best inducing abstinence norms within the treatment community, and an attitude to relapse that does not burden the patient with an unnecessary sense of guilt connected to their failing in their efforts and thus does not worsen their situation by placing excessive demands on them. Abstinence is considered to be not only a goal, but also a means of achieving a higher level of perceived quality of life and resuming the patient's previous social roles to the maximum degree possible; in practice, however, abstinence is highlighted as a goal.
In addition, Dvořáček (2003) presents a set of progressive or partial goals (objectives):

- to stabilise secondary addiction-related problems,
- to develop an insight (to recognise addiction as a problem and to realise its consequences and the steps that need to be taken to compensate for them, including the acceptance of the need to undergo long-term treatment and adhere to certain rules afterwards),
- to adopt progressive measures to address the consequences of the patient's drug career, or to begin to tackle their substance use-related problems,
- to reframe the motivation (from the original external pressure to internal, positively formulated motivation),
- to internalise abstinence norms,

[18] With the exception of the private mental health hospital PATEB s.r.o., situated in the town of Jemnice.
[19] The current practice is rather 3-4 months. Any treatment lasting less than 3 months is usually referred to as short-term treatment or extended detoxification. This form has not been very common in the Czech Republic so far. Three months are considered a minimum period for effective residential treatment (Dvořáček, 2003; Kalina, 2008a).
[20] A structured programme consists of a minimum of 20 hours of structured activities per week distributed over a minimum of five days (Dvořáček, 2003; Kalina, 2003).

- to internalise the structures of the day and the week (especially the time structures associated with the development of the ability not to respond compulsively to both pleasurable and unpleasurable situations),
- to address in parallel other problems that are not directly related to addiction (such as to initiate treatment of any concurrent mental disorders),
- to identify the risks of relapse and develop strategies for minimising such risks,
- to bring about changes in the original social environment (e.g. avoiding risk-posing jobs, friends, recreational settings, etc.),
- to achieve a reasonable increase in the level of self-esteem and experiencing.

The goals cannot always be accomplished because there is a relatively high percentage of patients with other significant mental health and social issues, as well as those who drop out of the treatment programme. According to Dvořáček, a treatment facility must be able to offer help in seeking to achieve the partial and temporary objectives which are more realistic at a given point. Such objectives may include social stabilisation with referral to other services, stabilisation prior to entering a substitution programme, and education in harm reduction.

Treatment Process and Strategy

As stated above, treatment is based on a structured programme. Dvořáček (2003) explains that a structure applies to:

- the course of treatment: it is divided into several stages with boundaries of varying explicitness,
- the week: the structure of the week assures the well-balanced composition of the programme; all the segments making up the comprehensive programme, encompassing the required minimum of 20 structured hours per week, are applied over a period of one week,
- the day: each activity is performed according to a specific timetable.

The structured programme consists of a balanced body of activities, including psychotherapy (mainly group psychotherapy), work, and recreation. In addition to ensuring the balance and stability of the comprehensive programme, the structure also makes it easier to follow patients' daily activities and the progress of their treatment.
"Treatment structure is closely linked to a set of rules – a regimen," Dvořáček continues (2003, p. 196). "In addition to defining the structure and rules necessary to maintain an ideal therapeutic environment, the regimen also allows for benefits and sanctions, depending on the extent to which the regimen is observed. (…) The majority of the treatment facilities try to objectify and evaluate the way in which the patients cope with the structure and the regimen, mostly using a scoring system. In its elaborated form, the scoring system involves a set of rules against which compliance with structured treatment is evaluated using positive and negative points which entail various advantages or disadvantages for the patient or the group he or she belongs to (as well as the community). In this form, the scoring system serves as one of the tools used for the weekly evaluation of the course of treatment."

Referral and Follow-up

Patients are usually referred to medium-term treatment by outpatient physicians; motivated patients with a relevant diagnosis may also be admitted without a medical referral.
Dvořáček (2003) suggests that a specific aftercare plan is a key element of the final stage of the therapy. Some patients join long-term programmes provided by therapeutic communities or various intermediary programmes (such as aftercare centres with sheltered housing and day care facilities) after they have finished medium-term treatment. However, such services for clients in recovery from legal substances are scarce. They thus usually return to their original environment, where aftercare is provided in the outpatient form. Some treatment facilities organise aftercare groups for their former patients, as well as providing "booster stays" as elements of aftercare, usually within the first year of recovery, or later, as appropriate.

Therapeutic Communities – the Sananim Model

Historical Background

The first therapeutic community (TC) for drug addicts in the Czech Republic was founded by Dr. Martina Těmínová and her co-workers from the SANANIM civic association in the village of Němčice, South Bohemia, in 1991. At that time it was becoming obvious that the Apolinar model of alcohol dependency treatment was not really suitable for young people with immature personalities who had developed an addiction to illicit drugs. The Němčice therapeutic community was established in order to offer a new service to this emerging and growing group of clients.
The founders of the Němčice TC were young special education professionals with a background of working in youth institutions. They established the community on a non-healthcare basis, as a facility with a focus on social rehabilitation and education, featuring a psychotherapeutic element. In part, they drew inspiration from

their knowledge of "hierarchic" therapeutic communities for drug addicts, but they also made good use of the national tradition of "democratic" therapeutic communities, which they espoused.[21] It was this tradition that provided the natural professional basis for the development of communities for drug addicts in the Czech Republic. Professional expertise was emphasised from the very beginning. Therapeutic communities founded by ex-users were rare and were either closed down or professionalised over time.
The Sananim model (Těmínová, 1997) became an example to follow for a number of other communities for people dependent on illegal drugs that came into being in the 1990s. A total of 20 therapeutic communities were established during that period; some of them ceased to exist, others have stayed away from the mainstream providers of professional care. The data on the current numbers of these facilities vary according to different sources[22] – the members of the Therapeutic Communities Section of the Association of NGOs,[23] i.e. 11 therapeutic communities with an overall capacity of 490 beds, may be regarded as the mainstream providers of these services; see Table 0-1.

There are at least five additional establishments in the Czech Republic that refer to themselves as therapeutic communities. They were created on an ex-user or religious basis and maintain contact with neither the professional community nor public authorities. Apart from the often misleading information posted on their websites, nothing is known about them and they are generally regarded as not being credible in professional terms, which does not necessarily mean that they cannot be useful.
The broader circle of therapeutic communities may also be seen as including five residential special education establishments for juvenile substance users with emotional and behavioural problems, with a total capacity of 68 beds; for more details see the chapter **Error! Reference source not found.** (p. **Error! Bookmark not defined.**). In fact they represent the type of services where the idea of therapeutic communities for drug addicts in the Czech Republic was conceived in the 1990s. Most of these facilities show close links to the Sananim model and apparently developed under its influence. Their staff, or managers at least, are in contact with the professional community. Nevertheless, such services do not meet the criteria for residential treatment models as envisaged in this chapter.[24]

Table 0-1: Therapeutic communities for drug addicts in the Czech Republic associated in the Therapeutic Communities Section of the Association of NGOs

Name	Municipality	Region	Operated by:
TK Advaita	Nová Ves – Chrastava	Liberec	*Advaita*, a civic association
TK Fénix	Bílá Voda	Olomouc	Bílá Voda Psychiatric Hospital
TK Fides	Bílá Voda	Olomouc	Bílá Voda Psychiatric Hospital
TK Krok	Kyjov	South Moravia	*Krok*, a civic association
TK Magdaléna	Mníšek pod Brdy	Central Bohemia	*Magdaléna*, a public service company
TK Podcestný mlýn	Kostelní Vydří	South Bohemia	*Sdružení Podané ruce*, a civic association
TK Renarkon	Čeladná	Moravia-Silesia	*Renarkon*, a public service company
TK Karlov	Karlov – Čimelice	South Bohemia	*SANANIM*, a civic association
TK Němčice	Němčice u Volyně	South Bohemia	*SANANIM*, a civic association
TK Sejřek	Sejřek	Vysočina	*Kolpingovo dílo*, a civic association
TK White Light	Mukařov – Úštěk	Ústí nad Labem	White Light I., a civic association

In the last decade some therapeutic communities have catered to certain types of clients with specific needs, including mothers with small children, very young clients, long-term users with a criminal history, and clients with dual diagnoses.

[21] Foreign TCs for drug addicts that served as model examples included the North American Daytop Village and Phoenix House projects, and also MONAR in Poland. The domestic tradition was represented especially by the Lobeč and Palata psychotherapeutic communities, Kratochvíl's centre at the Kroměříž Psychiatric Hospital, and, last but not least, the SUR psychotherapeutic training communities (Kalina, 2008b; Kalina, 2011).
[22] Kalina refers to 13-14 therapeutic communities of this type (Kalina, 2006; Kalina, 2007a; Kalina, 2008b). The chapter **Error! Reference source not found.** (**Error! Reference source not found.**) indicates 15-20 TCs; 14 programmes identified as therapeutic communities are listed by the Register of Social Service Providers maintained by the Ministry of Labour and Social Affairs, 9-10 programmes receive support from the Government Council for Drug Policy Coordination as part of its subsidy proceedings, the Therapeutic Communities Section of the Association of NGOs has 11 members, and the 2012 Drug Services Census recorded 16 facilities that claim to operate a therapeutic community programme.
[23] http://www.terapeutickekomunity.org (2012-07-07)
[24] They involve the application of therapeutic community approaches in residential educational facilities ("TC approach" according to Kennard, 1998), which cannot be regarded as "treatment".

Therapeutic communities are generally said to have their own peculiar culture and distinctive identity (see Kennard, 1998). This also largely applies to the Czech TCs for drug addicts, which came into being in new times, as autonomous projects, with no guidelines recommended or required on a top-down basis. Despite the above-mentioned diversity of character, the therapeutic communities' operation shows rather converging tendencies that are facilitated by meeting together as part of the activities of the Therapeutic Communities Section of the Association of NGOs, joint events, and impressive publication activities in the past decade. It does make sense, therefore, to talk about a model, despite certain inconsistencies.

Latest Developments

The Sananim model is based on an *interdisciplinary, bio-psycho-social* approach.[25] Institutionally, it falls within the sector of social services for administrative reasons. With several exceptions, therapeutic communities are registered as social services, operated by NGOs (civic associations and public service companies), and receive financial resources from national and regional public subsidies. However, the formal affiliation of therapeutic communities with social services reflects neither their distinctive identity, nor the real nature of the activities they are develop.[26] The policy document covering addiction health services stipulates that in the light of the comprehensive approach to patients embraced by addictological services it is insufficient to define the nature of therapeutic communities from the social perspective only (Společnost pro návykové nemoci ČLS JEP and Klinika adiktologie 1. LF UK a VFN v Praze, 2012).

In terms of the ASAM criteria (ASAM, 2006), this type of treatment should be carried out *under medical supervision*; a physician-psychiatrist or a specialist in addiction medicine is not generally the head of the facility, but a member of the team or a contracted consultant. The therapeutic team is typically multidisciplinary, comprising both health and non-health professions (Adameček et al. 2003; Společnost pro návykové nemoci ČLS JEP and Klinika adiktologie 1. LF UK a VFN v Praze, 2012). The new paramedical (health, non-medical) profession of an addictologist has been gaining significance within the therapeutic communities' teams recently, as the involvement of these practitioners draws therapeutic communities nearer to the bio-psycho-social model of services grounded in health care, which is where they belong much more than to the less comprehensive social model.

As regards duration, it is referred to as *medium-term to long-term residential treatment* lasting 6-12, or up to 15 months (Adameček et al. 2003; Kalina, 2003). The planning of the length of treatment is sometimes made with the needs of specific client groups being taken into consideration, e.g. six months for juveniles and young adults, eight months for dependent mothers with small children, and 12 months or more for older long-term users. A 12-month programme, nevertheless, is generally regarded as a mainstream standard. In a specific community, the length of the programme is not flexible. It is set in advance and is a subject of the contract with the client.[27]

A therapeutic community-based treatment programme of any duration is always divided into "stages" (see further below).

As for the nature and focus of the treatment, therapeutic communities are drug-free and are intended to promote and motivate their clients to a drug-free life; the term "abstinence-oriented treatment" is also used in relation to this approach. Although, similarly to the Apolinar model, their immediate goals are to achieve and maintain abstinence, stabilise the patients' psychological and physical conditions, and reintegrate them into the community to the greatest degree possible, (Společnost pro návykové nemoci ČLS JEP and Klinika adiktologie 1. LF UK a VFN v Praze, 2012), therapeutic communities place a greater emphasis on personality changes (involving growth, maturing, and the influencing of underlying personality problems that contribute to the development and maintenance of addiction) and lifestyle-related changes; abstinence is not the aim, but a vehicle to achieve those changes, a precondition that needs to be met, although not sufficient in itself (Adameček et al. 2003; Kalina, 2008b); (Kalina, 2008a) Skála defined the notion of abstinence in similar terms (1987).

The comprehensive structured programme[28] encompasses therapeutic activities involving psychotherapy (mainly group therapy), education, and social reintegration-related and leisure activities. In comparison to the Apolinar model, much more stress is placed on self-help and self-management, which mostly involves the clients' participation in, and responsibility for, the everyday life of the community. Medical interventions, including pharmacotherapy for mental problems, are common and necessary given the structure of the

[25] In Czech addictology, the three-dimensional bio-psycho-social notion of a human being, illness, and treatment according to the WHO is expanded to include a fourth dimension – the spiritual or existential one.

[26] Indeed, some therapeutic communities for drug-dependent individuals exist within the healthcare modalities of psychiatric hospitals.

[27] The client makes an informed entry into a treatment programme of a specific duration. At the final stage of treatment, nevertheless, earlier completion without the completion ritual and progress to aftercare are often negotiated on an individual basis.

[28] As in the Apolinar model, this term refers to a programme consisting of a minimum of 20 hours of structured activities per week distributed over a minimum of five days (Adameček et al. 2003; Kalina, 2003).

clients (see further below). Various forms of work with clients' family members and significant others are also common.
Therapeutic communities in the Czech Republic are primarily intended for users of illicit drugs. Similarly to illicit drug users in psychiatric hospitals, in therapeutic communities, too, users of methamphetamine outnumber those of opiates/opioids (the ratio ranging from 2:1 to 3:1, depending on the region). The rate of cannabis and cocaine users is very low. While clients who are dependent solely on alcohol or pills are rare in facilities funded by public subsidies, the number of polydrug users, both legal and illegal drugs, sometimes also in combination with gambling, seems to be rising. The rate of dual diagnoses in terms of psychiatric comorbidities is reported to be from 30 to 50% according to different sources (Miovská et al. 2008; Kalina et al. 2012).

Treatment Goals

To a great extent, the immediate goals of the treatment provided by therapeutic communities coincide with what Dvořáček (see above) stated in relation to medium-term treatment of the Apolinar model. According to Adameček et al. (2003), abstinence is not the aim of treatment in a therapeutic community, it is only a way, a means and an integral part of recovery. It is the precondition for the client's future reintegration into normal life. Treatment in therapeutic communities aims towards a change in lifestyle which may be achieved through personality growth and a change in self-concept, experiencing, behaviour, and relationships.
The above-cited authors point out the following partial goals, or objectives, of treatment in therapeutic communities:

- to empower clients, enhance their resilience and coping skills, and prepare them to "fight craving" on a daily basis,
- to change clients' patterns of self-destructive thinking and behaviour,
- to promote the development of clients' sense of personal responsibility for themselves, their decisions, and other people,
- to develop a sense and feeling of human community among clients,
- to help clients learn basic social skills, communication skills, and conflict management skills,
- to help clients adopt work and hygiene routines,
- to promote changes in clients' negative self-concept and encourage their self-acceptance and the adoption of realistic self-perception,
- to provide an environment in which a human being can grow, assume responsibility, and engage in personal development,
- to promote clients' awareness of the importance of their health and the improvement and maintenance of their physical condition.

Highlighting the existential dimension of treatment and recovery, Richterová-Těmínová postulates the aims of therapeutic community-based treatment as follows (Richterová Těmínová, 2007):

- to promote clients' finding and accepting the meanings of their own lives,
- to promote clients' finding their own freedoms and responsibilities,
- to promote clients' knowing and accepting themselves and their potential and limits,
- to promote clients' personal growth, development, and confidence,
- to promote clients' finding their place within a community of people,
- to promote clients' developing positive and creative life attitudes,
- to contribute to clients' contentment and happy lives,
- to promote clients' developing and improving the knowledge, abilities, and skills needed to achieve their personal goals.

Treatment Process and Strategy

The client's stay in a therapeutic community is divided into four stages (an extra zero stage is common in the Czech Republic) which correspond to the progress of their treatment. Each stage is also associated with expectations as to what the clients are capable of and their responsibilities ensuing from their functioning and the roles they have in the community (Adameček, 2007; Kalina, 2008b).
The therapeutic drug treatment community model and method are thoroughly described in the professional literature (De Leon, 2000; De Leon, 2001; De Leon, 2005). Despite their different tradition, Czech therapeutic communities generally fit within this universal framework. They are, however, less "hierarchic", less confrontational, and managed on a more professional basis. This may be demonstrated by the fact that Czech therapeutic communities do not use the confrontational Synanom Encounter technique,[29] but their psychotherapeutic work stems from group psychotherapy based on psychodynamic and interpersonal approaches, complemented by the flexible utilisation of cognitive-behavioural methods.

[29] An encounter group technique applied in the first therapeutic communities for drug addicts in the USA.

While the scoring system in the form peculiar to the Apolinar model is not used, therapeutic communities apply a few fundamental “cardinal” house rules: no drug use or any handling of them, no violent behaviour, submission to the community’s decisions, and no sexual relationships. The violation of any of the cardinal rules results in a client’s being expelled from the programme. In addition to the above, there are other rules, the violations of which result in less severe sanctions; each case is openly discussed, and it is the group feedback rather than sanctions that has an impact on the client’s inappropriate or dysfunctional behaviour (Adameček, 2007; Kalina, 2008b).

Referral and Follow-up

Admission to a therapeutic community does not require medical referral. Common referral sources include low-threshold drop-in centres, which also perform pre-treatment counselling and motivational interviewing and, in general, serve as screening facilities. The precondition for referral is the client’s undergoing of institutional detoxification immediately prior to their entering a therapeutic community. Other referrals include clients who decide to undergo treatment in a TC during or after their medium-term treatment in a psychiatric hospital.[30] Under all circumstances, however, any applicant for admission to a therapeutic community must show a personal interest and send a cover letter and CV. There are waiting lists for practically all the therapeutic communities.

After completing their treatment in TCs, clients are usually referred to aftercare centres, where they can also use the offer of sheltered housing. The repeated treatment episode common in the Apolinar model (see above) is rather exceptional in therapeutic communities.

Comparing the Apolinar and Sananim Models

In terms of the quality and effectiveness of treatment, both models display mutual differences which are largely associated with the requirements placed on service providers on the part of the government authorities, including care funders. The characteristics of both models are summarised in Table 0-2.

Table 0-2: Two models of residential treatment in the Czech Republic

Indicator	Specialised units in hospitals and treatment institutions	Therapeutic communities
Sector – providers	Hospitals and psychiatric institutions managed by the central or local governments and other legal entities	Mostly not-for-profit non-governmental organisations
Registration	Health services	Mostly social services
Funding	Public health insurance	National and regional subsidies
General description of the model	Medical, bio-behavioural	Interdisciplinary, bio-psycho-social
Type of treatment according to ASAM	Medically managed treatment	Medically supervised treatment
Patients/clients	Users of both legal and illegal drugs	Users of illegal drugs
Length of treatment	Medium-term: 3-4 (up to 6) months	Medium- to long-term: 6-15 months (mostly 12)
Quality assurance system	Public hospital accreditation	Certification of professional competency Inspection of social services
Special standards	Non-existent in the accreditation system	The certification system includes a special standard for therapeutic communities
Independent supervision	Rare	Common, required
Process and outcome monitoring	Rare	Regular
Relationship with the general therapeutic community model	Use of certain approaches and principles	Full use of the TC model and method

Quality Assurance

As providers of health services, since April 2012 specialised addiction treatment units in hospitals and psychiatric institutions have been governed by the stipulations of a new legal regulation, Act No. 372/2011

[30] Neither short-term nor medium-term institutional treatment is, however, a precondition for entering treatment in a therapeutic community (Společnost pro návykové nemoci ČLS JEP and Klinika adiktologie 1. LF UK a VFN v Praze, 2012).

Coll., which introduces both obligatory internal evaluation of quality, to be performed by an organisation that is a provider of health services itself, and voluntary external evaluation of quality, which may be performed only by a competent individual who posses an authorisation issued by the Ministry of Health.
The internal evaluation of quality is covered by a methodological guideline entitled the Minimum Requirements for Establishing an Internal System of the Evaluation of the Quality and Safety of Health Services. The external evaluation of quality in inpatient healthcare facilities is generally regulated by Decree No.102/2012 Coll., on the evaluation of the quality and safety of inpatient health care. No decree in relation to outpatient services has been issued yet.
Until recently the external evaluation of quality in Czech healthcare facilities was carried out under the departmental health care quality and safety programme which had formulated quality standards for hospitals and treatment institutions audited by the Joint Accreditation Commission (SAK), a public service company, as part of its accreditation process. The Joint Accreditation Commission is always concerned with a hospital or treatment institution as a whole and mainly looks into areas such as the necessary human and technical resources, records management and security, sanitation and the prevention of hospital infections, and the observation of patients' rights. The accreditation system of the Joint Accreditation Commission (and the system of public health care in general) does not encompass any regulation or standard that lays down how drug rehabilitation should be performed so as to be effective. Thus, there is no benchmark for assessing whether a unit meets the criteria for good practice in addiction treatment. Neither have the public health insurers which reimburse the treatment established and applied such criteria.
Therapeutic communities that apply for public funding must have their professional competency certified according to the relevant standards of professional competency for drug services (the so-called GCDPC Certification Standards); see also the chapter **Error! Reference source not found.** (p. **Error! Bookmark not defined.**) and the respective Selected Issue chapter in the 2009 Annual Report. The General Part of the Standards concerns basically the same parameters as the accreditation requirements of the Joint Accreditation Commission. The Special Part, however, includes a standard for residential treatment in therapeutic communities, executed as a set of specific good practice criteria for this type of treatment which a facility must comply with in order to be certified.
The Special Part of the Certification Standards also contains a standard for medium-term institutional treatment, i.e. for the Apolinar model, but this remains basically unused; only two programmes hold valid certificates[31] – see **Error! Reference source not found.** on page **Error! Bookmark not defined.**. Hospitals and treatment institutions do not generally apply for certification, as they do not demand subsidies, so it is not known to what extent the specialised units following the Apolinar model are in fact compliant with the applicable standard.[32] On the other hand, certification has been passed by some therapeutic communities which do not rely on subsidies.
Therapeutic communities registered as social facilities are subject to mandatory inspection of social services (see also the relevant Selected Issue in the 2009 Annual Report). However, this process involves no specific criteria for good practice of therapeutic communities and its true relevance for the professional quality of their services is debatable. The sharing of experience and feedback among fellow-practitioners within the professional platform provided by the Therapeutic Communities Section of the Association of NGOs appears to be of much greater significance in this respect. It is noteworthy that the Apolinar model has been dramatically lacking such a facility recently.

Independent Supervision

Independent qualified supervision is another means of assuring and enhancing the quality of professional services.
In Czech therapeutic communities (as in other addiction treatment professional services provided by non-governmental organisations), supervision has enjoyed a long tradition and advanced culture (Broža, 2009). First and foremost, supervision is performed by supervisors who have received training in integrated supervision provided by the Czech Institute for Supervision under the international aegis of the European Association for Supervision (EAS). Since 2005 supervision has been required by the certification standards, but both providers of services and funders had discovered its importance long before that. As in many other cases, it was NGOs that pioneered good practice in this area.
In the Apolinar model, this type of supervision was rare for a long time; with several exemplary exceptions, it was met with mixed feelings or even rejected as incompatible with the traditional structure of hospitals and

[31] It is symptomatic that this applies to the men's and women's units of the Apolinar centre.
[32] While Dvořáček (2003) considered the preliminary version of the standard for medium-term institutional treatment authoritative, the credit of these standards has somewhat declined since then. Certification is considered an entrance ticket to certain funding programmes rather than a token of quality. Nevertheless, the Society for Addictive Diseases of the J.E. Purkyně Czech Medical Association endorses the Certification Standards (Společnost pro návykové nemoci ČLS JEP and Klinika adiktologie 1. LF UK a VFN v Praze, 2012) and is considering assuming greater responsibility for the process of certification, which has hitherto been in the remit of the Government Council for Drug Policy Coordination.

treatment institutions featuring a hierarchy topped by the head physician vested with exclusive competences of professional supervision in his or her workplace. The situation seems to have undergone certain changes in recent years as head physicians have come to terms with the idea that independent supervision may be useful.

Treatment Process and Outcome Monitoring

Therapeutic communities collect detailed statistical data about their clients and the services they provide and report their aggregates to donors. Some of these data are also used to monitor the process and outcomes of treatment and thus provide relevant information indicative of the level of effectiveness of the treatment (including that about retention rate, early termination of treatment during the first period of the stay, and time spent in the programme; see the chapter **Error! Reference source not found.** (p. **Error! Bookmark not defined.**), **Error! Reference source not found.**. While beneficiaries of public funding are required to collect and report such data, therapeutic communities also use them for their own purposes as feedback on their performance. The Therapeutic Communities Section of the Association of NGOs uses and discuss these data too.[33] Some TCs also carry out follow-up surveys which are subsequently published in their annual reports. Formal research studies have also been conducted (Kalina, 2007a; Kalina, 2007b; Šefránek, 2012); see also the chapter **Error! Reference source not found.** (p. **Error! Bookmark not defined.**).
In comparison to the targeted reporting mentioned above, statistical data from the Apolinar-type residential treatment units are available from the general National Register of Hospitalisations, which records only some of the data reflecting the treatment process and outcomes, including the length of hospitalisation, the reason for the termination of hospitalisation, and the need for follow-up care after discharge (Nechanská, 2012c). However, the specialised addiction treatment units perform no monitoring of their own, and neither their managing agency (Ministry of Health) nor public funders (health insurers) require this practice from them. Follow-up surveys or research studies are virtually non-existent, despite the fact that Skála's *Apolinar* was a facility that pioneered research into the effectiveness of addiction treatment prior to 1990. It is therefore very difficult to assess whether, and to what extent, the Apolinar model works.

Scoring System

The scoring system represents a specific tradition and almost an identifying symbol of the Apolinar model. It may be seen as an equivalent of the conventional behavioural "token economy", currently known as contingency management (Gossop, 2009). In comparison to these well-established schemes, the Apolinar scoring system features negative points associated with sanctions, which the behavioural approaches to addiction treatment regard as counterproductive (Rotgers, 1999). Scoring systems tend to be very complex; usually only the staff can make sense of them. Points are scored automatically. In some establishments, a patient may be discharged from treatment after exceeding a certain threshold number of points, irrespective of the severity of the instances of their non-compliance with the regimen. Even its founder would make critical comments about the scoring system (Skála et al., 1987). Dvořáček (2003) suggests that it may end up causing an imbalance between penalties and rewards and, from a certain moment (particularly when sanctions accumulate), the loss of its therapeutic effect. Both criticism and advocacy of this tradition were summarised by Mladá (2012), who also reported that some units had already abandoned the practice of scoring systems (Mladá, 2012).
Therapeutic communities have not been using this scoring system at all, as it is considered incompatible with the principles of a therapeutic community and its effectiveness is not evidence-based.

Application of the Therapeutic Community Principles

Both Czech models of the residential treatment of drug addiction have subscribed to the therapeutic community approach, although their specific history, background, and sources make them distinct from international developments and, mutually, each other. The question is to what degree both models apply the TC principles and approaches, what their profile is, and, accordingly, to what extent the requirements for the provision of standard treatment with proper results are met.
This question was explored as part of a survey undertaken by Kalina in 2006 (Kalina, 2006; Kalina, 2007a). The survey was based on a cumulative questionnaire compiled from two inventories – the SEEQ scale (De Leon and Melnick, 1993) used to cover the items relevant for "generic" therapeutic communities for drug addicts in the USA, and the KLAC checklist intended for European TCs focusing on personality and behavioural disorders, particularly on severe mental disorders without the involvement of addiction issues (Kennard and Lees, 2001). The questionnaire was completed by a total of 24 residential treatment facilities, including 13 therapeutic communities for drug addicts and 11 specialised hospital-based units embracing the

[33] Recent discussions concern the circumstances under which treatment in a therapeutic community may be considered "successfully completed": whether this applies to treatment completed with a ritual after Stage 3 or whether it also covers the so-called "planned departure" for medical, employment, or family reasons during Stage 3, where the client may pass the completion ritual later after he or she has successfully completed an aftercare programme.

Apolinar model and, accordingly, the principles of a therapeutic community. Only the major findings are presented below.
The vast majority of therapeutic communities was found to be in compliance with the internationally recognised criteria for therapeutic communities for drug users to a high standard and most of them also attained satisfactory results in terms of the internationally recognised criteria for therapeutic communities addressing personality and behavioural disorders.
Only about a half of the specialised hospital-based units (6 out of 11) reached satisfactory or high levels of compliance with the internationally recognised criteria for therapeutic communities for drug users, and only a minority of them (4 out of 11) met the internationally recognised criteria for therapeutic communities intended for personality and behavioural disorders to a satisfactory degree. Differences from therapeutic communities were found especially in the domains relevant to the appropriate therapeutic approach to dependent individuals and the comprehensive approach to the treatment of clients with multiple mental health problems. For example, significant differences were found in the items pertaining to the understanding of substance misuse, the nature of addiction and patients'/clients' problems, and treatment goals (Table 0-3) and in the items that concern the understanding of the general community and team processes, such as open communication, the accountability and transparency of decision making, maintaining boundaries and security concerns, the mutual learning process, and intensive teamwork.
The results suggest that the therapeutic communities can provide standard addiction treatment with the expectations of certain results, as well as being able to address the ever more complex problems displayed by their clients (including dealing effectively with the issue of the integrated treatment of dual diagnoses). In comparison to therapeutic communities, specialised drug addiction units of the Apolinar type show fewer characteristics of the effective profile which is a prerequisite for standard treatment with predictable results and fewer characteristics indicating their capacities to cope with the psychological complications of addiction.[34]
Naturally, today's Apolinar model is not a pure therapeutic community, much as the founder of *Apolinar* was a devotee of this concept (see Skála, 1987); it rather corresponds to the "TC approach" modality (Kennard, 1998).[35] Dvořáček (2003) notes that the application of TC approaches in medium-term institutional treatment always involves a compromise between the principles of a therapeutic community and the traditional hierarchical system of inpatient healthcare facilities. The author further states: "Given the specific characteristics of medium-term treatment (including the relatively high rate of patient turnover, less screening for eligibility for admission, and the medical nature of the facility), only some features that are typical of therapeutic communities can usually be retained."

[34] The latter finding, in particular, is striking. One would expect the opposite, given the medical and psychiatric background of the Apolinar model. Nešpor, a leading author concerned with this area, confirms that the integrated treatment of dual diagnoses, i.e. treatment provided by a single team within a single programme, is preferred to other forms, such as concurrent or subsequent treatment (Nešpor, 2003). He adds: "The treatment of a dual diagnosis patient also places specific demands on the team and interdisciplinary liaison. Not only does this apply to the team's theoretical preparation but also to greater flexibility, higher tolerance of frustration, and good communication and collaboration between physicians, psychologists, social workers, and other practitioners." The experience of psychiatrists working with therapeutic communities (as learnt from discharge reports and clients' statements) indicates that the treatment units following the Apolinar model do not pay much attention to the integrated treatment of dual diagnoses (with the exception of the symptomatic administration of psychopharmaceuticals, mostly little justified in diagnostic terms) and often refuse to accept dual diagnosis patients or discontinue their treatment.
[35] The author distinguishes between "TC proper" and "TC approach", i.e. the application of certain approaches in different contexts. This does not necessarily reduce the value of the "TC approach" modality, especially in view of the fact that, in the Czech Republic, no "TC approach" can be found in the vast majority of psychiatric wards of hospitals and mental health institutions other than those intended for drug treatment.

Table 0-3: Items showing the greatest differences between therapeutic communities and hospital-based specialised units (the first 10 items of the SEEQ inventory)

A	**View of the Addictive Disorder**
1	Substance abuse reflects a general problem of coping.
2	Substance abuse is a disorder of the whole person.
3	Substance abuse is a symptom, not the essence of the disorder.
4	The treatment problem to be addressed is not the drug, but the person.
B	**View of the Addict**
1	Substance abuse stems from other, more general problems, such as psychological and developmental ones.
2	Immaturity, conduct or character problems, and low self-esteem are typical psychological features of substance abusers.
3	The pattern of drug use is less important than the psychological and behavioural disorders.
C	**View of Recovery**
1	Recovery involves a global change in self-esteem, behaviour, and lifestyle.
2	Recovery involves the development of a personal identity and global change in lifestyle, including conduct, attitudes, and values.
3	Abstinence from psychoactive drugs is a prerequisite for sustained recovery.

Conclusions

Alongside the traditional Apolinar model, another, autonomous residential treatment model has been formed in the past twenty years. Despite their mutual differences, or, perhaps, thanks to them, these two models of residential care for drug addicts in the Czech Republic provide a unique opportunity to choose for patients/clients seeking treatment and for case management.

Both models have experienced rather dynamic developments during the past twenty years. The Apolinar model opened itself up to clients dependent on illegal drugs and learnt to work with them. It embarked on the road leading from the bio-behavioural model towards a more comprehensive one and from its somewhat self-contained nature to greater interdisciplinary and interagency liaison, which is what Skála always visualised and wished for (see Skála, 1987). The Sananim model of autonomous therapeutic communities steered a course from its initial enthusiasm and rebelliousness to professionalism, from a model based on psychotherapy and education to one involving a more comprehensive approach, and has gained acceptance from the professional community and learnt to collaborate both inside and outside the healthcare framework. The bio-psycho-social (and spiritual or existential) model of addiction and the principles of a therapeutic community are the factors that have made these two residential treatment modalities close to each other at present. The overcoming of differences and barriers, collaboration, and closer contacts are a promising trend.

The comparison made in this chapter may imply that, from a certain perspective, therapeutic communities seem to enjoy a higher level of professional culture and to be able to offer more comprehensive and individualised care than the specialised units of the Apolinar type. Such an impression may be strongly misleading. It may only be concluded that some criteria discussed in this chapter suggest that the Apolinar model is less transparent. To maintain a greater balance of views, it should be pointed out that the network of Apolinar-model facilities can deliver professional care to an incomparably higher number of patients/clients than the facilities that operate on the basis of the Sananim model.

In particular, the treatment of a significant number of users of legal drugs rests fully on the shoulders of the Apolinar model. The above-mentioned possibility of choice between the two treatment models practically applies only to a segment of the indicated clients – those dependent on illegal drugs. Given the access to treatment in therapeutic communities, discrimination against individuals addicted to alcohol (or pills, inhalants, and gambling, or with other non-substance-related, process addictions) is evident. It arises, however, from the distorted and limited purposefulness of the allocation of public funds. Making therapeutic communities fully accessible to all indicated clients of all the addiction-related diagnostic groups would require multiples of the amounts of subsidies that have been provided until now, which is currently unrealistic. On the contrary, the reduction of public subsidies and public funding in general poses a risk of the stagnation of the development of both models of residential treatment and of a reduction in their availability; see also the next Selected Issue on **Error! Reference source not found.** (p. **Error! Bookmark not defined.**).

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DENMARK

Inpatient treatment of drug abusers

Inpatient treatment of drug abuse has always been a crucial element in the treatment of drug abusers in Denmark. As an introduction, this chapter provides a historical overview with a special focus on the organisational changes and socio-political events of significance to the Danish inpatient treatment. This is followed by a description of the availability and special characteristics of Danish inpatient treatment, and the chapter ends with a discussion and perspectives on the Danish inpatient treatment of drug abuse.

Historical overview from an organisational perspective

The predecessor of the kind of drug abuse treatment that we know today has existed since the end of the 1960s. In those days, the treatment of young drug abusers was removed from the psychiatric treatment system. Instead, a special treatment system for young people was established, which first and foremost was based on a sociological and socio-psychological understanding of the drug abuse problem (Houborg 2008). In the 1970s and the 1980s, this system consisted of 20 institutions spread all over Denmark. The majority of these institutions were youth centres based in either the municipalities or the counties. For these 20 institutions, there were approximately 400 inpatient places (Alkohol & Narkotikarådet 1983, Winsløv 1986). These inpatient places, however, were not only reserved for drug abusers, and inpatient treatment of drug abuse was undistinguishable from other social interventions offered to young people with problems.

Inpatient treatment of drug abuse, as it is today, started in the last half of the 1980s. At this time, the first private and proprietary inpatient treatment programs were established, and today, they still make up 80-90% of the available inpatient places for drug abusers. The remaining 10-20% of the inpatient treatment programs are publicly owned. The initiators of the establishment of the first inpatient programs were typically persons who had undergone treatment themselves for their drug abuse, and at this time, most of the therapists were also former alcohol and drug abusers without any socio-professional education. This has changed drastically since then.

To some extent, the change in inpatient treatment since the 1980s may be attributable to the drug abusers becoming older and therefore did not really belong anywhere in the social and health care system. From the late 1980s and until the mid 1990s, there were, however, still relatively few inpatient treatment programs for persons who had developed drug abuse symptoms, and often the drug addicts and alcoholics were treated under the same roof. This changed in 1996.

Crucial organisational and socio-political markers

In 1996, drug abuse treatment turned into a speciality under the then county system. The treatment that had previously been given in different places, with nobody really having the full picture, was not merged. This centralisation of drug abuse treatment therefore meant a much higher volume of abuse treatment with more visibility and clearer referral procedures. Atthe same time, the first national register on all persons admitted to drug abuse treatment (the Danish Health and Medicines Agency's register on drugs abusers in treatment /SIB) was established. This was the first time that a systematic and national CPR-based register was made, which, apart from holding personal data, provided information on social and financial markers as well as information on the actual drug abuse problem among those admitted to drug abuse treatment. From 1996, the number of admissions to outpatient treatment rose drastically, and the number of drug abusers referred to inpatient treatment rose accordingly. The number of inpatient treatment programs more than tripled within a period of 5 years. The increase in the number of admissions in outpatient as well as inpatient treatment from 1996 as well as the establishment of more and better organised treatment courses, should also be seen as a result of an increasing need for treatment following drastic increases in the consumption of illicit drugs up through the 1990s (Sundhedsstyrelsen 2011g).

In 2003, the treatment guarantee was introduced for social drug abuse treatment. A person requesting for a treatment program must then be offered such a program within 14 days (Section 101, of the Danish Social Services Act). The guarantee only applies to outpatient psycho-social treatment - in other words not medical treatment, and the person is not at liberty to ask for inpatient treatment, as the referral authorities are the ones to assess whether or not inpatient treatment is relevant for the individual client. Nevertheless, the number of referrals to inpatient treatment have gone up drastically the first two years after the introduction of the treatment guarantee.

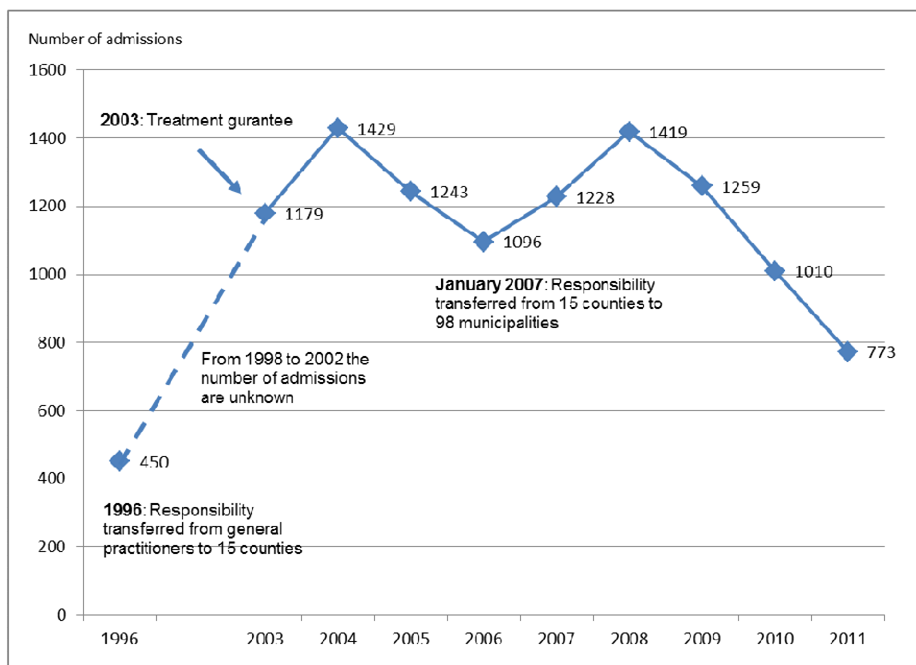
In 2003, it was also compulsory for all inpatient programs treating drug abusers to report about all admissions financed by the public sector to the registration system DanRIS (Dansk Registrerings- og Informations-System). From 2003, full data are provided on all the admissions to inpatient treatment paid by the public sector as regards the inpatient clients' occupancy rates (European AddictionSeverity Index), the duration of admission, the cause of discharge etc. Furthermore, DanRIS contains organisational information on treatment methods, employee education and training, etc.

From January 2007, responsibility for the treatment of drug abusers was transferred from the then counties to the 98 newly established municipalities. In other words, drug abuse treatment has been decentralised, with an ensuing establishment of minor treatment units - not the least in the small municipalities.

During the first two years after the introduction of the treatment guarantee, an increase in the number of admissions was observed. However, following this, a drop in the number of admissions appeared until the municipalities take over the tasks of the counties, effective January 2007. The decrease in the admissions up until 2007 cannot be explained directly, but the primary assumption is financial uncertainty in the municipalities up until the closing of the county system, but it is most likely not the whole reason.

The development in the number of referrals to inpatient treatment during the period from 1996 to 2011 can be illustrated in the figure below.

Figure 11.1. Other referrals to specialised inpatient treatment of drug abuse, 1996-2011



Financing

Inpatient treatment is financed almost exclusively by public sector means (today the municipalities), and there are hardly any citizens paying for treatment out of their own pockets. Financing is different than, for instance, financing of inpatient treatment for alcoholics, where several inpatient programs almost primarily admit alcoholics who pay for the treatment themselves.
During the years from 2006 to 2010, the average price per month for inpatient treatment went up from EUR 4.8 to EUR 5.8. It is estimated that in 2006, the public sector used approximately EUR 30.8 million on inpatient treatment, which in 2011 had dropped to approximately EUR 20.1 million. This estimate, however, does not take into account the special agreements between paying authorities and specific inpatient programs.
For the past 10-12 years, by far the majority of the inpatient programs have been run by private institutions.

Since the mid-1990s, between 1 and 7 institutions have been owned by the public sector and thus financed by municipalities or counties. In 2011, there were two publicly owned inpatient programs which had specialised in drug abuse treatment.

Availability and characteristics

Although the number of referrals to inpatient treatment as described earlier in the chapter have dropped drastically within recent years, the number of inpatient treatment programs have remained on a stable level. In 2011, there were thus 40 inpatient programs in Denmark, which is the same number as in 2006. Out of the 40 inpatient treatment programs in 2011, 6 are pure detox institutions or so-called halfway houses, whereas 3 institutions describe themselves as interim nursing homes. The remaining 31 inpatient programs are all treatment institutions, the aim of which is to achieve permanent addiction recovery (only the latter 31 inpatient programs make up the data basis for figure 11.1).

In 2011, the 31 inpatient programs aiming at complete addiction recovery had a total of 483 beds. By comparison, there were 602 beds associated with the service in 2006. In conclusion, there are thus the same number of inpatient programs today as in 2006, but the number of beds have been reduced by approximately 20% during the period.

Different types of inpatient treatment

Overall, the Danish inpatient programs can be divided into four different inpatient treatment types; the therapeutic society, the Minnesota institutions, the socio-educational inpatient programs, and the religious institutions.

The *therapeutic society* covers the socalled *democratic* therapeutic society and the *hierarchical* therapeutical society. The *democratic therapeutic society* also comprises the socio-psychological model, as drug abuse is not considered to be a disease, but a symptom of psycho-social troubles. These institutions base their work on a philosophy of "living-learning", where each situation in everyday life is used as a tool to live in and understand the world. The basic idea is an organised environment according to an "everybody is equal principle, partially without power and expert structures. The working tools are, among others, long group sessions every day. Especially the early Danish therapeutic society was indeed influenced by this concept[36]. In these institutions, an equal share of men and women are admitted, which is normally not seen in other Danish inpatient programs. The therapeutic society of today is much more structured and hierarchical than when it was established many years ago.

The *hierarchic concept-based therapeutic* society is heavily structured and uses, to a large extent, junior therapists who are clients admitted to treatment for typically 3-6 months. In this type of treatment, a higher degree of responsibility is delegated to the therapist who thereby gains an increasing number of privileges. The hierarchic concept-based therapeutic society is founded on an American model which is a treatment method used very much in the US today. This is a model which is based on reward principles and "operant conditioning" and therefore also on a model more focused on behaviour. Similar to the democratic-based therapeutic society, the hierarchic concept-based therapeutic societies apply psycho-therapeutic methods and long group sessions as their working tools and view abuse/addiction as a socio-psychological phenomenon (Mølholm 1999, Pedersen 2009,Vanvelde et al 2004). In Denmark, there have only been two institutions throughout the years working under the hierarchic concept-based therapeutic society, of which one institution closed in 2005, whereas the other still exists. Today, 14 institutions define themselves as therapeutic societies.

The philosophy behind the *Minnesota treatment* is much different from the philosophy behind the therapeutic society. From the outset, the Minnesota movement thus perceives addiction as a biogenetic-based disease which can be compared to a kind of allergic reaction. The disease therefore also exists before the first drink has been taken (Anonymous Alcoholics 1994). Addiction to intoxicants is therefore considered as a chronic disease, which, however can be controlled through lifelong abstinence. The means to this is to recognize that something is bigger than oneself and to be confronted with this reality throughout life by participation in AA/NA meetings. The Minnesota treatment is based on 12 steps, through which the addict systematically moves. Typically, the addict works his/her way through the first 4 steps during the inpatient treatment stay and it is then expected that the individual in question goes through the next 8 steps with his/her "sponsor" and through participation in NA meetings (NarcoticAnonymous)

[36] Hjulsøgård og Projekt Menneske.

In the 1990s, there was a large gap between the Danish therapeutic society and the Minnesota inpatient programs. Today, this gap has to some extent been eliminated. Today, several inpatient programs that call themselves therapeutic societies apply elements from the 12-step treatment methods, however without necessarily having adopted the philosophy of the Minnesota treatment. Quite a few of the therapeutic societies recommend their client to take part in NA meetings after the end of treatment and might even help them establish contact to NA. Also, several Minnesota institutions use the motivating conversation and different cognitive methods and recognize the social element as a co-player in the explanation to addiction.

The *socio-educational inpatient programs* cover a wide variety of institutions that neither defines themselves as Minnesota or therapeutic societies - nor as religious (below). On a list of 12 different orientations, they have all, however, checked the field of "socio-educational". Most of the publicly owned inpatient programs have defined themselves as socio-educational, which also applies to inpatient programs that have a strong focus on hand-on work. The socio-educational institutions may, however, also use elements from environmental therapy and 12-step treatment.

Finally, throughout the years, there have been inpatient programs that openly recognized that there treatment is based on a religious platform One of these institutions has been linked with the Scientology movement. However, no clients have been referred to this institution by the public sector. The other religious institutions profess to various Christian religions. Today, there are 3 religious inpatient programs receiving clients on referral from the public sector.

In summary, it should be mentioned that on the establishment of the inpatient treatments and activities, there were differences in treatment philosophy and treatment methods that have now been more or less eliminated. Today, it can be more difficult to know the difference between the therapeutic society and the socio-educational institutions, and elements from the 12-step treatment are part of the treatment in inpatient programs in a number of institutions.

The proportion of drug abusers admitted to the more "clean" Minnesota treatment programs have decreased drastically within the past 10 years. While around 70-75% of the drug abusers in inpatient treatment in 1997 were treated on Minnesota programs, this had dropped to around 30% in 2008. In 1997, around 20% of the drug abusers received inpatient treatment in therapeutic societies, however this had gone up to 49% in 2008. In 2008, around 20% were treated in socio-educational inpatient programs, whereas in 1997 only a few (if any at all) defined themselves as socio-educational inpatient programs specialising in drug abuse treatment.

Education, training, and special interventions

Between 1997 and 2008, the proportion of therapists with a socio-professional education rose from 26.5 to 50.4%. Also the proportion of therapists that have a diploma[37] from therapeutic studies more than doubled from 23.5 to 52.5%. For instance, the share of inpatient programs employing therapists trained in cognitive therapy has gone up from 20 to 51%, whereas the proportion of inpatient programs using system-oriented therapy has gone up from 8 to 31%. The proportion of inpatient programs that use therapists trained in the 12-step model have dropped from 25 to 15%. A large share of the therapists are trained within gestalt and psycho-dynamic psychotherapy, and it is very common to be trained in several therapeutic methods. Therapist age as well as years of experience has gone up drastically the past 10 years. Today, the average age of a therapist is 45.8 years, and the average years of experience as an abuse therapist is 8.5 yeras.

The proportion of programs, where *self-help groups* are part of the treatment, have gone down from 65% to28%, whereas the proportion using *couples and/or family therapy* has gone up from 23% to 64%, Quite a few inpatient programs offer long-term stabilisation to clients in *substitution treatment*. Also the Minnesota programs offer this kind of treatment. The number of beds available to this group is unknown. However, it is presumably a small share. Most of the inpatient programs apply *relapse prevention* which is an integral part of the treatment as long as the client is admitted. One of the key methods is the so-called *Gorski method* (Gorski 1997, CENAPS, 2007). Follow-up relapse preventive interventions after discharge are rarely seen

In most of the 31 actual inpatient treatment programs it is possible to start a treatment course with *detoxification*. Some inpatient programs use specific detoxification centres in order to separate the detox clients from the other clients. There are no specific figures indicating how many start their treatment with detoxification in the same institution as the one where they received treatment.

[37] Defined as at least a 1-year training programme including at least 15 days of training in a defined methods.

Basically, treatment in inpatient programs are separated from the outpatient social and health care intervention, which means that inpatient programs do, for instance, not offer follow-up treatment, case management nor services such as screening, treatment of HIV/AIDS, hepatitis C or sexually transmitted diseases in general. Work training or education in general schooling skills is normally not seen as well.

Finally it should be mentioned that the average duration of treatment in inpatient programs is much shorter than it was in the 1990s. Planned courses of 1-2 years are no longer seen. Most of the planned courses of treatment typically last less than 6 months and are most often offered for 3 months. Today, the average duration of treatment is 136 days (including those who discontinued treatment) against 211 days in 1997. This also means that a higher number of persons complete a treatment program than before (36% in 1997 against 56% in 2011).

Quality assurance

Private inpatient treatment programs in Denmark must be approved by the municipality, in which they are provided (Pedersen 2007). Without such an approval, they are not entitled to receive clients paid by the public authorities. This approval only deals with the institution's compliance with various legal conditions and obligations, including obligations relating to occupational health and safety, accounts, boards, etc. The approval does not concern the use of a specific treatment method, the education of the therapist group and the composition, guidelines or other professional aspects of the treatment

Many inpatient programs, however, have an education policy, certain methods and an overall treatment philosophy. This, however, is changed on a continuous basis and therefore not necessarily documented for each individual program.

All inpatient programs are monitored on their methods/services, the professional competencies of the therapists, client vulnerability and the individual client's course of treatment. Reportings are made to DanRIS mentioned above. Via this monitoring it is possible for each individual municipality to assess and analyse a number of conditions in relation to the individual inpatient program.

Finally, it should be mentioned that the Ministry of Social Affairs and Integration has set aside funds for the evaluation of the inpatient treatment every three years (Pedersen et al 2011). The effect measured as addiction recovery 1 year after end of treatment has turned out to have stabilised between 20% and 25% for opioid addicts for the past 10 years. However, the effect measured as addiction recovery *the past month* has gone up from between 40% to 50% month-by-month during the years after discharge to between 50% to 60% during the same period. This positive trend could be attributed to the implementation of the treatment guarantee in 2003. Today, when a client suffers from a relapse after discontinuation of inpatient treatment, the person is much more frequently admitted to drug abuse treatment shortly after the relapse than was the case prior to the implementation of the treatment guarantee (Pedersen et al 2011).

Discussion and future perspectives

Throughout the past 10 years, inpatient treatment seems to start matching the standards for other modern treatment programs. The therapists are much more educated than they were before, and evidence-methods have become implemented (primarily cognitive therapy). However, today it is very difficult to distinguish between the various inpatient treatment programs. For instance, there is no clear-cut line between the Minnesota treatment and the Democratic Therapeutic Society, and not specific category of programs can be referred to as better than the others. Instead, the referring authorities must assess the quality on the basis of the competence profile of the therapists and the municipality's experience with certain inpatient programs.

The traditional target group for inpatient treatment in Denmark (heroin addicts aged 30-40 years) is disappearing, and the inpatient programs are standing at a cross roads, where there might be a need for new and different programs targeted at new drug abuser groups. The heroin abusers have grown older, and among them, there is a large and very vulnerable group, which has not become drug-free in spite of repeated efforts. These people need special programs. The often young abusers of stimulants and cannabis need other programs than the heroin addicts. This requires that the municipalities plan the right mix of programs that match the needs of the various target groups of drug abusers.

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GERMANY

PART B: SELECTED ISSUES

1. In-patient treatment of drug addicts in Germany

1.1 History and general conditions

1.1.1 Overview

Inpatient treatment is a key element of treatment and rehabilitation forms for drug addicts. In Germany there are approximately 320 facilities with over 13,200 beds offering inpatient rehabilitation services for people with substance-related disorders. Of these, 4,000 beds are for drug addicts. The aim of rehabilitation is to achieve and maintain abstinence, remove or offset physical and mental disorders and maintain or achieve sustained reintegration into work, profession and society.

This focus chapter is based on the specifications of the EMCDDA, which has encouraged the description of inpatient care at a country level to allow an EU-wide comparison. The historical developmental trends and the current role and developments in the primary addiction support system as well as the availability and features of inpatient treatment programmes are presented accordingly. A description of quality assurance systems and a forecast of future developments complete the chapter.

Following the provisions of the EMCDDA, "in-patient treatment" is defined as a bandwidth of in-patient treatment models and programmes, therapeutic or other offers for drug users who go through medical and psycho-social interventions in the context of in-patient placement. A decisive criterion of such programmes is that they correspond to different treatment needs and consider drug use, health and quality of life as well as professional and social participation. The focus section explicitly does not deal with

- inpatient detoxification,
- programmes that are solely dedicated to the provision of social support for drug addict (e. g. emergency shelters, residential homes) and
- programmes for drug users in prisons or for drug-addicted prisoners in forensic psychiatric hospitals according to § 61 StGB.

These areas, primarily inpatient detoxification, are of course significant components of inpatient care. In order to ensure the comparability of inpatient care on an EU level, the focus is placed first and foremost on medical rehabilitation, which is closely linked to social rehabilitation measures. Abstinence obtained through detoxification should be stabilised here and dependency should be stopped on a long-term basis.

Different sources are used in order to allow an image of inpatient treatment that is as comprehensive as possible. However, they can only be compared with each other conditionally due to their selectivity. In addition to the German figures for rehabilitation treatment, basic data for addiction psychiatry, diagnostic statistics of the Statistisches Bundesamt (Federal Statistics Office), the statistics of the Deutsche Rentenversicherung-Bund (German Pension Fund), the basic and catamnesis data of the Bundesverband für stationäre Suchtkrankenhilfe (Federal Association for Inpatient Addiction Care), basic documentation of the Fachverband Sucht (Addiction Association) as well as regional monitoring systems provide key data for inpatient treatment.

1.1.2 History of inpatient treatment

In the post-war period, addiction-care services in Germany were poorly organised and worked primarily with volunteers. In 1962, the number of inpatient facilities for alcoholics throughout Germany stood at 18 and in 1968 the number was 26. In total there were between 1,000 and 2,000 beds available. There were no specific facilities for people addicted to illegal drugs (Vogt & Scheerer 1989). In light of the rise in the number of adolescent drug users at the end of the 1960s/start of the 1970s as well as the setting of a new direction by transforming the Federal Law on Opium into the Narcotics Act (1981), the expansion of inpatient drug dependence treatment began. An important milestone was the recognition of addiction as a disease in 1968 (Federal Social Court decision of 18 June 1968) through which the costs of addiction treatment and rehabilitation had to be taken over by public insurance funds (Schmid & Vogt 1998). As a result, both demand for treatment centres for alcoholics and the need for suitable treatment programmes for drug addicts rose. Professional and systematically supported programmes developed from so-called "Release Groups" which previously served as shelters for adolescents dependent on opiates.

The necessity for differentiated programmes for alcoholics or drug addicts was confirmed in respect of inpatient treatment, in particular through the "Aktionsprogramm zur Bekämpfung des Drogen- und Rauschmittelmissbrauchs (Action Programme for Combating Drug Abuse)" from 1970:

“The lumping together of drug addicts with alcoholics or the mentally ill in psychiatric clinics should be rejected from a therapeutic point of view. The lack of individual facilities and specific departments in clinics for these groups is alarming” (BMJFG 1972).
A comprehensive support programme of the Federal Government was initiated which became known as the “Großmodell zur Beratung und Behandlung drogen- und alkoholgefährdeter und -abhängiger junger Menschen (Large-scale model on counselling and treating young people abusing drugs and alcohol)” (Schmid 2003). As part of this, rehabilitation clinics and Therapeutic (shared-living) Communities (therapeutische (Wohn-) Gemeinschaften (TG)) were promoted in addition to drug help centres. “Minimum criteria” were developed for inpatient drug treatment as part of scientific support. In particular, the employment of skilled psycho-social personnel led to increasing professionalisation of treatment facilities. Being accepted into a Therapeutic Community (TC) was subject to significant bureaucratic hurdles, not least because of the programme’s still-limited capacity (Bühringer 1996). Inpatient and outpatient drug treatment was formed from the paradigm of abstinence as well as from a rigid therapy concept of “post-maturation” and “resocialisation”. However, these therapeutic approaches based on confrontation and repression led to high dropout rates and subsequently low rates of success (Schmid & Vogt 1998).
On 20 November 1978, the “Empfehlungsvereinbarung Sucht” (recommendation agreement on addiction) was adopted between health insurance funds and pension insurance institutions (Association of German Pension Schemes 1978 (Verband deutscher Rentenversicherungsträger 1978). This established a maximum size of 30 beds for drug treatment centres. The reasons at the time are still applicable today: this moderate size provides drug addicts with better orientation and contributes to their comprehensive and individual support (DHS 2008). This additionally established that health insurance funds are the primary cost carriers for detoxification treatment and pension insurance funds are responsible for inpatient withdrawal treatment. This should be allowed if long-term reintegration into working life and society seem possible. Furthermore, withdrawal treatment was able to be administered only at facilities and financed by pension schemes if they were recognised by them (Verband Deutscher Rentenversicherungsträger (Association of German Pension Schemes) 1978 (Verband deutscher Rentenversicherungsträger 1978). Therapeutic Communities especially had problems meeting the requirements for financing through pension schemes since neither diagnoses were given nor treatment plans or physicians were available. In order to be recognised by pension schemes based on their quality standards, treatment facilities professionalised their concepts, strengthened their co-operation with the medical sector and focused more strongly on additional treatment qualifications (Schmid 2003).
In the 1980s, Therapeutic Communities lost their monopoly position of treating drug addicts (Schmid & Vogt 1998) (see chapter 2.2.1). Inpatient halfway homes and so-called “compact treatments” were expanded (see chapter 2.2.4) and long-term treatments were shortened as part of the Therapeutic Communities The approach to dealing with relapses changed to the extent that they were increasingly understood as a part of the therapeutic process and no longer led to direct dismissal. Different forms of medically assisted withdrawal treatment programmes were established in addition to “cold” withdrawal treatment (Schmid & Vogt 1998).
Starting in 1980, for-profit organisations supplemented the previously exclusive sponsorship of addiction services through the association of voluntary social welfare work (Täschner et al. 2010).
A significant milestone was the Betäubungsmittelgesetz (BtMG) (Law on Narcotics) that came into effect on 1 August 1981, which targeted co-operation between judicial policy, addiction support and cost centres in order to be able to combat drug addiction and associated criminality (Kraatz-Maček 2011; Künzel et al. 2012). It was now possible to allow drug addicts subjected to punishment to be treated for their dependencies outside of the penal system. Corresponding to § 35 BtMG (Law on Narcotics), the execution of penalties in particular cases can be deferred in favour of therapeutic care, counted as part of the sentence or the remaining part of the sentence can be suspended. Until 1992, this rule applied only to treatment at inpatient facilities. Since then it has been possible to allow those convicted to comply with court-ordered conditions as part of an outpatient treatment (Schmid & Vogt 1998).
Furthermore, the renouncing of relatively uniformly-targeted, therapeutic concepts in favour of the development of addiction support programmes specific to target groups can be seen in the past two decades in the German addiction support system. A significant milestone in 2001 was the replacement of recommendation agreements from 1978 with the “Agreement on co-operation between health insurers and pension schemes for acute treatment (detoxification) and medical rehabilitation (withdrawal treatment) of dependence sufferers” (dependence illnesses agreement). This is where the form and content of treatment are presented, the specialist staff selected, the organisational structure of rehabilitation determined and the length of treatment recommended, all in a decisive manner (DRV et al. 2001c).

1.1.3 Strategies and basic framework conditions of inpatient care

According to the landmark decision of the Office of Social Affairs, Family, Health and Consumer Protection (Behörde für Soziales, Familie, Gesundheit und Verbraucherschutz, BSG) of 18 June 1968, this involves an illness requiring treatment in the case of alcohol or drug dependency (buss 2012). Under the consideration of

other conditions, (see chapter 11.2.1) people with a substance-related disorder are entitled to have their costs for required acute medical (withdrawal or detoxification) and weaning-oriented treatment (medical rehabilitation) covered.
Inpatient withdrawal treatment is primarily one of the services of medical rehabilitation in Germany according to §§ 9 and 15 SGB VI. 85% of the measures for medical rehabilitation in the indication area of dependencies are funded by the German Retirement Insurance-Federation (DRV) as a pension insurer (Koch 2011). The basis for this is the "dependence illnesses agreement" from 2001. If there are no claims with respect to the statutory pension insurance (Rentenversicherung - RV) according to SGB VI, a check is performed to determine whether a claim towards cost absorption exists in the case of statutory health insurance (gesetzliche Krankenversicherung - GKV). If there are no claims with respect to RV or GKV, the competent welfare agency intervenes to finance inpatient addiction treatment in accordance with SGB XII as part of the subsidiary principle (subordinate competence) (Jungblut 2004). Unemployed and elderly citizens also have an enforceable claim to withdrawal treatment or the financing of it. In the case of officials, the respectively applicable civil servant pension arrangements are to be taken into account. Most private health insurance companies have excluded addiction treatment from their benefits on a contractual basis. Either cost transfer can be obtained on a goodwill basis or the patients must pay for treatment themselves (buss 2012). In cases involving a lack of financing for treatment, patients can resort to programmes free of charge, such as self-help.
The aim of rehabilitation is to achieve and maintain abstinence, remove or offset physical and mental disorders and maintain or achieve sustained reintegration into work, profession and society (DRV et al. 2001c).
The costs for drug rehabilitation in 2010 amounted to 17% (500 million Euros out of 3.011 billion Euros without transitional allowance) of the total cost of medical services of the DRV (German Public Pension Insurer) (Beckmann & Naumann 2012). The total expenses of the RV (Public Pension Scheme) in connection with illegal drugs in the form of medical rehabilitation, services for participating in work life and pensions as a result of reduced earning allowance amounted to approx. 171.7 million Euros in 2006. Furthermore, drug addicts receive acute medical treatment in psychiatric addiction centres of psychiatric specialist clinics and psychiatric wards of general hospitals and university clinics, for example through emergency care, crisis intervention or qualified withdrawal treatment. The expenditure of statutory health insurance companies for medication, hospitalisation, rehabilitation, etc., in connection with illegal drugs is estimated at 1.4 billion Euros (Mostardt et al. 2010).

1.2 Availability and characteristics

1.2.1 Nation-wide availability and access

Access
Medical rehabilitation is only taken into account for dependency sufferers if a need and readiness exist for rehabilitation as well as a positive rehabilitation prognosis. The approval for rehabilitation therapy requires a notification procedure in which formal and content-related criteria for approval must be met (buss 2012). The application procedure includes a medical opinion in which the necessity for withdrawal treatment is confirmed, and as a rule, a social report that is prepared by an information centre or a social service. In addition, the minimum insurance periods / payments of contributions that are individually provided depending on the insurer are required. All insurers require a minimum insight into the disorder by the affected parties and motivation for treatment and aftercare. Voluntary action is a compulsory condition for approving treatment[38]. Additionally it is expected that performance in working life can be re-established following withdrawal treatment (DRV et al. 2001c). In order to begin withdrawal treatment as early as possible, the DRV for Central Germany for example has been gradually simplifying access paths since October 2003 and eliminated the obligatory preparation of the social report in November 2011 (DRV 2012 quoted by the Federal Government Commissioner on Narcotic Drugs 2012 (Die Drogenbeauftragte der Bundesregierung 2012a). Since general practitioners are the first point of contact in 80% of cases of addiction, the decision to undergo rehabilitation can be made based on the physician's findings alone (ibid.)
The selection of the form of service is directed at the commonly established criteria of pension insurance and insurance companies (DRV et al. 2001a).

[38] "Performance and utilisation of addiction care are based on the principle of voluntary action with the exception of Section § 35 BtMG "Treatment instead of penalisation". According to § 63 and § 64 of the Strafgesetzbuch (StGB) (Penal Code), psychiatric treatment under a hospital order (Maßregelvollzug - MRV) can be mandated in special forensic psychiatric hospitals under particular circumstances for offenders with mental illnesses or addictions.

Criteria for approving inpatient rehabilitation (Dependence illness agreement, appendix 3)

There exist severe disorders in a mental, physical or social area that bring successful completion of out-patient rehabilitation into question.

Removal from a pathological social environment (e. g. in the case of massive family conflicts or destructive relationships with partners) is required to guarantee successful rehabilitation.

The social environment of the dependency sufferer has no supporting function. (Note: the place of treatment alone cannot take over the function of an intact social environment.)

The dependency sufferer is not integrated professionally and as a result requires specific services to prepare for professional reintegration, which cannot be provided on an out-patient basis.

Lack of a stable living situation.

It is evident that the ability to actively co-operate, regularly participate in or maintain the treatment plan in relation to the requirements of outpatient withdrawal treatment is insufficient.

The dependency sufferer is not ready or not in the position to lead an abstinent life during outpatient withdrawal treatment and to participate in an outpatient treatment program drug-free in particular.

A long or intensive history of addiction can be an indication of inpatient withdrawal treatment in particular against the background of the aforementioned criteria.

Fundamentally, a decision must be made on the application within six weeks (approval procedure); an “accelerated procedure” is possible in special cases. If all requirements are met, the funding agency must approve the measure. If there is no positive prognosis concerning reintroduction to occupational activity, insurance companies or welfare agencies must fund treatment according to the Federal Association for Inpatient Addiction Care (buss 2012). A negative decision must be justified, against which an objection (free of charge) can be filed.

Once approved, the rehabilitation facility invites the affected person on a short-term basis. Patients’ entitlement to express their wishes and make their choices in accordance with § 9 SGB IX must be taken into account here so as not to endanger the treatment’s chances of success before it even starts. Their wishes are to be taken into account when making decisions – generally concerning the type, scope and location of the services rendered – as well as during their execution – type, scope, intensity and quality of the withdrawal method. This could be understood to mean for example a treatment location nearby or the desire to receive outpatient withdrawal treatment. The suggestions are maintained in coordination with the affected person in the social report or in the medical opinion. If the wishes of the beneficiary are not in conflict with the duties of the rehabilitation service providers and the principals of sound financial management are maintained, they are complied with (DRV et al. 2001c).[39] Adaptation treatment for supporting reintegration can be included if necessary.

Facility types

Through their service guarantee, rehabilitation service providers are (§ 19 Paragraph 1 SGB IX) are responsible for there being a sufficient amount of rehabilitation facilities[40] available, which meet the corresponding quality requirements. Depending on the diagnosis and indication, medical rehabilitation can start either:

- in a recognised psychosocial information centre (outpatient rehabilitation) or
- in an outpatient clinic (all-day outpatient or semi-inpatient rehabilitation) or
- in a specialised clinic or weaning ward of a psychiatric hospital (inpatient rehabilitation (buss 2012)

All facilities have to meet minimum requirements with respect to structure and quality (see Chapter 3). In addition, the configuration contains some flexibility so that there are major differences with reference to

[39] In the case of immediate treatment, such as the “Therapie sofort (Immediate Treatment)” programme of the emergency drug services in Berlin, the offering cannot always comply with the patients’ entitlement to express their wishes and make choices, due to direct transition to a treatment facility. As a result of immediate appointment, selection of a facility is determined by available bed capacity (Notdienst für Suchtmittelgefährdete und -abhängige Berlin e.V. 2012).

[40] “The service guarantee regulates first and foremost the target to be reached: functionally and regionally required rehabilitation services and facilities must be available in sufficient number and quality. Which rehabilitation services and facilities are required at all, how their number and quality are to be measured and how the professionalism and regional presence are to be arranged is not defined. However, this can be specifically deduced from the requirements resulting from the type, scope, quality and other requirements of services for participation” (Welti et al. 2007).

length of treatment, treatment models, treatment methods and not least the qualifications of the treatment personnel between facilities (Klosterhuis et al. 2011).

Duration

Long-term treatment in the scope of illegal drug addicts can generally last up to 26 weeks, short-term treatment 12 to 16 weeks, repeat treatments 16 weeks and interceptive treatment (relapse management and renewal following previous withdrawal treatment) 10 weeks. In addition, adaptation treatment from eleven to twelve weeks is possible. Furthermore, treatment combined with all-day outpatient and/or outpatient rehabilitation while working (with varying lengths of the inpatient module) is possible. Extending or shortening the duration of inpatient rehabilitation can be applied in case of existing medical necessity and/or negative prognosis within the framework of the reference values provided to the facilities (time budget) (DRV 2010a).

Number of facilities and beds

In Germany there are approx. 320 facilities with over 13,200 beds offering full inpatient rehabilitation services for people with substance-related disorders (Table 11.1) (Pfeiffer-Gerschel et al. 2011). In addition, there are at least 7,500 beds available in about 300 specialised hospital wards. There are also about 300 inpatient psychiatric facilities dealing with addiction in which about 220,000 patients suffering from dependency are treated throughout the course of a year (Pfeiffer-Gerschel et al. 2011).

Table 11.1 Overview of inpatient addiction services offers

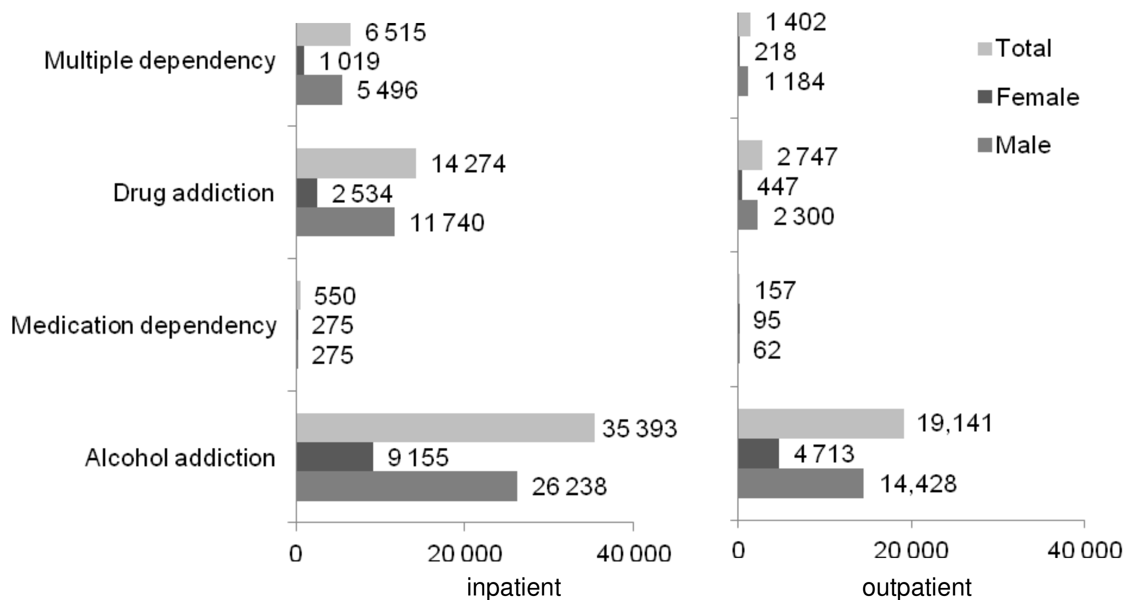
Type of facility	Number	Beds
Full inpatient withdrawal treatment facilities	>320	>13,200
→ including for drug users*		4,000*
Semi-inpatient withdrawal treatment facilities	>100	>1,000
Adaptation facilities	>115	>1,200
Social therapy facilities		
→inpatient	268	>10,700
→semi-inpatient	112	>1,200
Assisted living*	275*	7,500*
→including for drug users*	80*	2,750*
Inpatient psychiatric facilities for addictions	approx. 300	n/a

*Information pursuant to country summaries on the situation in the field of drug abuse 1998 to 2004 and forward projections by J. Leune quoted in Fachverband Sucht e.V. 2011.

Pfeiffer-Gerschel et al. 2011.

Based on the data of the Statistical Report on Substance Abuse Treatment in Germany (Deutsche Suchthilfestatistik, DSHS), Hildebrand and colleagues (2009) reported estimates for response ratios of outpatient and inpatient addiction treatment facilities. Between 45% and 60% of the estimated people who harmfully use or have a dependency on opioids is reached, however only about 4% to 8% of the corresponding cannabis users (Pfeiffer-Gerschel et al. 2011).

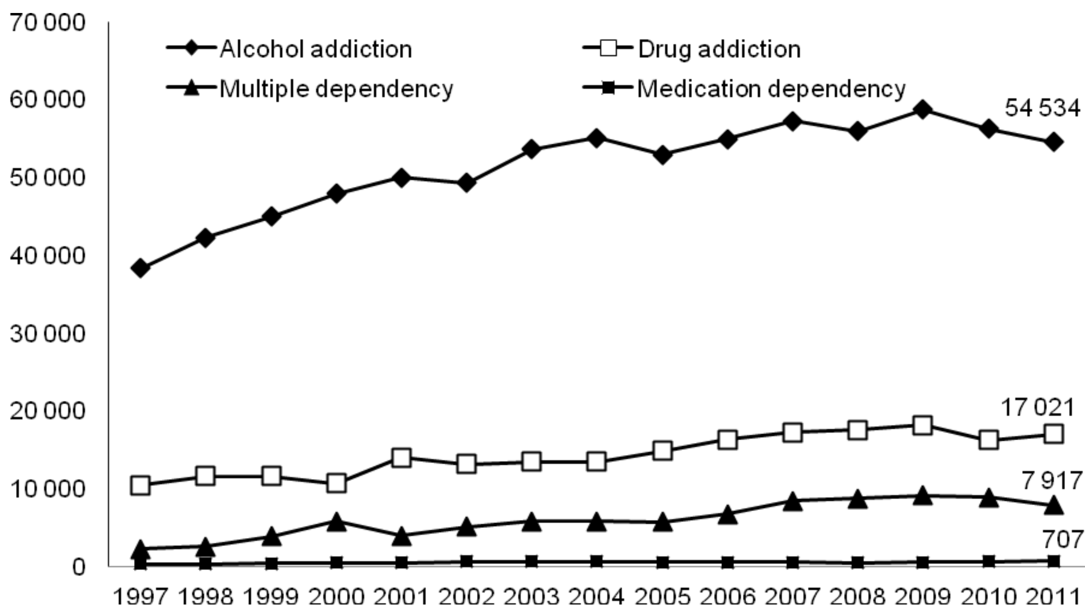
Within the framework of the facilities participating in the DSHS, the predominant share of inpatient facilities are financed by voluntary welfare agencies or other non-profit organisations with a share of 56%. 13% of inpatient facilities have a public sponsor, 3% have a commercial sponsor and 3% have a different type of sponsor (Pfeiffer-Gerschel et al. 2011). Two-thirds of the facilities participating in the DSHS also address users of illegal drugs.



DRV 2012, personal notification.

Figure 11.1 Approvals of withdrawal treatments according to the type of approved service as well as gender in 2011

In total, the number of approvals for inpatient services rose from 42,795 in 2007 by 32.6% to 56,732 approvals in 2011 (see Figure 11.1 for inpatient and outpatient approvals in 2011). The increase in approvals of outpatient services in the same period was more considerable, at 255.6% (1997: 8,653, 2011: 30,767) (DRV quoted by the Federal Government Commissioner on Narcotic Drugs 2012). In total, the number of approvals for withdrawal treatment for drug addicts between 1997 and 2011 rose by 62.2% (1997: 10,491, 2011: 17,021) (Figure 11.2).



Without integration services according to § 31 Par.1No. SGB VI with follow-up treatment followed by withdrawal treatment.

DRV-Bund quoted by Die Drogenbeauftragte der Bundesregierung 2012a.

Figure 11.2 Development of approvals for withdrawal treatment for the entire German Pension Insurance between 1997 and 2007 (itemised according to the type of dependency illness)

In 2011, the DRV-Bund provided a total of 41,733 services in inpatient withdrawal treatment, of which 27,982 were for alcohol, for the diagnostics area F10-F19 mental and behavioural disorders using psychotropic substances. Table 11.2 illustrates that approximately 47% of all services are based on polyvalent consumption. 3,404 services (24.7%) concern initial diagnoses of opioid consumption, 2,237 services (16.3%) concern cannabinoid consumption. While the average age in the F10-F19 area amounts to 40.4 years, the lowest average age in the area of illegal drugs relates to the main diagnosis of cannabinoids at 28.1 years, and the highest average age relates to sedatives/hypnotics at 44.8 years (see Table 11.2). The percentage of men who completed inpatient withdrawal treatment due to drug addiction is 83 % (DRV 2012, personal notification).

Table 11.2 Completed services provided for medical rehabilitation in the reporting year of 2011 - inpatient withdrawal treatment for adults

Main diagnosis	Services	Average age
Opioids	3404	34.8
Cannabinoids	2237	28.1
Sedatives/hypnotics	244	44.8
Cocaine	515	34.3
Stimulants	867	28.7
Hallucinogens	15	28.9
Volatile solvents	41	35.9
Multiple/other substances	6421	31.5

DRV 2012, unpublished data source.

Treatments: Psychiatry
To support the data of the DSHS and the DRV-Bund, obtaining the basic data set for addiction psychiatry can be included. The number of addiction treatments is additive due to potential overlapping with the data of DSHS or the DRV-Bund. The psychiatric addiction facilities of the psychiatric specialist clinics and psychiatric addiction wards at general hospitals and university clinics are the second major pillar for addiction care in Germany behind the facilities for consultation and rehabilitation. These facilities also conduct low-threshold qualified withdrawal treatments, however emergencies and crisis interventions are also treated and complex treatments are provided in the case of co-morbidity. In-depth diagnostics and reintegration planning are also carried out. A multi-professional team treats all types of addiction illnesses on an inpatient, part-time inpatient or outpatient basis. This guarantees all-round medical, psycho-social and psychotherapeutic treatment. Projections show that in 2010 approximately 300,000 inpatient addiction treatments took place in psychiatric clinics. This includes about 300,000 quarterly treatments that were carried out in psychiatric outpatient institutions of the clinics. 31% of inpatient psychiatric cases involved patients with dependencies. By comparison, the Federal Government performed only 150,000 treatments in facilities for internal medicine as a result of alcohol or drug addictions according to the report on health. Most patients were primarily alcohol-dependent (approx. 70 %). Disorders related to opioid consumption or consumption of multiple substances were the reason for inpatient treatment in approximately 10 to 13% in each case (DGPPN/Bundessuchtausschuss der psychiatrischen Krankenhäuser (Federal Committee for Addiction of Psychiatric Hospitals) in 2011 quoted by Die Drogenbeauftragte der Bundesregierung 2012a).

Treatments: Diagnostic statistics for hospitals
The diagnostic statistics for hospitals of the Statistisches Bundesamt (Federal Statistical Office) includes the discharge diagnoses of all patients of inpatient facilities, analogue to ICD diagnoses (F10-F19) among others. This also involves statistics that overlap with the previously mentioned data source. Short-term treatment takes place in hospitals, for example as a result of acute intoxication. In reporting year 2010, a total of 95,844 patients with a diagnosis of addiction to illegal substances were treated in hospital on an inpatient basis (Statistisches Bundesamt 2011b; see Table 11.3). 43.2% of all acute drug cases were based on polyvalent consumption, however the declining trend of the past few years has continued (2008: 45.8 %, 2009: 43.2% An increase in acute treatment of cannabis users can be observed (2010: 8.5 %, 2009: 7.7 %). It must be assumed that in 50-80% of cases opioid consumption plays the greatest role since substance use

mainly involves a combination of opioid and cocaine and/or other substances (see Pfeiffer-Gerschel et al. 2011).

Table 11.3 Patients diagnosed with addictions to illegal substances receiving inpatient care based on hospital statistics in 2010

	Hospital statistics 2010	
Main diagnosis	**Absolute**	**Percentage**
Opioids	32,538	33.9%
Cannabinoids	8,145	8.5%
Sedatives/hypnotics	9,270	9.7%
Cocaine	1,076	1.1%
Stimulants	2,805	2.9%
Hallucinogens	430	0.4%
Volatile solvents	171	0.2%
Multiple/other substances	41,449	43.2%
Total	95,884	100.0%

2011e; Statistisches Bundesamt 2011b.

1.2.2 Features of inpatient addiction treatment facilities

General approaches

Throughout the year, different treatment concepts have developed further. They are based on different theoretical foundations and are implemented in professionally run inpatient facilities. In order to guarantee quality of the facilities, uniform standards of the funding agency apply (see Chapter 3). These are located in the area of dependency illnesses, including in the "Gemeinsamer Leitfaden der Deutschen Rentenversicherung und der gesetzlichen Krankenversicherung zur Erstellung und Prüfung von Konzepten ambulanter, ganztägig ambulanter und stationärer Einrichtungen zur medizinischen Rehabilitation Abhängigkeitskranker" ("Common guidelines of the German Pension Insurance Scheme and Statutory Insurance for the Creation and Monitoring of the Concepts of Outpatient, All-day Outpatient and Inpatient Facilities for the Medical Rehabilitation of Dependency Sufferers" that came into force in 2012 (DRV 2011a). Regardless of the form of service, the same minimum requirements apply in principle to all services for medical rehabilitation with respect to structure and quality.

A basic requirement for rehabilitation concepts are evidence-based treatment processes (e. g. in consideration of the guidelines of the Association of Scientific Medical Societies (see Chapter 3.1)), which are based on the biopsychosocial model of the International Classification of Functioning, Disability and Health (ICF). Mono-methodical use of a specific procedure did not prove successful in psychotherapy. Instead, so-called "integrative" cross-procedural therapies were utilised. This is how psychotherapy and sociotherapy are used for "psychosocial treatment" for example (Täschner et al. 2010). The most common form of psychotherapeutic measure is motivational treatment and is based on the principles of "Motivational Interviewing" (Miller & Rollnick 1999). After targeted development of motivation to change, targets and procedures are subsequently worked out. The procedure is treated as suitable particularly for drug users with minimal motivation for treatment and abstinence. Furthermore, a diversified range of measures based on behavioural therapy (including cognitive therapy, competence training, etc.) is often offered. Two focal points here are motivation according to Miller and Rollnick as well as relapse prevention (Marlatt & Gordon 1985). Furthermore, pharmacotherapy and psychotherapy are frequently linked in drug treatment. The principle holds true: no medical intervention without additional motivation (ibid.). Pharmacological treatment of opium dependency and abuse is oriented towards the guidelines of the World Federation of Societies of Biological Psychiatry (WFSBP) published in 2011 (Soyka et al. 2011a).

Excursus: The Therapeutic Community (TC)

Patients are not just “treated” in therapeutic communities. TCs are equally formed by the activity and application of patients and therapists; they are based on mutual aid and support; learning from one another and with each other is an operating principle of treatment (DHS 2008). There is only a very small number of TCs that still exists in Germany as in their original sense. They lost their monopoly on the treatment of drug addicts in the 1980s (CaSu 2007; DHS 2008).

Nevertheless, numerous specialist clinics involved with medical rehabilitation are working according to the principle of TCs. These include first and foremost the structuring of daily routines, psychodynamic procedures for promoting abstinence as well as observing specific rules for living with other drug users (Jungblut 2004 (Jungblut 2004). Medical clinics specialising in medical rehabilitation integrating the principle of the therapeutic community into their concept generally have between 25 and 50 treatment rooms and therefore belong to the smaller rehabilitation facilities (DHS 2008). TCs primarily admit young adults (including their children), who in the genesis and consequence of their dependency illness frequently are affected by profound personality disorders, serious deficits in development, distinct tendencies towards neglect and partially heavy strains in their history such as massive violence, being uprooted or forced prostitution. The concepts of specialist clinics are involved in quality assurance programmes and are recognised by the leading funding agencies.

However, facilities that invoke the operating principle of the TCs fear for their economic existence due to the shortening of treatment times, capping of standard rates or budgeting of time quotas (CaSu 2007). A statistic of specialist clinics that are specifically based on the operating principle of TCs is not available due to the low number of cases. The numbers on beds and yearly clients are even harder to determine since in some communities those affected spend their entire lives there (e. g. Synanon[41] in Berlin).

Integration of programmes

Significant components of drug treatment

The significant components of rehabilitation are described below. This description is oriented towards the Common Guidelines of the German Pension Insurance Scheme and Statutory Insurance for the Creation and Monitoring of the Concepts of Outpatient, All-day Outpatient and Inpatient Facilities for the Medical Rehabilitation of Dependency Sufferers from 23.09.2011 (DRV 2011a). There are comments on the following components:

- Admission procedures
- Rehabilitation diagnostics
- Medical treatment/rehabilitation
- Psychotherapy-oriented individual and group discussions
- Work-related interventions
- Sport and exercise therapy, relaxation therapy
- Leisure activities
- Social service
- Health education/health training and nutrition
- Care provided by family members
- Relapse management

An examination by a specialist and the *initial diagnosis* including documentation are carried out on the day of admission. The time and form of institutionalisation of the person undergoing rehabilitation are also determined on the first day (DRV 2011a).

Rehabilitation diagnostics are the basis for creating an individual rehabilitation and treatment plan. Various instruments are used here, for example, screening procedures, checklists or structured and standardised interviews (e. g. the “Action Severity Index” (EuropASI)). These are used at the start, throughout the duration and completion of medical rehabilitation and cover the present disorders, resources and possible potential for change. The diagnosis has a biopsychosocial aim and is oriented according to the ICF (DRV 2011a).

[41] www.synanon-aktuell.de

Medical rehabilitation/treatment is exclusively carried out at facilities with multi-professional teams. The facilities are under the responsibility and supervision of physicians. Health-promoting measures, physiotherapy, and smoking cessation expand the spectrum of medical services (DRV 2011a). Detoxification is not included in the services of a withdrawal treatment facility of the DRV. This is carried out in addiction-specific specialist wards in hospitals or psychiatric facilities. Although drug addicts generally should lead abstinent lives from the time they are admitted to withdrawal treatment, emergency treatment cannot be ruled out. Treating *comorbidities* is a further component. Hepatitis particularly caused by viral infections is the classical consequence of intravenous drug use that is treated in withdrawal treatment. The guidelines of the Deutsche Gesellschaft für Suchtmedizin (German Society for Addiction Medicine) (DGS e.V) published in 2006 provide orientation in the treatment of hepatitis C (DGS e. V.) (Backmund et al. 2006) published in 2006 provide orientation in the treatment of hepatitis C as well as the S3 guidelines revised in 2010 by the Deutsche Gesellschaft für Verdauungs- und Stoffwechselkrankheiten e.V. (German Society for Digestive and Metabolic Disorders) (DGVS) (Sarrazin et al. 2010). Treatment for Human Immunodeficiency Virus (HIV) and sexually transmitted diseases is also the rule at inpatient facilities for drug treatment. An additional overview of the differentiated forms of treatment is provided by Täschner et al. (2010).

Psychotherapy-oriented individual and group discussions are core components of withdrawal treatment on the basis of scientifically substantiated psychotherapy methods. As a general rule, the combination of individual and group discussions is provided for. The arrangement of the groups depends on the needs of those undergoing rehabilitation and the therapy concept. A therapeutic member is essentially responsible for a group whereby it must be made guaranteed prior to arrangement that the therapeutic member will be substituted if on holiday or in case of illness (so-called “co-therapy system”). The size of the group is 6 to 8 people undergoing rehabilitation for drug addiction. Group discussions last about 100 minutes, individual discussions normally last 50 minutes (DRV 2011a). Furthermore, gender-specific or otherwise specific group therapies are offered.

Work-related interventions are a significant component of medical rehabilitation. They are used for professional orientation and re-integration, which demonstrably represent a stabilising factor for enduring abstinence in the case of dependency illnesses and minimise the “risk of illness-related relapse”. Work-related interventions for drug addicts focus more strongly on the practice of basic competences before additional services are introduced, whereas professional education and specific professional experience are often present in the case of alcoholics and the advancement of professional reintegration is in the foreground.

Within the framework of overall responsibility of the medical and therapeutic management of treatment, the occupational therapy department of a facility is responsible for the occupational therapy that has been adjusted to the limitations, is able to support patients and has been determined within treatment management. Apart from the qualitative aspects such as diagnostics/recording of findings (supported by standardised procedures, such as “Merkmalprofile zur Eingliederung Leistungsgewandelter und Behinderter in Arbeit (MELBA) (“Feature profiles for integration of underperforming and disabled persons”), the quantitative level (duration, intensity, context) is also relevant for assuring the success of rehabilitation and supporting further target levels (improvement of symptoms on a psychosocial and somatic level, increasing awareness and insight into the disease) (Hylla & Peter-Höhner 2010). Work-related interventions include occupational therapy, ergotherapy, occupational/crafts therapy and employment-integration measures. People undergoing rehabilitation with mental disorders, physical or mental disabilities are introduced to the basic requirements of working life as part of their *occupational therapy*. Also system-maintaining services for the facility, such as activities in the kitchen, dining area and housekeeping or repairs are partially, though not exclusively, part of occupational therapy measures (DRV 2011a). The use of occupational therapy is not mandatory. Work-related interventions can also take place through occupational integration measures such as stress tests, practical training, employment and in training or PC training courses. This also includes for example the “Problem-solving at the workplace” module in which behavioural strategies are put to the test in order to maintain employment and in order to learn and test competences for dealing with authorities, criticism, excess and insufficient workloads and in communicating.

Occupational participation: Exemplary models

The “accompanied rehabilitation” model project is directed towards people dependent on alcohol, medications and drugs with employment-related problems. Since 2007, the DRV in Rhineland Palatinate has involved 16 specialist clinics in Rhineland Palatinate and Saarland in the project. Dependency sufferers, who have been unemployed for a long time or whose professional histories are greatly disturbed and have gone through withdrawal treatment without sustained success or have not entered authorised withdrawal treatment, are assigned a rehabilitation case worker even before rehabilitation services are performed. A personal integration plan is worked out together with the case worker. This plan will then be implemented step by step accompanied by continuous monitoring. Monitoring includes targeted interventions in order to strengthen the affected person and to motivate them to use all aids until occupational reintegration. This should not only motivate those undergoing rehabilitation to enter withdrawal treatment but also contribute to guaranteeing the success of rehabilitation. This programme provides good support for the majority of those insured (Die Drogenbeauftragte der Bundesregierung 2012a).

The DRV in Rhineland Palatinate together with specialist clinics for dependency sufferers offers a specific assessment in the Southern Palatinate region. The Berufsorientierungscenter für die Rehabilitation und Integration Suchtkranker (BORIS) (Career Guidance Centre for Rehabilitation and Integration of Dependency Sufferers) addresses people undergoing rehabilitation for alcohol, prescriptions and narcotics whose employment history is seriously impaired. As long as they are in withdrawal treatment for at least eight weeks and are sufficiently motivated, a one-day stay at a career guidance centre can be made possible. To supplement the routine and standard diagnostics in specialist clinics, work related assessment procedures and role-playing with video recordings are carried out. Standardised behavioural testing of social and communicative behaviour displays how the person behaves in daily work situations. Every year about 150 people undergoing rehabilitation take part in the project (ibid.).

“Step by step” is a project for the advancement of reintegration of people with problematic drug consumption on the general job market. The project is led by the Baden-Württembergischer Landesverband für Prävention und Rehabilitation gGmbH (Baden-Wurttemberg association for prevention and rehabilitation) (bwlv) and the Fischer-Haus specialist clinic. It is financed through the European Social Fund (ESF) and the Job Centre of the Rastatt region and the city of Baden-Baden. The target group are people receiving social security benefits (SGB II) (Basic security for people seeking employment) with placement handicaps for the general job market due to problematic substance use. The project aims to improve the reintegration of such persons into the general job market and to help stabilise their mental and physical health. Companies in the surrounding area that offer placement positions are significant cooperative partners. The concept involves the qualification of case managers/job centres, special psychosocial and occupational incentive measures for those affected (tiered programme), the inclusion of the existing “Übungswerkstatt (Exercise Workshop)” project by the Fischer-Haus and the mediation/acceptance into an employment relationship or an upstream rehabilitation measure. The initial experience shows that the dropout rate is low because of the low-threshold approach. On the other hand, a large part of the assigned clients cannot be entered into placement training promptly or at all since other primarily aids are indicated in part (e.g. inpatient treatment) or longer motivation and relationship activities are required. The high synergetic effects are underscored through direct co-operation between job centres and addiction support (Höhner 2012).

The aim of *ergotherapy* is to improve lost or still-unavailable physical, mental or psychological functions using appropriate measures in co-operation with other occupational groups. For this purpose, life skill activities, manual activities and creative processes are utilised as targeted therapeutic measures (DRV 2011a).

Playful, creative ways of handling materials and the self-awareness aspect are in the foreground of occupational and creative therapy in order to encourage expression using symbolic means. Specific topics of psychotherapy can be taken up in dealing with various materials and processed this way using a different medium (DRV 2011a).

Therapeutic exercise measures are an additional component of treatment since physical movement demonstrably improves many physical illnesses. As a result, participation-relevant aims of improved physical performance can be additionally achieved (DRV 2011a). Useful recreational activities are also part of the services for participating in social life and are decisive for maintaining abstinence as well as returning to work. People undergoing rehabilitation are encouraged to spend their free time actively and in a self-reliant manner. An appropriate qualification is required for the person running recreational activities (e. g. sports teacher or physical education instructor) (DRV 2011a).

Furthermore, treatment facilities cooperate with internal or external social services that offer accompanying help in the social environment (e. g. advice in matters of social law, measures for professional reintegration, preparation of after-care and contact with self-help groups). These co-operations are based on the joint recommendation of “Social services” (BAR 2005b).

Patient training and health education are also therapy components as the lifestyle of drug addicts is a cause of increased risk of somatic and psychological illnesses. The DRV-Bund has made available the “Promote active health” programme, which concerns the model of health promotion and offers seminars on protective factors, nutrition, exercise and stress among others (DRV 2011b).
An intact social environment is a significant prognostic factor for an abstinent life. It is essential for interventions, within the framework of working with family members, that there is a continuous relationship that requires adaptation in the view of the person undergoing rehabilitation or the therapist. This is particularly important for those undergoing rehabilitation alone. Care by family members is provided on an accompanying and supportive basis (e.g. family seminars). Proximity to home facilitates the inclusion of family members in therapeutic family care (DRV 2011a).
Relapsing or threats of relapsing are natural when dealing with dependency illness. Treatment facilities have a *relapse concept* which regulates prophylaxis and the handling of relapses. Measures include regular indication-dependent sobriety checks dependent (e. g. breath tests or ethyl glucuronide (EtG) tests) as well as prescription and illegal drug screening (DRV 2011a).

Target group-specific offers

Providing offers in the area of caring for dependency sufferers makes sense in order to allow specific topics to be processed. On the other hand, this allows employees to create competences in order to therapeutically combat special topics accordingly and to help those affected (Korsukéwitz 2010). There are a few specific inpatient offers for women, parents with children, minors or migrants. At the same time, the limits to differentiation need to be pointed out since special therapeutic services cannot be comprehensive, but rather provided only at competence centres (ibid.).

Women/ pregnant women

The DRV-Bund currently funds four inpatient facilities for drug addiction nationwide, whose treatment programmes are directed exclusively at women. Regional funding agencies fund additional facilities (Korsukéwitz 2010). Even male-specific facilities in which men's roles and their behaviours in gender-specific groups or questions are a subject of discussion have proven effective.

Parents with children

There are family therapy programmes at inpatient addiction and rehabilitation facilities for drug-using parents. In addition, seminars that promote the parenting skills of parents are offered (as an example for offers that are directed at parents) (Pfeiffer-Gerschel et al. 2011). A good example is the specialist clinic Böddiger Berg, which offers a target-group specific programme as part of inpatient rehabilitation for drug-using parents.[42] Furthermore, the special section titled “Drogenkonsumenten mit Kindern (Abhängige Eltern und kindesbezogene Themen) (Drug users with children (Dependent Parents and Child-related topics))” of the drug and addiction report from 2011 is referenced.

Adolescents and young adults

With respect to adolescent drug users, two different help systems come into conflict with each other: youth welfare and addiction services. Interface problems or problems with financing inpatient measures result from the transition from adolescence to adulthood. According to the information of the Fachverband Drogen und Rauschmittel e.V. (Professional Association for Drugs) (fdr 2011)) youth welfare offices are increasingly refusing aid once adolescents have reached the age limit of 18. This occurs regardless of the fact that SGB VIII (Children and Youth Support) still provides a claim for first-aid services up to the age of 21 and follow-up care is guaranteed up to the age of 27. The legislator has arranged an amendment to the law here (§ 78, SGB VIII), which has the aim of establishing new age limits.
In child and youth psychiatry, inpatient post-acute treatment - the actual addiction therapy in this sense - runs for 8-10 weeks. In the case of long-term substance use, a negative environment and many pre-treatments, inpatient post-acute treatment is required as rehabilitative long-term therapy (12-18 months) in facilities specialising therein and financed by SGC V (Health Fund) and/or SGB VIII (Youth Support). If there is no social support, particularly in the case of dysfunctional families, patients can be placed in an appropriate youth welfare institution (Child and Youth Support) (Kinder- und Jugendhilfsgesetz (KJHG)) (KJHG §§ 34, 35, 35a and 41 SGB VIII) (fdr 2011).
The “Youth Addiction Network” expert’s report shows an excerpt from inpatient facilities for adolescents (fdr 2011). It is a common feature for withdrawal treatment facilities (e. g. treatment stations “COME IN!” in Hamburg, “Teen Spirit Island” in Hannover, Jugendbauernhof “Freedom” in Neureichenau/Bavaria, Inizio Munich or JELLA Stuttgart) that they aim at developing maturity, identity building and reintegration into an age-appropriate social framework. This is obtained on the basis of therapeutic community, positive bonding and relationship experience, psychotherapy, combined with (curative, social and socio-) education and social programmes. The age of those supervised is between 11-18 and it can last approx. 12 months. The funding agencies are pension insurance schemes, health funds, youth and social welfare services. The youth welfare institution “Balance” in Gransee/Brandenburg is a facility that admits adolescents between the ages of 14 and 22 after detoxification treatment. The psychosocial programmes are financed by the competent youth

[42] www.drogenhilfe.com/boeddiger_berg

welfare offices (§§ 34, 35a and 41 SGB VIII), and by health insurers in exceptional cases (individual agreements) (fdr 2011). Currently the DRV-Bund is funding five inpatient specialised clinics for this group of people (Korsukéwitz 2010).

People with a migration background

Gaps in provision for people with migration backgrounds were also closed in the past few years through a variety of native-language and culturally sensitive concepts and programmes that have developed in the meantime. An example is the Landschaftsverband Westfalen-Lippe (LWL) specialist clinics in Warstein participating in the current federal pilot project "TransVer - Transkulturelle Versorgung von Suchtkranken (Transcultural Care for Addiction Sufferers). Their services are directed at drug-using migrants from Russian-speaking areas. With the help of Russian-language therapy groups, individual preparations for release and family care groups, those affected should be motivated to continue and complete treatment. At the same time, the connections to follow-up outpatient offers should be improved.

Another participant in the project is the funding agency mudra e.V., to which the treatment facility "dönus" belongs, which has existed since 1995 (mudra e.V. 2012). Drug-users from the Turkish-Oriental cultural area whose special situation as migrants is taken into account in daily therapeutic life are treated here. The team consists of native-speakers and German employees and the facility has over 22 beds. The results of the project will be presented at the end of 2012 (FOGS 2012).

Elderly persons

Studies and statistics today indicate a larger percentage of older drug users than 10 years ago. The average age has increased during this period. Alcoholics and drug addicts however are not included in the target groups in most facilities for elderly mentally ill people. In the study titled "Ältere Drogenabhängige in Deutschland (Elderly Drug Addicts in Germany)" (Vogt et al. 2010), it arose that drug and addiction services specifically target older addiction sufferers with some programmes. Nine inpatient treatment facilities in Berlin that can be used by older addiction sufferers are listed as examples (ibid.).

Complementary facilities

A long-term treatment programme is required for drug addicts with significant impairments with regard to activities and participation in particular (BAR 2005a). Social aid and programmes for providing a daily structure with the aim of having a life that is as autonomous as possible and not dependent on help are in the foreground. These aid programmes could also be taken into account for guaranteeing the success of rehabilitation as follow-up services (after-care measures, adaptation). For example, if withdrawal treatment therapy at an addiction treatment facility is insufficient in reaching the goals of rehabilitation due to the specific effects and consequences of dependency (particularly in the case of a significant risk of relapse due to homelessness and/or joblessness) when treating dependency sufferers, a test must be conducted under everyday conditions to see whether the person undergoing treatment can stand up to the requirements of working life and leading an independent lifestyle. A therapeutically indicated change of environment can be a measure for this

The adaptation phase is embedded in the medical rehabilitation system for dependency sufferers and covers the improvement in performance and strength of the person undergoing rehabilitation, support for preparation for leading an independent life as well as therapeutic services in individual and group therapy in an accompanying form that decreases in its intensity. As a general rule, the adaptation phase aligns itself seamlessly to the treatment phase (withdrawal) as a second component of medical rehabilitation services (DHS 2008).

Aftercare and adaptation facilities are either embedded in a network of inpatient addiction treatment facilities or are geographically separated facilities of inpatient addiction treatment facilities. Such care programmes are particularly available in the form of residential communities, assisted living, halfway homes and sociotherapeutic homes.

Integration of substitutions in inpatient care

As a rule, addiction rehabilitation means guiding people towards abstinence or therapy under the conditions of abstinence. Medical rehabilitation of dependency sufferers with the temporary use of methadone should be viewed as an exception. Since 2001, it has been possible to admit substituted patients to withdrawal treatment. In appendix 4 of the "dependence illnesses agreement" between health insurance companies and pension insurance companies, the Health Insurance Fund and Pension Insurance Scheme established objectives and aids to decision-making for medical rehabilitation of drug addicts at rehabilitation facilities for dependency sufferers with respect to the temporary use of a substitute substance (DRV et al. 2001b). Complete abstinence from drugs is the aim in the case of medical rehabilitation services using substitute substances as well. This also applies in reference to the substitute substance. Their use is "transitional" in this sense.

Nationally there is only a small number of inpatient programmes for substitute drug addicts. These clinics have partially established a maximum number of patients receiving substitutes while undergoing rehabilitation in order to prevent substitution from becoming the sole dominant topic (Korsukéwitz 2010). The Deutsche Rentenversicherung Bund (German Pension Insurance Association) funds two inpatient facilities in

this area, namely the Psychosomatic Clinic in Bergisch Gladbach and the Specialised Facility for Psychosomatic Medicine of the Wied Clinics. Regional funding agencies fund additional facilities. In Baden-Württemberg in particular, an expansion of the programmes for this group of persons is expected since the DRV Baden-Württemberg has supported appropriate concept modifications in special facilities (Korsukéwitz 2010).
One of these for example is the SURE project (Substitutionsgestützte Rehabilitation) (substitution rehabilitation). Since January 2011, the three-year project has been carried out in the Fachklinik Drogenhilfe (Specialised Addiction Clinic) in Tübingen on an inpatient basis and in the "Tagwerk" rehabilitation facility in Stuttgart on an all-day outpatient basis. The target group are opiate addicts, who in principle are eligible for rehabilitation but cannot begin abstinence-oriented treatment without a substitute. The attempt is made for these people to reintegrate on a professional level and to participate in society and social life. The readiness to reduce dosage and abstinence is a requirement for being admitted. The substitute substance is reduced step-by-step under the supervision of authorised substitution physicians and then discontinued entirely. The patients undergoing rehabilitation are integrated into the conventional treatment programme of both facilities. Eleven admissions were made up to February 2012, of which 5 people were still undergoing treatment, therefore only a few results can be reported. At the time of reporting, a patient had reduced dosing over eight weeks as scheduled and completed treatment normally and successfully after a total of 24 weeks (Drogenhilfe Tübingen & Tagwerk Stuttgart 2012).

Cooperation and networking
According to the SGB IX ("Rehabilitation und Teilhabe behinderter Menschen - Rehabilitation and participation of disabled persons"), rehabilitation is not a closed sector of the health care system or of an individual funding agency. The legislative authority calls for joint planning and coordination of different rehabilitation agencies, services and facilities in the interest of those affected. Therefore SGB IX stands for a new form of rendering services in the sense of comprehensive participation that goes beyond the specific demands of SGB V and SGB VI (DHS 2008). The aim is to join participation services as seamlessly as possible in order to offer aid measures that have been aligned as individually and specifically as possible to the needs and resources of those affected.[43] In its guidelines on concept assessment, (DRV 2011a) the DRV-Bund requests rehabilitation facilities to provide support through and in cooperation with companies, particularly in the areas of alcohol, prescription medication, drugs, tobacco and gambling. The DHS shows the current status and the optimal arrangement of forms of association in the document titled "Suchthilfe im regionalen Behandlungsverbund (Addiction assistance in the regional treatment association)" (DHS 2010b). Specifically the document illustrates the linking of the support segments of acute treatment, monitoring and consultation in the integrated system of addiction service, in health care and in social security as well as in the support segments for promoting participation and treatment. Selected examples for regional integrated systems give an impression of the status of implementation as well as advantages and disadvantages of regional integrated systems.
The increasing combination treatments can be named for the inpatient sector in particular. The flexible design of outpatient, all-day outpatient and inpatient treatment possibilities in the form of modules allows for customised aid programmes for dependency sufferers. Furthermore, interface problems are being reduced through closer cooperation between service providers in order to raise the effectiveness and efficiency of the measures as a result.

[43] See for example the project titled 'Step by Step", Chapter 2.2.2, in which cooperation between job centres and addiction services is described.

Combined models: Regional examples
The DRV in Braunschweig-Hannover, the DRV in Oldenburg-Bremen and the DRV Nord together have been running "Kombi-Nord", a combined treatment facility for dependency sufferers in Northern Germany since 2009/2010. 2012 will bring an improvement whereby handover discussions will be able to take place between the facilities involved via video conference. In addition, there will be a uniform release report in the future (Federal Government Commissioner on Narcotic Drugs 2012a).
An additional model for combined treatment, the Kombi Saar, can be found in Saarland. The model by SHG Specialised Clinic for Dependency Illnesses in Tiefental and the IANUA Gesellschaft für Prävention und Sozialtherapie mbH (association for prevention and social therapy) addresses insured persons with alcohol, prescription medication and drug addictions, with the exception of heroin addicts and people participating in substitution programmes. At the start there is an outpatient preliminary talk with IANUA in order to determine whether abstinence was achieved during previous detoxification. If not, qualified detoxification measures must be initially carried out before a treatment agreement can be concluded. Combined treatment is approved as an overall service with established inpatient and outpatient phases. As a rule they should not exceed one year. Inpatient treatment takes place in the Tiefental Specialised Clinic and lasts eight weeks. During the outpatient phase, the person undergoing rehabilitation attempts to make steps towards changes and deepen them. This generally includes 80 therapy sessions (TS) as well as eight TSs for family members (ibid.).
The DRV in South Bavaria has recognised a combination therapy for cannabis dependency in the Grafrath therapy centre as a supplementary programme. Rehabilitation begins on an inpatient basis, which lasts twelve weeks as a rule. This is followed by 40 outpatient therapy units in the cooperating outpatient places of treatment (ibid.).

1.3 Quality management

1.3.1 Guidelines and standards for inpatient addiction assistance

The effort to provide medical, psychotherapy and psychosocial interventions for people with substance-related disorders at the highest level of quality possible was promoted with lasting effect by the standards of the "Recommendation agreements for addiction" from 1978.
Current foundations for providing services for inpatient medical rehabilitation are firstly the agreement titled "Dependency illnesses" (DRV et al. 2001c) Secondly, the BAR[44]work assistance for rehabilitation and participation of people with dependency illnesses is a basis for work in the inpatient addiction assistance sector (BAR 2005a). Work assistance provides an overview of the general principles and foundations for services for rehabilitation and participation, substance-related disorders and dependency illnesses (incl. diagnostics, rehabilitation aims, treatment principles, indications), the arrangement and organisation of the addiction assistance system for people with dependencies, the available rehabilitation programmes and the basis for claims from a social law point of view.
An additional basic requirement of inpatient treatment facilities is the orientation of the therapy concept towards the guidelines of the Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF) (Association of Scientific Medical Societies). Currently the guidelines on "Cannabis-related disorders", "Opioid-related disorders" (Acute treatment and post-acute treatment), "Psychological and behaviour-related disorders resulting from cocaine, amphetamines, ecstasy and hallucinogens" and "Medication dependency (sedatives, hypnotics, analgesics, psychostimulants)" as well as on the substances of alcohol, tobacco are being revised (see Special section of the REITOX report 2011, Pfeiffer-Gerschel et al. 2011).
In order to guarantee uniform documentation in psychosocial counselling centres and inpatient facilities for people with substance-related disorders, eating disorders and pathological gambling behaviour, the Deutsche Kerndatensatz (KDS) (German Core Data Set) has been utilised in the current version nation-wide since January 2007 for documentation in the area of addiction help. It was created in 1998 as a common minimum statistical data set in the scope of a consensus process between many involved institutions and persons, which took place in the Fachausschuss Statistik (Trade Statistics Committee) (previously Statistik-

[44] The Bundesarbeitsgemeinschaft für Rehabilitation e.V. (Federal Working Committee for Rehabilitation) (BAR) promotes and coordinates the rehabilitation and participation of disabled persons. In accordance with the statutes, it pursues the primary target to work towards providing rehabilitation services according to the same principles for the benefit of the disabled and the chronically ill. It represents funding agencies of the statutory health insurance, statutory accident insurance, statutory pension insurance and the Federal Employment Agency. Additional members include the Federal States, the Federal Association of German Employers' Associations, the German Trade Union Confederation, the Federal Association of Integration Offices and Main Welfare Associates, the Federal Task Force on Supra-Local Welfare Agencies as well as the National Association of Statutory Health Insurance Physicians (www.bar-frankfurt.de).

AG) of the DHS. Since 2002, the core set of data has been determined as a nation-wide uniform data set for documenting addiction treatment by Working Group for the Statistical Report on Substance Abuse Treatment in Germany (AG Deutsche Suchthilfestatistik, AG DSHS), in which federal, *Laender*, pension insurance and statutory health insurance are represented in addition to the service providers. The data collected using the KDS of the individual facilities are sent using different software solutions in aggregated form to the Institute for Therapy Research where they are bundled and evaluated in the DSHS project funded by BMG. Significant aims of the German Addiction Statistics (Deutsche Suchthilfestatistik, DSHS) are to present and analyse the quality of the health care system, early detection of new problem areas as well as to prepare suggestions for improvement in order to optimise care for consumers with (primarily) substance-related disorders. Furthermore it is used as a monitoring system on a federal state, association and consumer level. The DSHS has developed into a recognised and highly valued monitoring instrument in the area of German addiction treatment, which also enables trend analyses of data for care research (DHS 2010a).
In order to promote cooperation among rehabilitation agencies in quality assurance, a joint declaration was made for the first time in 1999 by the association of pension, health and accident insurance companies on cooperation on quality assurance. This applies to facilities of outpatient and inpatient rehabilitation and inpatient preventative treatment. In the process, specific requirements, aims and content of external quality assurance and internal quality management were established. In accordance with § 135a SGB V, providers of preventative services or rehabilitation measures as well as facilities with which a preventative care agreement has been signed in accordance with § 111a are obligated to do the following:

- participate in measures of quality assurance across facilities, which particularly aim at improving the quality of results and
- introduce quality management and further develop it internally.

The contents of the agreement take into account the rules of the Common Recommendation in accordance with § 20 par. 1 SGB IX. Since October 2009, a quality management procedure is mandatory for all providers of inpatient services for medical rehabilitation. To complete this statutory task, the "Vereinbarung zum internen Qualitätsmanagement nach § 20 Abs. 2a SGB IX (Agreement on internal quality management according to § 20 par. 2a SGB IX)" was worked out on the level of the Bundesarbeitsgemeinschaft für Rehabilitation (Federal Working Group for Rehabilitation) (BAR 2009), in which the fundamental requirements of a quality management procedure are regulated. Additionally, it defines a uniform, independent certification procedure.

Requirements of internal quality management (BAR 2005a)
Participation-oriented model
Facility concept
Indication-specific rehabilitation concepts
Responsibility of quality management at the facility
Basic elements of a quality management system
Relations with those undergoing rehabilitation/reference persons/relatives, clinicians, service providers, self help
Friendly management of complaints
External quality assurance
Internal results measurement and analysis (procedure)
Error management
Internal communication and personnel development

Inpatient rehabilitation facilities are required by law to conduct a quality management procedure that is recognised by the BAR. Most quality management systems (QM systems) in medical rehabilitation are based on DIN EN ISO 9001:2000 (DHS 2008). The Deutsche Gesellschaft für Qualitätsmanagement in der Suchttherapie e.V. "deQus" (German Society for Quality Management in Addiction Treatment), founded in 2001, supports addiction treatment facilities in the introduction and certification of QM (deQus 2000). The rehabilitation facility must issue a release report based on the "Leitfaden zum einheitlichen Entlassungsbericht in der medizinischen Rehabilitation der gesetzlichen Rentenversicherung" (Guidelines on uniform release reports in medical rehabilitation of statutory pension insurance) after every service rendered for medical rehabilitation (DRV 2009). The guidelines provide information on how reporting in medical

rehabilitation is to be structured in terms of content and which rules apply to social medicine documentation. Further guidelines are additionally used[45]. Extensive information on development, methods and implementation of national treatment guidelines can be found in the REITOX Report 2010 (Pfeiffer-Gerschel et al. 2010a).

The pension insurance companies' quality assurance programme for medical rehabilitation is based on a system of structure, process and results quality. The survey of persons undergoing rehabilitation, the peer-review procedure, evaluations of the rehabilitation performance data as part of the classification of therapeutic services (KTL) and the rehabilitation treatment standards for alcohol dependency are part of the practiced procedure of rehabilitation quality assurance (DRV 2012a; Klosterhuis et al. 2011). Rehabilitation quality assurance of pension insurance is initially supported by routine data, which are documented during the application process, decision-making and implementation of rehabilitation measures. Features such as age, gender, severity of addiction and social situation are fundamental for assessing the person undergoing rehabilitation. (Klosterhuis et al. 2011). The continuous survey of persons undergoing rehabilitation concerns the satisfaction of rehabilitation patients with treatments and consultations carried out as well as the assessment of the success of rehabilitation from the patient's point of view (ibid.). The figures are calculated according to the principle of optimum quality (=100 quality points). In the process, the individual results are converted to quality points. In 2011, 76% of all patients undergoing rehabilitation with dependency illnesses rated the rehabilitation measures carried out as successful on average, which consequently corresponds to 76 of 100 quality points. 74 quality points were achieved for satisfaction by patients undergoing rehabilitation, which corresponds to an average mark of "2" on a scale of "1" (very good) to "5" (bad). In the assessment of individual rehabilitation processes in the peer-review procedure, the addiction facilities received 74 quality points in 2011, which corresponds to the results of the previous year (DRV quoted by the Federal Government Commissioner on Narcotic Drugs 2012a). Furthermore, the therapeutic range of services is rated and compared by evaluating the routine documentation of the treatments performed according to the release reports. Looking at the services provided by 66 addiction treatment facilities, you get an average of 74 out of 100 possible quality points. The best facility had 82 and the worst 68 quality points (ibid.).

Personnel

Only professionals with relevant training can work in addiction treatment. The German Pension Insurance enacted guidelines on advanced training of professionals for individual and group therapy within the framework of medical rehabilitation of addiction sufferers, in which advanced training courses can receive a "recommendation for recognition". As part of restructuring the education system in Germany according to European guidelines (introducing Master's and Bachelor's degrees at universities and colleges) the requirements for therapeutic employees of addiction support are also defined and designed anew. Postgraduate educations play a particularly important role when redesigning training courses for social workers, psychologists and physicians. Cooperation between different professional groups from social work/education, psychology, psychiatry and other fields of medicine is one of the significant standards of treatment when dealing with drug addiction (Pfeiffer-Gerschel et al. 2011).

The description of the establishment plan of the DRV-Bund is largely based on the "Abhängigkeitserkrankungen" (Dependency Illnesses) agreement (DRV et al. 2001c), which stipulates different group sizes in psychotherapy for people dependent on alcohol, prescription drugs and those dependent on illegal drugs. A therapist with suitable qualifications should be available for group and individual therapy for drug addicts with 6 to 8 patients each (either physician, psychotherapist, social worker/educator or ergotherapist). Furthermore, additional generally-active therapists should be available in sufficient numbers including medical personnel if necessary (ibid.). Personnel assessment is generally directed at the latest structural requirements. It is individually established in connection with the therapy concept of treatment facilities (DRV 2010a).

When comparing across indications, it makes sense to refer employee numbers to a uniform number of patients undergoing rehabilitation. With respect to personnel assessment, the DRV-Bund has selected such a ratio where the number of employees required for a facility with an average occupancy of 100 rehabilitation patients is listed (DRV 2010b). The specifics of smaller ward sizes must be taken into account precisely for facilities dealing with dependency illnesses. Table 11.4 brings together the required professional groups in function groups in order to make meeting personnel requirements more flexible. Assessment of the number of required employees takes place on the level of function groups. In this respect, it should be noted, particularly in the case of dependency illnesses, that graduate social educators and workers in addition to physicians and graduate psychologists could also be employed on a psychotherapeutic or addiction treatment level as long as they also have completed recognised additional therapeutic training. The group of social workers, however, is also responsible for the duties part of clinical social work.

[45] Clear presentation found at http://www.suchthilfe.de/themen/basis.php.

Table 11.4 Personnel requirements – Number / 100 people in rehabilitation

	Dependency illnesses			
	Alcohol / prescription medication		Illegal drugs	
Professional groups	**Number / 100**	**Functional group**	**Number / 100**	**Functional group**
Physicians	3	3	3	3
Graduate psychologists	5	10	5	14
Graduate social workers / graduate social ed. pedagogues	5*		9*	
Care workers	6	6	6	6
Physiotherapists Graduate phys. ed. teachers Phys. ed. teachers / Gymnastics teachers	2.5	2.5	2.5	2.5
Diet assistants / Ecotrophologists	0.5	0.5	0.5	0.5
Ergotherapists Occupational therapists Vocational therapists Creative therapists Gestalt therapists, art therapists	4.5	4.5	4.5	4.5

* including 1 graduate social worker for clinical social work.

abridged according to DRV 2010b, p. 21.

Regular advanced training of employees must be guaranteed according to the requirements of the "Dependency illnesses" agreement from 2001 (see appendix 1, number 7, attachment 2 number 8). Facilities that are public and non-profit organisations are generally bound to the respective tariff schemes. The Working Hours Act must also be taken into consideration when organising the employment of staff. Employment costs are 70% of the total costs of a specialised addiction clinic. In the past few years it has become more and more difficult to occupy positions at facilities due to the lack of skilled professionals and the strict requirements of funding agencies. The situation with respect to this and to physicians is problematic, and especially for small facilities (DHS 2008). The problem concerns assistant and medical specialist positions as well as medical director positions.

Link between funding and effect

Particularly in times of limited resources, funding agencies demand quality certificates from facilities. Nonetheless, there are only a few evaluation studies available on the issue examining the extent to which the measures of inpatient rehabilitation contribute to abstinence and social and professional integration of drug addicts. Catamnestic studies show a limited response rate due to a lack of agreement to participation in follow-up reports, invalid addresses of the patients listed or because of people who refuse, people who are unavailable or have died or patients who are incapable of being interviewed. Fischer et al. (2007a, b) examined two abstinence-oriented drug rehabilitation facilities in Rhineland-Palatinate within the drug catamnesis research project in a prospective study. Among the 429 patients involved, data was gathered at four measurement times (Start/end of treatment, 6 and 12-month follow-up history). The rate of response for the 6-month follow-up history was 55.3% and 41.5% for the 12-month follow-up history. Due to methodical difficulties, "success records" hover between conservative and optimistic. If one were to follow conservative estimates in this study, the rate of success hovers between 21.5% and 25%. Optimistic estimates are between 41% and 55%. Sonntag und Künzel (2000) documented a response rate between 30% and 60% as well as abstinence rates between 23% and 37% for 12-month follow-up histories in their review of different catamnesis studies. They state that approx. one quarter of drug addicts remain abstinent one year after their inpatient treatment (ibid.). Overall, treating drug addicts is more successful catamnestically if the end of treatment goes according to plan, the length of treatment is 16 weeks, patients undergo treatment voluntarily and display a rather short length of dependency of a maximum of 10 years. Other beneficial factors include being female and a rather young age when entering treatment (Fischer et al. 2007b).

Studies on cost-effectiveness with respect to illegal drugs are rare in Germany. As part of the German model project on heroin-assisted treatment of opiate addicts,[46] general information on treatment costs was also gathered in the accompanying research in addition to the specific costs and benefits of heroin-assisted treatment (v.d.Schulenburg & Claes 2006). The costs of drug treatment, outpatient and inpatient (psychiatric) treatments per week are listed in Table 11.5. These are fundamentally applicable not only to the project itself, but toward the addiction support system in general. Inpatient drug-free treatment is estimated at €3,047 per patient per week, staying at a therapeutic community is listed at €700 and €1,048 for psychiatric clinics. Most of the information is based on estimates or calculations using secondary data (e. g. DSHS, Bundesarbeitsgemeinschaft der Träger psychiatrischer Krankenhäuser (Federal Working Committee for Psychiatric Hospital Agencies). The percentages for staff or material costs cannot be estimated.

Table 11.5 Costs of various treatments per week

	Costs of treatment per week
Outpatient detoxification treatment	€ 32
Inpatient detoxification	€ 2,469
Outpatient substitution (without costs of the substitute)	€ 32
Psychosocial monitoring	€ 37
Outpatient drug-free treatment	€ 52
Inpatient drug-free treatment	€ 3,047
Therapeutic community (complementary)	€ 700
Day clinic	€ 700
Psychiatric clinic	€ 1,048
Outpatient psychiatric clinic (complementary)	€ 50
Other clinics/stations	€ 3,047
Other treatment	€ 700

v.d.Schulenburg & Claes 2006.

1.4 Discussion and outlook

Inpatient treatment of drug addicts is a significant component of the differentiated and effective addiction support system in Germany. Not only scientific results and experience-oriented knowledge based on practice have led to continuous further development, modification and innovation of service programmes. Also, increasing economisation and rationalisation entail expanded organisational requirements for inpatient facilities for drug addicts (DHS 2008). Finally, the effects of demographic change lead to challenges for inpatient addiction treatment.

From the point of view of the DRV-Bund, the question arises with great urgency as to how the few resources can be applied with greater efficiency and even better individual accuracy (Hebrant 2011). It is stressed that despite the general scarcity of financial resources, the DRV-Bund's policy of "no rehabilitation based on cash situation!" still remains and therefore every application is reviewed according to the guidelines and no reduction in the approval rate can be seen (Hebrant 2011). Nevertheless, experts are talking about a "financial crisis for rehabilitation" (Koch 2011). Professional addiction associations warn that the addiction rehabilitation system is coming under massive pressure (see buss et al. 2011). The resources for medical rehabilitation are scarce due to the capped budget for rehabilitation of the German Pension Insurance Scheme and the implementation of austerity measures. The effects of the austerity measures are visible in the decision titled "Anpassung und Harmonisierung der Richtwerte für die Verweildauern (Adjustment and harmonisation of the reference values for length of stay" of 21 September.2010 (Koch 2011)). As part of these austerity measures, the tendency to shorten the length of stay for inpatient facilities treating drug addictions or increasing outpatient or combined treatments as well as stricter controls for approving rehabilitation measures is becoming evident (Koch 2011; Zellner 2011). As a result, specialised clinics in particular that work according to the principle of therapeutic communities have been placed in a precarious

[46] The German Federal Model Project on heroin prescription deals with a scientific drug investigation study that took place between 2002 and 2004 in seven cities with a total of 1,015 study participants. As part of this, serious addicts received injectable heroin as medication. A control group received the replacement drug in parallel.

situation (DHS 2008). In the past few years it has become clear that the budgetary situation for rehabilitation remains tense and no clear relief is expected in the coming years. Increasing the budget for rehabilitation is advocated by many sides, however it seems unlikely that the legal framework will be changed in the near future (Koch 2011).

Improved flexibility in the programme structure becomes evident primarily in the expansion of part-time inpatient and outpatient treatment programmes. Starting in 2012, the DRV-Bund has allowed patients undergoing rehabilitation to switch from inpatient to all-day outpatient facilities in their proximity as a so-called "extended all-day outpatient release form". Previously this was possible only in individual cases if the insured person happened to be living close to the respective inpatient rehabilitation facility (Hebrant 2011). Four of the 35 all-day outpatient rehabilitation facilities funded by the DRV-Bund (Status as of: February 2010) are exclusively specialised in rehabilitation of drug addicts, 22 treat only alcohol and prescription medication dependency and seven rehabilitate all three indications together (Korsukéwitz 2010). A regular combination of inpatient and all-day outpatient rehabilitation is targeted as an alternative and supplement for the market (Hebrant 2011). The definition of short-term and long-term treatment is thus broken down and the length of treatment is made more flexible.

The Kombi-Nord model represents good practice. The previous model for combination treatment "inpatient/outpatient" provides only an inpatient start to the procedure in principle. Flexible handling of outpatient and inpatient elements that allows for need-based entry into and transfer between rehabilitation treatments is needed (DHS 2008).

The fact that patients with increasingly worse health conditions are entering inpatient rehabilitation must be taken into account (Fachverband Sucht e.V. 2012). Furthermore, it is also clear that the detoxification phase has become significantly shorter due to the flat-rate system and austerity measures. Patients cannot be motivated sufficiently in such a short time span of the detoxification phase and prepared for inpatient withdrawal treatment. As a result, the withdrawal phase is more difficult or the cost of care increases (Fachverband Sucht e.V. 2012; Zellner 2011). Seamless integration between acute care and rehabilitation facilities is important to avoid a possible "revolving door" effect in the field of detoxification. However, the time after rehabilitation must not be ignored in the networking structure. Rehabilitation after-care as well as the inclusion in a self-help group, assist in securing sustained success of the treatment (DHS 2008).

The on-going development of quality assurance and review of effectiveness, particularly against the background of scarce financial means will continue to remain a central topic in inpatient addiction treatment. The significance of certifications will increase due to legal requirements. This leads to significant improvement of treatment quality (DHS 2008). The use of new technologies will also enter the field of rehabilitation treatment (Fachverband Sucht e.V. 2012). This includes for example online applications, improved data exchange or clinic information systems. However, sufficient and above all qualified staff must be available for this. Since neither fair or customary salaries can be paid using grants, allowances or cost rates, there are signs of a lack of skilled professionals in all professional groups for addiction treatment (Leune 2012). The situation appears problematic especially in the case of physicians particularly in this respect and for small facilities (DHS 2008).

Work-related measures are an indispensable component of rehabilitation with the aim of restoring the ability to work. More attention will also have to be paid in the future so that professional rehabilitation services for the transition to working life is secured during and at the end of medical rehabilitation for the transition to working life (DHS 2008). Finally, even more intensive cooperation is required between individual treatment facilities and companies that take SGB IX into account due to the increasing flexibilisation and differentiation of services.

The observation and analysis of trends and changes among clientele is of great importance for the development of the programmes. The total population of addicts portrays an increasingly heterogeneous image: people with multiple dependencies or additionally diagnosed with psychiatric disorders, people with a migration background, the homeless or the long-term unemployed (DHS 2008). The consumption of multiple psychoactive substances in particular is more frequently described as "normal" (Zellner 2011). In the case of drug addictions, double diagnoses can be seen in up to 70% of cases depending on the examination (DHS 2008). A tendency can be observed whereby the leading diagnosis for multiple dependencies turns the balance and decides on the patient's allocation, appearing as a result as the only diagnosis statistically (Hebrant 2011). Depending on the severity of the disorder, different requirements arise for the profile of the rehabilitation facilities, such as the treatment of lesser comorbid disorders, combined treatment or specialised treatment with a particular focus on the comorbid disorder (DHS 2008). In addition, the size of the facility must be adjusted to the needs of the clientele. Longer duration of treatment must be made possible particularly in individual cases. A modified cost structure arises from this even with respect to equipment. Patients with comorbidities require not only a specially qualified staff, but oftentimes higher expenditures on supplies (medication) as well (DHS 2008). Rehabilitation and the measures used in individual cases will be increasingly adapted to individual needs and person-related aims with respect to the type, compactness and scheduling of services (DHS 2008).

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ESTONIA

Chapter 11. Residential treatment for drug users in Estonia

11.1 History and legislative framework

11.1.1 History of drug addiction treatment

Inpatient addiction treatment is still in development stage in Estonia and we cannot speak of any historical consistency. Coercive treatment could in theory have been imposed on drug addicts by courts in the 1980s, but generally this practice was not applied, since in that period the drug problem was largely absent in Estonia. Drug addiction treatment started to develop in the beginning of 2000s due to the rapid spread of drug injection. In an Estonian context the drug addiction treatment consists mainly of methadone treatment. Methadone detoxification treatment was started in 1998 and a substitution treatment in 2001. Methadone treatment was implemented more extensively in 2003, when the first special methadone treatment centres were established.

The first rehabilitation farms were created at the end of 1990s. Operation of the rehabilitation farms was organised through non-profit associations financed from various sources, such as donations, state budget and self-financing.

11.1.2 Legislation regulating inpatient addiction treatment

'Drug addiction treatment is regulated through the NSPD. Furthermore, drug addiction treatment is regulated by the Mental Health Act (Mental Health Act. (RT1 I 1997, 16, 260), enforced from 16.03.1997.

Provision of opiate substitution treatment has been regulated by the Regulation No. 73 of the Minister of Social Affairs "Terms and conditions for medical and scientific handling of narcotic drugs and psychotropic substances and relevant accounting and reporting and lists of narcotic drugs and psychotropic substances" (enforced from 05.06.2005) (RTL 2005, 57, 807), the Health Care Services Organisation Act (enforced from 01.01.2002) (RT I 2001, 50, 284) and the Personal Data Protection Act[1] (enforced from 15.02.2007) (RTI 2007, 24, 127). The aforementioned regulation specifies medical and scientific handling of narcotic drugs and psychotropic substances and relevant accounting and reporting. Supervision of the execution of the law, i.e. compliance of drug handling, is the competency of the State Agency of Medicines.

The Health Care Services Organisation Act specifies the requirements to the provision of health care services and the procedure of management, financing and supervision of the field of health care. The Minister of Social Affairs shall establish the requirements for facilities, installations and equipment necessary for the provision of health care services (RTL 2002, 25, 353). Supervision of the organisation of health care services is performed by relevant officials of the Health Board.

The objective of the Personal Data Protection Act is to protect basic rights and freedoms of a natural person, above all the right for privacy, during the processing of personal data. Information about the state of health or disability of a person is a delicate information, which processing (collection, storage, organisation) shall be based on the principles of processing of personal data.

11.2 Availability and characteristics of treatment

11.2.1 Overall availability and accessability

No data available.

11.2.2 Types and description of stationary drug addiction treatment

Of the inpatient treatment types targeted to drug users, only short-term detoxification treatment service and inpatient rehabilitation is provided in Estonia.

Hospital-based drug addiction treatment

Since June 2011 an agreement was concluded with Wismari Hospital for the provision of short-term inpatient detoxification treatment basing on non-opiate pharmaceuticals (maximum 21 days), which is financed from

the national drug strategy. Before that, the patients had to cover the treatment costs themselves. In 2011 the hospital had four treatment places and service was provided to 46 clients in total. Treatment options are available for the users of fentanyl, amphetamine as well as mixed drugs. To fix the results of short-term detoxification treatment, the patients can receive outpatient follow-up counselling service for up to 3 months. Follow-up counselling includes weekly consultations of a psychologist and consultations of a psychiatrist held every second week. 16 persons used this possibility in 2011.

There are six places in total for drug addiction treatment for minors in Estonia (2 places at the Children's Department of the Psychiatry Clinic of Tartu University Hospital and four places in Tallinn Children's Hospital). Inpatient treatment will last up to three weeks. Conduction of psychological, study and education work in the unit for children and adolescents with addiction disorders at Tallinn Children's Hospital is funded from the NSPD. In 2011 there were four beds for addicts in the Children's Hospital and inpatient addiction treatment was provided to 100 adolescents.

Inpatient rehabilitation

48 places of round-the-clock rehabilitation for male clients were funded from the NSPD in 2011. In the reporting period the service was provided to 137 persons in total for 391 058 Euros. The duration of rehabilitation is generally 9-12 months, but it can also be longer. Inpatient rehabilitation service funded from the national strategy is provided in three centres. Two of these are operating as rehabilitation farms: MTÜ NARK „You will not remain alone" in Vaivara near Narva, 12 places, and MTÜ AIDSi Tugikeskus in Lääne-Viru County, 10 places. The farms operate with the principle of 12 steps as therapeutic communes, where the proportion of professional services is low and more stress is laid on work therapy and religion. Since 2012 the farms are no longer funded from the national strategy.

In addition to the farms there are 26 treatment places for men in Sillamäe drug rehabilitation centre, which is also using the 12-step methodology. The centre has also a music therapist, activity instructor, experience counsellor, psychologist, social worker, nurse and psychiatrist.

Since November 2010 OÜ Comenius in Tallinn provided round-the-clock rehabilitation service for male and female patients, funded from the ESF programme, but from April 2012 OÜ Comenius suspended provision of the service. 21 persons in total received rehabilitation service during the mentioned period.

There are more centres providing inpatient rehabilitation service for drug and alcohol addicts, but these are not funded from the state budget. Two centres with longer experience are MTÜ Lootuse Küla in Laitse near Tallinn and MTÜ Sotsiaalrehabilitatsiooni Keskus Loksa. These centres are faith-based. Working methods are group, family and work therapy.

OÜ Corrigo in Jõhvi provides inpatient rehabilitation service for minors. The centre is open also for minors who are still using drugs. The centre is providing therapy to minors for the treatment of addiction problems, developing their social skills and enabling continuation of education in Jõhvi Vene Gümnaasium. Duration of the service is 10 months. In exceptional cases (e.g. children from orphanages) also longer or shorter (three-month) rehabilitation is available. There is a waiting list to get the service and from September 2011 the volume of the service was increased from 18 to 24 places funded from the NSPD. 52 adolescents, including 37 boys and 15 girls, received inpatient rehabilitation service in the centre in 2011.

Tallinn Children's Shelter is a social welfare institution providing rehabilitation and reintegration services for minors after the necessary medical care. The centre is financed by Tallinn City Government. There are 48 places for minors in the centre, waiting period for the service is approximately one year. Normal duration of the service is 10-12 months. School education can also be continued in the centre.

11.2.3 Treatment connections with other services

No data available

11.2.4 Opioid substitution treatment

Only outpatient methadone treatment is available in Estonia.

11.2.5 Typical levels of collaboration and networking

As for adults, cooperation takes place mainly with local governments and the Unemployment Insurance Fund. Also, the courses of Estonian language and computer study have been organised for the addicts. Since 2004 Ida-Viru Vocational Education Centre has provided education to drug users, but the aspect of vocational study still needs development. As for minors, cooperation takes place with schools, child protection and local governments.

11.3 Quality of treatment

As the inpatient addiction treatment service is still in the development stage, no surveys of the quality of treatment have yet been conducted and it is difficult to assess the quality.

11.3.1 Availability of guidelines and service standards for inpatient treatment

As the inpatient addiction treatment service is still in the development stage, no official treatment guidelines are available. There have been two consensus documents for the specialists dealing with drug addiction treatment: drug addiction treatment guidelines (2001) and opiate addiction treatment guidelines (2007). The treatment guidelines drafted in 2001 cover drug addiction treatment in broader sense and concentrate only on detoxification treatment, while the 2007 version concentrates only on opiate addicts and extends the options of treatment methods.

For the services funded from the national strategy, the NIHD has set requirements on the basis of a contract. A contract specifies requirements to the staff, their training and facilities used for the provision of the service.

11.4 Discussion and summary

Taking account of the seriousness of drug problem in Estonia, there is strong need for inpatient treatment. At the moment the possibilities for inpatient treatment are relatively limited, especially in Ida-Viru County, where the option of inpatient treatment is completely lacking. At the same time the drug problem is very sharp in this region. Hospitals provide only short-term detoxification treatment for adults as well as minors, with maximum duration of three weeks, while a successful treatment should last at least three months. Since April 2012 the NIHD has concluded a contract with Jämejala Hospital for the provision of long-term inpatient drug addiction treatment services.

More places should be also created for inpatient treatment for minors. The survey mapping the needs of minor addicts for health care and support services found that Estonia would need centres dealing with addiction and psychic and behaviour disorders of minors and basing on common standards. The need for a treatment and rehabilitation centre dealing with addiction problems of minors is the sharpest in South Estonia. It would be important to establish a place, where to send the minors after their stay in a hospital or in cases where the child does not need active hospital treatment. The optimum size of a rehabilitation centre would be 10-15 places.

One reason for limited treatment possibilities is the lack of necessary staff. Estonia would need psychologists, psychiatrists, social workers and other specialists, who could treat people with addiction problems. Another problem is financing. Until now the financing of drug addiction treatment has been project-based; this restrains development and prevents drafting of long-term plans.

Chapter 12. Recent trends of drug-related public expenditures and drug services

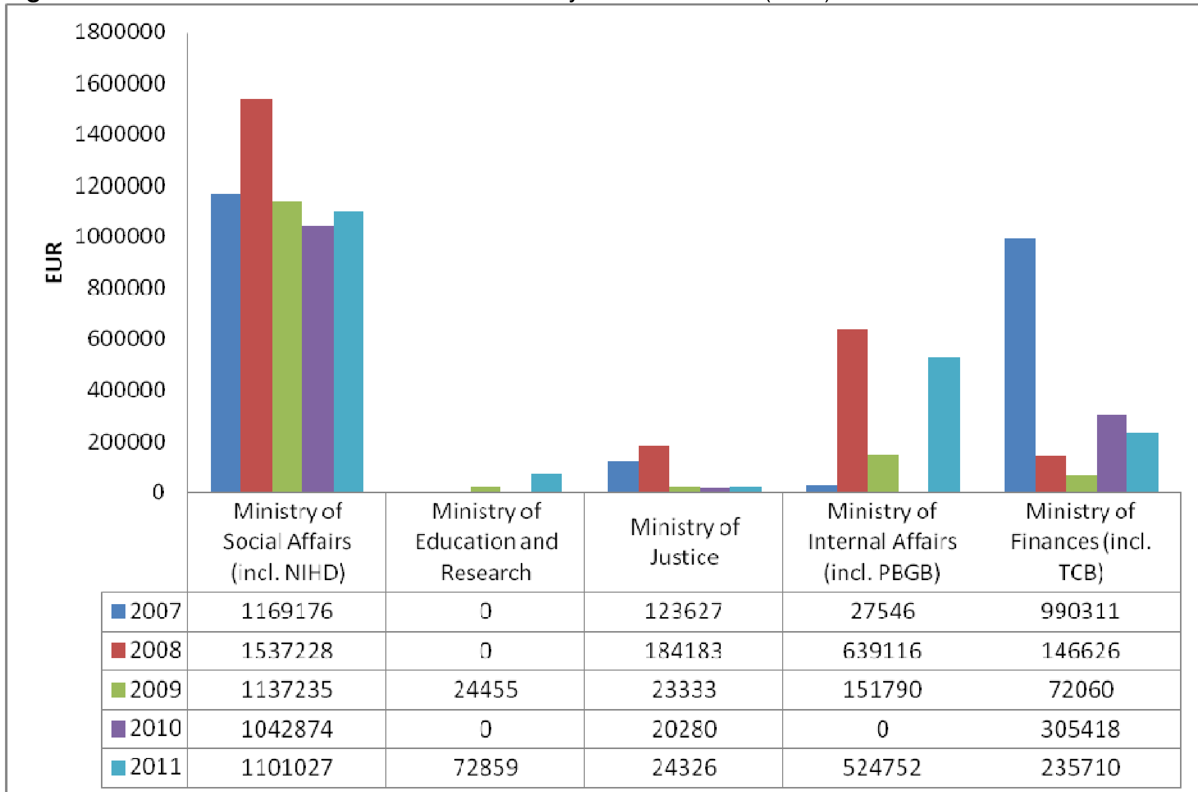
The goal of this chapter is to present an observation of whether the economic pressure and the wish to keep the state budget balanced has affected public expenditures for prevention of drug addiction. In preparing this chapter, the implementation plan reports of the years 2007-2011 of the NSPD were used. Those plans provide an overview of the actions taken and the interventions applied for implementing the NSDP and the financial expenditures made to that end by ministries and their agencies involved in implementing the strategy.

The National Strategy for Prevention of Drug Addiction until the year 2012 and its implementation plan are coordinated by the MSA. NSPD is a multi-sector strategy implemented by not only the MSA but also the NIHD (prevention, treatment and rehabilitation, monitoring and evaluation), the MER (primary prevention in schools), the Ministry of Justice (drug prevention and combating drug related crime in prisons), the Ministry of Interior and the Police and Border Guard Board (PBGB) in its area of government (combating drug related crime), and the Estonian Tax and Customs Board in the area of government of the Ministry of Finances (cross-border detection and combating of drug related crime).

Figure 1 shows the distribution of resources for various implementers of NSDP in the years 2007-2011. In the years 2009-2010 the expenditures of NSDP decreased in activities for demand reduction and in most activities for supply reduction. There was a positive trend of increasing the financing for the NSDP in the year 2011. We cannot present the expenditures of monitoring the field of drug addiction across separate years.

Monitoring expenditures are included in the expenses for demand reduction. External financing was also used for financing the monitoring activities in the reviewed period.
In the year 2009 expenditures of the Ministry of Justice also decreased by several times (Figure 2). This decrease has practical causes as in the year 2008 there were large one-time investments made into equipment for combating import of drugs into prison environments (drug detector, preventing mobile telephone coverage). All drug-related activities of the Ministry of Justice cannot be detailed as several activities (incl. therapy and rehabilitation of drug addicts) are financed from the budgets of prisons instead of the NSDP. The number of prisoners receiving substitution and rehabilitation therapy in prisons has been growing year by year (2011 Selective issue).

Figure 2. Use of the resources of the NSPD in the years 2007-2011 (EUR)



	Ministry of Social Affairs (incl. NIHD)	Ministry of Education and Research	Ministry of Justice	Ministry of Internal Affairs (incl. PBGB)	Ministry of Finances (incl. TCB)
2007	1169176	0	123627	27546	990311
2008	1537228	0	184183	639116	146626
2009	1137235	24455	23333	151790	72060
2010	1042874	0	20280	0	305418
2011	1101027	72859	24326	524752	235710

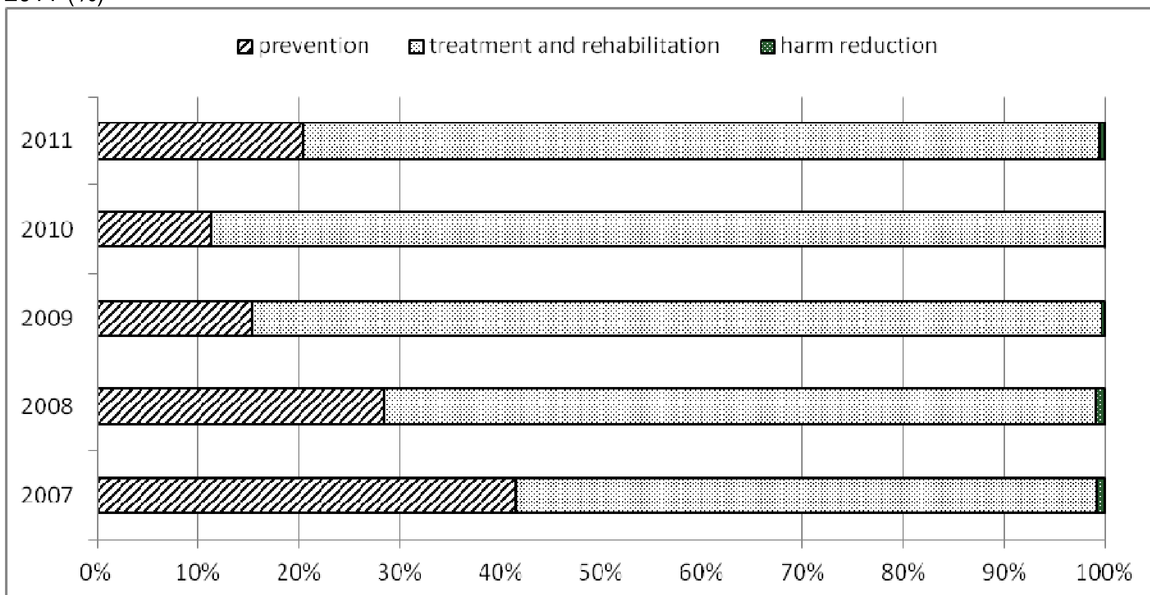
Source: NSPD reports in the period of 2007-2011
Comment: The activity of the MER is implemented on account of its main activity, thus it cannot be presented as a separate expenditure in the NSDP's budget. Expenditures of the Ministry of Interior and its agency (the Police and Border Guard Board) are presented together. Expenditures of the Ministry of Social Affairs and the National Institute for Health Development are also presented together.

In the years 2007-2011 a total of 9,553,932 euros were used for implementing the NSPD; 64% of this (6,084,854 euros) were spent on demand reduction (the MSA and its agency, i.e. the NIHD, and the MER) and 32% (3,093,329 euros) were spent on supply reduction (the Ministry of Interior and its agency, i.e. the Police and Border Guard Board, and the Tax and Customs Board as an agency of the Ministry of Finances). According to the relevant reports, the expenditures of the Ministry of Justice for implementing the NSPD in the period made up 4%.

Demand reduction

In the years 2007-2011, 98% (5,987,540 euros) of the finances allocated for demand reduction were spent on the activities of the MSA and the NIHD (prevention, treatment and rehabilitation, monitoring and assessment). Expenditures of the MER made up only 2% (97,314 euros) of the total expenditure for demand reduction). At the same time, the percentage share presented here does not reflect all expenditures made by the MER in the field of drug addiction in the years 2007-2010. The specifics of reporting and the problems of separating expenditures of the MER must be taken into account when looking at its financial expenditures. In the years 2007, 2008 and 2010 the MER did not separate its drug prevention expenditure from its general education-related expenditure.
Figure 3 shows that the expenditures of treatment and rehabilitation services did not decrease in the reporting period. That decision was made knowingly and was caused by setting priorities during the economic hardship. The share that did decrease due to budget cuts was that of primary prevention. Harm reduction expenditures have been low in the NSPD throughout the years. Harm reduction has been divided between two different strategies in Estonia: The NSPD and the National Strategy for HIV and AIDS prevention.

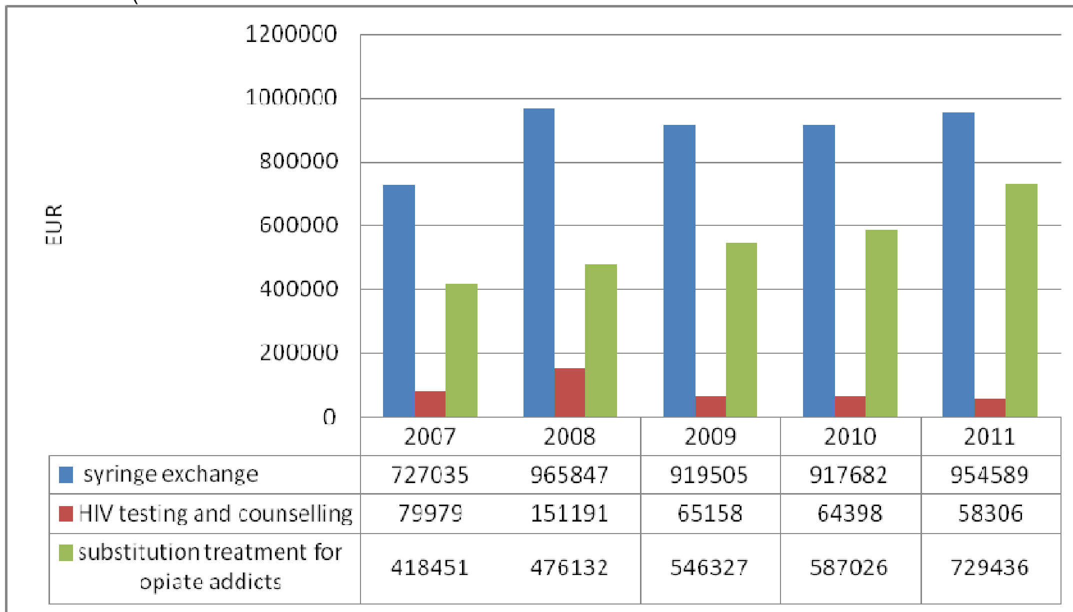
Figure 3. Distribution of expenditures for primary prevention, treatment and rehabilitation in the years 2007-2011 (%)



Source: NSPD reports in the period of 2007-2011

In Estonia the services of harm reduction for drug injectors are financed from the funds of the HIV/AIDS strategy. Financing of the harm reduction services is shown in Figure 4. Since year 2008, financing of the service of the syringe exchange programme and the voluntary testing and consulting for HIV and other drug-related infections has been decreasing. In the year 2011 financing for the syringe exchange programme increased again. Expenditures on substitution therapy of opiate addicts have been growing continually since the year 2007.

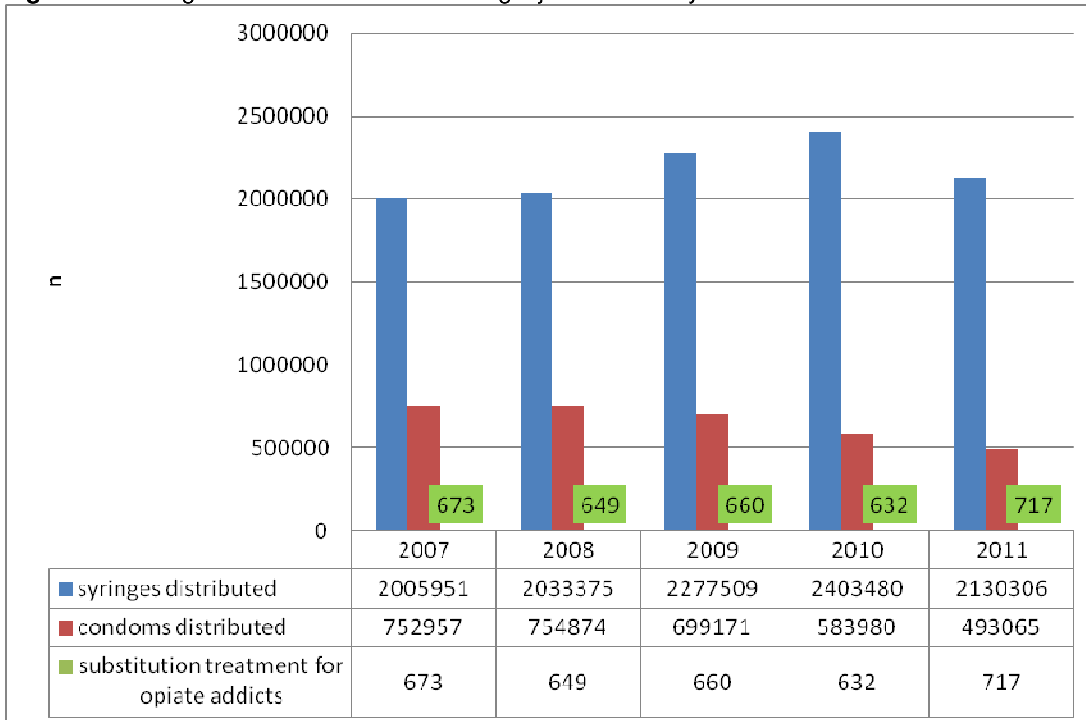
Figure 4. Financing of the harm reduction services from the funds of the HIV/AIDS strategy in the years 2007-2011 (EUR



Source: Annual reports of the HIV/AIDS strategy in the years 2007-2011.
Note: Since the year 2008, drug injectors and their sexual partners can test themselves for HIV and blood-borne infections. Before that, this service was provided for drug injectors only.

Figure 5 shows the statistics of harm reduction services for drug injectors. In the year 2011 the number of syringes exchanged decreased significantly, although the funds allocated for the syringe exchange programme increased that year. The number of condoms distributed has also decreased significantly. The decrease of the number of syringes exchanged has been affected by changes in the target group of drug injectors and by additional services offered within the framework of the syringe exchange programme. The change of the target group of drug addicts is illustrated by the study of HIV spread and risk behaviour conducted in Narva in the year 2010; that study indicated that 71% of respondents were using amphetamine as their main drug and 69% were injecting once a week.

Figure 5. Damage reduction services for drug injectors in the years 2007-2011



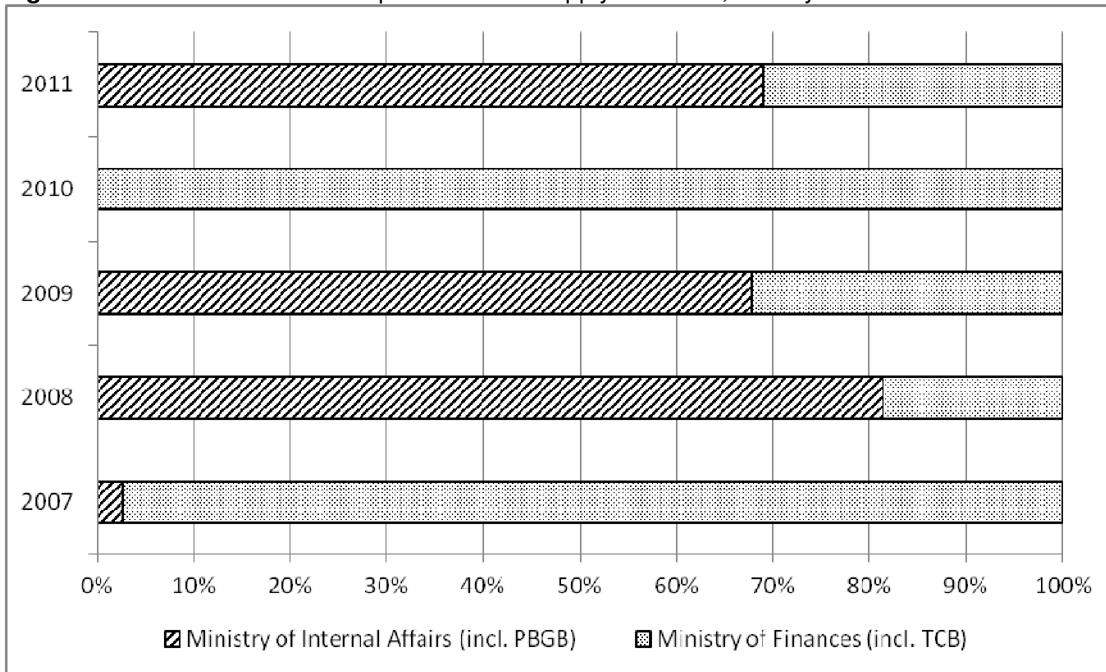
Source: Annual reports of the HIV/AIDS strategy in the years 2007-2011.

Figure 5 shows that less than 1000 people were receiving substitution treatment in Estonia as of the end of year 2011. The number of people on methadone substitution treatment in the year 2011 has increased when compared to year 2010. At the same time it needs to be taken into account that any increase of the number of people in methadone substitution treatment is hindered by the low numbers of health care institutions providing drug therapy in Estonia. It must be also kept in mind that there is a significant target group of amphetamine addicts in addition to opiate addicts, and that services (primarily treatment) offered for the amphetamine addicts are very limited.

Supply reduction

In the years 2007-2011, the largest part of the budget of the NSPD for reducing supply was made up by the activities of the Tax and Customs Board (57%; 1,750,125 euros), followed by the activities of the Ministry of Interior and its agency, i.e. the Police and Border Guard Board (43%; 1,343,204 euros). Similarly to the problems with separate presentation of the expenditure of the drug addiction field of the MER, the expenditure for supply reduction is also often impossible to present separately from the overall expenditures of the ministry.
Due to this, it is difficult to provide an adequate overview of the expenditure for supply reduction in the years 2007-2011. For example, the drug-related expenditure of the Ministry of Interior for the year 2010 cannot be discerned at all. The NSDP presents more detailed information about larger one-time expenditures for equipment facilitating the combating and prevention of drug related crime (e.g. procuring and installing license plate detection systems, drug tests). In the year 2007 the expenditures of the Tax and Customs Board related to implementation of the NSPD were high precisely because of acquiring expensive equipment (Figure 3).

Figure 6. Distribution of NSDP expenditures for supply reduction, in the years 2007-2011



Source: NSDP reporting in the period of 2007-2011.

Figure 6 shows that expenditures for supply reduction in the years 2007-2011 have been uneven. Due to specifics of reporting, problems with differentiating drug-related expenditures and the need-based nature of acquiring larger equipment, the fluctuations of expenditures cannot be related to economic decline.

Summary

As a summary it can be said that the current reporting system of the NSPD does not enable getting a good overview of the drug-related financing. Reports of the NSPD omit direct activity expenditures of the agencies related to drug prevention, as those expenses cannot be discerned in detail within a field of activities. Both the expenditures of the PBGB for combating drug related crime and the educational expenditures of the MER for prevention of drug addiction (incl. salaries and economic expenditures) are included in general drug

related crime combating and educational expenditures of those agencies. Everyday work of the Tax and Customs Board as an agency in the area of government of the Ministry of Finances for cross-border detection, combating and prevention of drug related crime and activities in the prison environment of the Ministry of Justice are also not reflected as separate budget rows in reports. The drug-related activities of the MSA and its area of government can be presented the best as these activities have specific contracts and volumes. To get a more accurate overview of the effects of the economic crisis on drug services, a more accurate study would need to be conducted instead of relying on existing reports.

The existing reporting indicates that the financing of both the NSPD and the HIV and AIDS strategy decreased somewhat in the years 2007-2011. Setting of priorities within the limited resources was very important during the years of reduced budget. Preserving the volume of drug services was set as a priority. The greatest decrease due to economic pressure has happened in the primary prevention activities. On the other hand, the financing and volume of the opiate substitution treatment has been increasing throughout the years. At the same time it needs to be kept in mind that in addition to providing methadone substitution treatment for opiate addicts, new treatment services need to be established for amphetamine abusers as well.

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IRELAND

11. Residential treatment for drug users in Europe

11.1 History and policy frameworks

11.1.1 History of residential treatment

In 1969 the Department of Health set up Ireland's first drug treatment services. They comprised an out-patient clinic for drug problem drug users, based in a general medical hospital in Dublin's city centre (Jervis Street Hospital), where emergency medical care and laboratory testing facilities were available, and an in-patient unit for treatment and rehabilitation, for both illicit drugs users and people who were alcohol dependent, located in a psychiatric hospital in Dublin (St Brendan's Hospital), where residential psychiatric nursing and other ancillary facilities were available. This system followed that being introduced in Britain around the same time, which emphasised the value of centralised and specialist services, with a minimal role for primary health care or localised service provision. The rationale behind setting up the residential unit in the psychiatric hospital was explained as follows: 'We feel that in-patient facilities are best suited in a psychiatric hospital where they will have available to them the background system and expertise of residential psychiatric nursing and other ancillary facilities' (p. 121) (Butler 2002).

It should be noted that problem drug use had been treated in Irish psychiatric hospitals before 1969. The report *Activities of Irish psychiatric hospital and units 1965 to 1969* (O'Hare and Walsh 1970) showed that in 1965, 84 people were treated for drug addiction, compared to 1,638 for alcoholism. Just over half were first admissions**.**

Within a year of opening the in-patient unit in St Brendan's, the relevant health authorities decided that it should only be used for the treatment of those who were alcohol dependent, leaving only Jervis Street to provide treatment for illicit drug use. The decision to stop treating problem drug users in the in-patient unit was the result of the difficulties experienced by the staff in providing a joint response to alcohol and drugs problems: problem drug users and those who were alcohol dependent 'appeared to feel a great mutual antipathy towards one another and the resulting conflict militated against the creation of a therapeutic milieu' (p. 123) (Butler 2002). Butler suggests that these difficulties could have been overcome but that, at a more fundamental level, the exclusion of problem drug users from the in-patient unit revealed 'the tendency of mainstream health service systems and professionals to distance themselves from illicit drug users' (p. 124).

A small, closed residential unit for drug users was set up at the Central Mental Hospital in Dundrum about the same time, again within the psychiatric system. It was based within the forensic psychiatric system and offered a therapeutic programme, based on behaviourist 'token economy' principles, to a small number of problem drug users transferred from Mountjoy prison. However, the unit was closed by 1977.

Around the same period, the voluntary sector was beginning to respond to the issue, as described by an editorial in the *Irish Medical Journal* of 1971:

> The treatment of the established drug taker is extremely frustrating and therapeutically unrewarding. The task is usually given to our psychiatric colleagues. … Subsequent management varies but psycho-therapy has not been demonstrably successful and psychiatrists are not willing to claim more than a very small percentage of cures…One of the most heartening features of health care in Ireland over the last twenty years has been the great revival of the voluntary effort in dealing with the handicapped members of society. (p. 125) (Butler 2002)

In 1966 Sister Consilio established the Cuan Mhuire (Harbour of Mary) centre (initially in the dairy of the religious convent of the Sisters of Mercy) to help those with problem drug and alcohol use. In 1972 Sr Consilio was able to fund a new purpose-built centre and so continue to provide residential treatment, including detoxification.[47] There are now five Cuan Mhuire residential centres on the island of Ireland.

[47] http://www.cuanmhuire.ie/index.php

In 1973 the Coolmine Therapeutic Community was set up, and was the first, and for almost a decade, the only voluntary body concerned with the treatment of problem drug users in Dublin. The programme was instigated by one individual, Lord Paddy Rossmore, who had seen his friends develop addiction problems. The programme was based on a self-help approach and for the first nine years, Coolmine could only accommodate nine people at a time. It has expanded since that time and still continues to provide residential care to this day (Coolmine Therapeutic Community 2012). In 1978 the Rutland Centre set up and continues to provide a range of private residential care for various addiction problems.

Following those early initiatives, other voluntary organisations set up (and expanded) a variety of residential services based on different therapeutic models of care. In response to the growing demand for treatment for young adolescents, the first residential centre for adolescents was set up in 1998: a subsidiary of Aiséirí Cahir and a registered non-profit making organisation, the Aislinn Centre, located on a 12-acre site in Ballyragget, County Kilkenny, is a twelve-bed drug-free residential centre for male and female adolescents aged 15–21 years.

11.1.2 Strategy and policy frameworks for residential treatment

The first official Irish report devoted solely to the issue of problem drug use, published in 1971, included among its recommendations with regard to treatment, a recommendation for a special controlled therapeutic 'closed' unit where appropriately trained staff would provide detoxification, industrial therapy and other basic facilities for education and general rehabilitation (Working Party on Drug Abuse 1971). The report also suggested that 'closed' units should contain a small ward for disruptive patients whose behaviour could be 'shaped'. The report recommended the integration of services for the rehabilitation of the problem drug user, including social services and probation, housing and vocational training. However, Butler (Butler 2002) points out that the recommendations in the report in relation to treatment and rehabilitation were 'effectively pre-empted' as the Department of Health had already set up a treatment system in 1969 (see Section 11.1.1).

In 1979 the Eastern Health Board (EHB) Community Care Programme took on responsibility for drug treatment from the EHB's Special Hospital (Mental Hospital). Rather than signalling a shift in policy away from centralised psychiatric services towards localised prevention and treatment initiatives, this change was made mainly for administrative convenience (p. 148) (Butler 2002). The EHB did set up a task force on drug abuse in 1982 but the report of this task force did not contain anything specific on residential treatment (Byers 1983).

In 1991 the *Government strategy to prevent drug misuse* (National Co-ordinating Committee on Drug Use 1991) recommended a shift away from centralised drug treatment systems, acknowledging the need for different treatment approaches, but it did not discuss residential treatment:

> Of its nature, the treatment, care and management of the drug misuser does not lend itself to any 'one-solution approach'. The Government accept that the provision of services aimed at the achievement of a drug-free society only or harm reduction programmes solely are inappropriate. There is a need to make available to the drug misuser, a range of possible approaches and the means of access to the service(s) most appropriate to his/her immediate needs and capabilities. A fundamental consideration in this respect is to ensure that services available are attractive and accessible in order to encourage misusers to avail of them and to motivate them to continue with treatment (p.16) (National Co-ordinating Committee on Drug Use 1991).

The report did acknowledge the importance of the voluntary sector in this area and urged them to work towards ensuring cohesive and cost-effective programmes in their regions.

In 1996 the first report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (the first Rabbitte report) recommended a broad environmental and multi-sectoral strategy for the prevention of drug problems (Ministerial Task Force on Measures to Reduce the Demand for Drugs 1996). The task force made two recommendations in this report with regard to residential treatment: more residential treatment centres should be established and there should be more emphasis on rehabilitation, therapeutic centres and psychiatric services (pp 62–63).

The second Rabbitte report contained a short chapter entitled 'The role of therapeutic communities' (pp *65–67)* (Ministerial Task Force on Measures to Reduce the Demand for Drugs 1997). This chapter did not review or evaluate this model of care but presented the findings of the (small number of) submissions to the ministerial task force on the subject of therapeutic communities. These asserted that the State's response to

the issue of problem drug users concentrated too heavily on methadone maintenance. While some of the submissions argued that abstinence was the only model of treatment capable of long-term success, others suggested that people had different needs at various stages of their addiction and a whole range of responses should be available to meet these needs. Additionally, some of the submissions stated that the State should improve the funding of the voluntary sector for this treatment and that admission to such a service should not be based on ability to pay. The second Rabbitte report concluded that the therapeutic community should be part of an overall range of treatment and rehabilitation services available for people with problem drug use.

In 2001 the *National Drugs Strategy 2001–2008* (NDS 2001–08) was published (Department of Tourism Sport and Recreation 2001). Public submissions to the Review Group tasked with drafting the NDS 2001–08 had highlighted the lack of residential treatment places, along with the need to increase funding for existing services. The Review Group concluded that 'detoxification programmes followed by drug-free residential programmes have been used with varying degrees of success in the treatment of opiate and other forms of addiction. However, to date they have been somewhat overshadowed by the demand-led requirement to eliminate waiting lists for methadone treatment' (para. 6.4.8) (Department of Tourism Sport and Recreation 2001). The strategy stated that the expansion of both types of services (detoxification and residential) went hand in hand, as many residential centres required clients to be drug-free on admission, and so were dependent on the availability of detoxification beds. Therefore there was a clear need to increase the availability of both these services.

The NDS 2001–08 included two actions relating to residential care:

Action 57: To oversee the development of comprehensive residential treatment models incorporating detoxification, intervention, pre-treatment counselling, motivational work, therapeutic treatment and high quality rehabilitation for misusers who wish to become drug-free. Resources should continue to be targeted at the most efficient and effective of these services.

Action 58: To report to the NACD [National Advisory Committee on Drugs] on the efficacy of different forms of treatment and detoxification facilities and residential drug-free regimes on an on-going basis.

In 2005, following a mid-term review of the NDS 2001–08, rehabilitation was adopted as a fifth 'pillar' (Department of Community Rural and Gaeltacht Affairs 2005). On foot of this, the HSE set up an expert working group on residential treatment and rehabilitation (substance abuse) in order to gain a detailed overview of the current situation and to make recommendations on requirements for residential treatment in the future. The expert group (Corrigan and O'Gorman 2007) mapped existing inpatient detoxification and residential services (see Table 11.2.1.3 below), but did not examine the different models/types of residential treatment.

The expert group endorsed the use of the four-tier model of care as the framework for drug and alcohol services in Ireland (Recommendation 3.1).[48] Subsidiary recommendations included (pp 4–5):

- All four tiers of this model need to be fully resourced for the model to be fully effective because one tier cannot be developed or function in isolation from the others.

[48] Four tiers of service delivery are used to denote different levels of service provision. These are:
Tier 1: Generic services which would include drug - related information and advice, screening and referral and would be aimed at those who might consider, or who are at the early stages of, experimentation with drugs or alcohol. Service providers might include An Garda Síochána, General Practitioners or community and family.
Tier 2: Services with specialist expertise in either mental health or addiction, such as juvenile liaison officers, local drugs task forces, home – school liaison, Youthreach, General Practitioners specialising in addiction and drug treatment centres. The types of service delivered at this level would include drug-related prevention, brief intervention, counselling and harm reduction and would be suitable for those
encountering problems as a result of drug or alcohol use. Tier 2 interventions are delivered through outreach, primary care, pharmacies, emergency departments, liver units, antenatal clinics or in social care, education or criminal settings (An Garda Síochána, the Probation Service, the Courts Service, Irish Prison Service).
Tier 3: Services with specialist expertise in both mental health and addiction. These services would have the capacity to deliver comprehensive treatments through a multi - disciplinary team. Such a team would provide medical treatment for addiction, psychiatric treatment, outreach, psychological assessment and interventions, and family therapy. Tier 3 interventions are mainly delivered in
specialised structured community addiction services but can also be sited in primary care settings such as level 1 and 2 GPs, pharmacies, prisons and probation services.
Tier 4: Services with specialist expertise in both mental health and addiction and the capacity to deliver a brief, but very intensive, intervention through an inpatient or day hospital. These types of service would be suitable for those encountering severe problems as a result of drugs or alcohol.

- While not all problem alcohol or drug users will require Tier 4 (inpatient/residential) services, client outcomes are generally recognised as being superior for inpatient versus outpatient provision for those whose care plan calls for Tier 4 services.
- The Four-Tier Model of Care implies that clients should be offered the least intensive intervention appropriate to their need when they present for treatment initially. Where this does not succeed, more intensive interventions should be offered.
- Attention is drawn to the fact that detoxification itself is not an effective treatment and that it must be followed up by post-detoxification psychosocial interventions as part of a client-centred rehabilitation programme.
- The group emphasises that the transition from detoxification from alcohol or any other drug into rehabilitation should be seamless so as to avoid waiting lists and delays which can result in client relapse. It is recognised that in the case of relapse to opiate use, there is a major risk of fatal overdoses occurring at this time.

With regard to existing service provision, the expert group recommended that, *inter alia* (p. 5):

- Clients with comorbidity issues who are in residential drug and alcohol services should be provided with adequate support by the mental health services, and that clear pathways into residential mental health services for those requiring them should be agreed, as outlined in the NACD-commissioned report on mental health and addiction services and the management of dual diagnosis in Ireland.
- Community-based or outpatient detoxification services, including the role of Level 2 GPs in their provision, should be reviewed.

With regard to the assessment of need for inpatient detoxification, stabilisation and residential rehabilitation (pp 6–8), the expert group made the following points:

- The group's strong preference is that such beds [for detoxification, stabilisation and residential rehabilitation] should be provided in fully-staffed, dedicated units but recognise that problems of patient and family access may militate against this in some parts of the country.
- The staffing of IPUs (inpatient units) as well as of residential rehabilitation services must be in line with recognised best practice to ensure full occupancy, maximum client safety and the highest standards of care.
- The group recommends that the treatment of problem drug and alcohol users who are homeless should be prioritised, since homelessness is one of the key criteria indicating client suitability for inpatient admission.
- The increased provision of inpatient unit beds the group has recommended will allow for the stabilisation and respite needs of drug users including pregnant women, cocaine and/or polydrug users. Such beds must be physically separated from detoxification beds.
- The needs of recovering drug users with young children present particular challenges when it comes to inpatient/residential treatment. The group welcome the investigation of innovative approaches such as providing the necessary supports so that family members can act as short-term foster parents.

The National Drugs Strategy 2009–2016 (NDS 2009–16) also addresses the issue of residential services (Department of Community Rural and Gaeltacht Affairs 2009). The need for more residential beds is acknowledged and the report states, 'While there has been a significant expansion of treatment services in clinical and community settings since 2001, detoxification and residential services have not progressed to the same extent' (p. 46) (Department of Community Rural and Gaeltacht Affairs 2009). The NDS 2009–16 promotes the four-tier model and therefore any changes or expansion of residential services should be considered within that context. Both residential and appropriate aftercare are seen as integral to providing alternative drug-free approaches to treatment for problem drug users, especially opiate users. The need for after-care/follow-on supports in the community is stressed to maximise recovery.

The NDS 2009–16 also endorses the findings and recommendations of *The report of the HSE working group on residential treatment & rehabilitation (substance abuse)* and specifically in relation to the identified number of additional beds required and the need for adequate detoxification facilities (Corrigan and O'Gorman 2007). One of the key performance indicators was 25% increase in residential rehabilitation places by 2012, based on 2008 figures.

Most recently, *the National Drugs Rehabilitation Framework Document* also endorses the four-tier model (Doyle and Ivanovic 2010). The document aims to provide 'A framework through which service providers will ensure that individuals affected by drug misuse are offered a range of integrated options tailored to meet their needs and create for them an individual rehabilitation pathway' (p. 7) (Doyle and Ivanovic 2010).

Within this framework, specialised care, such as detoxification, is provided in specialised wards or units, which may include general psychiatric wards. The framework envisages seamless care where a person needs to be referred on to residential rehabilitation. The framework states that 'The effective provision of facilities and services requires not only the availability of both existing and additional resources, but also the development of appropriate strategies for the planning, management, financing, implementation and co-ordination of these facilities and services. This will ensure best fit and value for money' (p.13) (Doyle and Ivanovic 2010). The framework was rolled out in a number of pilot sites all over the country and an evaluation is under way (Department of Health 2012b).

11.2 Availability and characteristics

11.2.1 National (overall) availability

National data on inpatient drug treatment

The only source of national data on residential treatment is the National Drug Treatment Recording System (NDTRS). There was an increase in the total number of drug treatment services available in Ireland and participating in the NDTRS between 2005 and 2010 (Table 11.2.1.1) (Bellerose*, et al.* 2011). In 2010, data were provided by 376 treatment services, an increase of 107 since 2005. The majority of services were in outpatient settings, while a tenth of services (n=37) were inpatient services. While the number of inpatient services participating in the NDTRS has increased from 21 in 2005 to 37 in 2010, it should be noted that not all inpatient treatment centres operating in Ireland participate in the NDTRS. Additionally, these figures include inpatient services which provide detoxification only and/or treat only problem alcohol use.

Table 11.2.1.1 Number of treatment services, by type of service provider, NDTRS 2005–2010

	2005	2006	2007	2008	2009	2010
All services	269	238	288	316	349	376
Outpatient	146	146	173	209	212	215
Inpatient	21	23	27	32	34	37
Low threshold	3	3	5	9	27	51
General practitioner	99	66	83	66	76	73

Source: (Bellerose*, et al.* 2011)

The majority (68%) of cases received treatment in outpatient settings. The number of cases entering treatment in outpatient services increased by 45%, from 3,828 cases in 2005 to 5,565 cases in 2010 (Table11.2.1.2). The number of cases entering residential treatment increased by 51%, from 817 cases in 2005 to 1,232 cases in 2010.

Table 11.2.1.2 Cases treated for problem drug use, by type of service provider, NDTRS 2005–2010

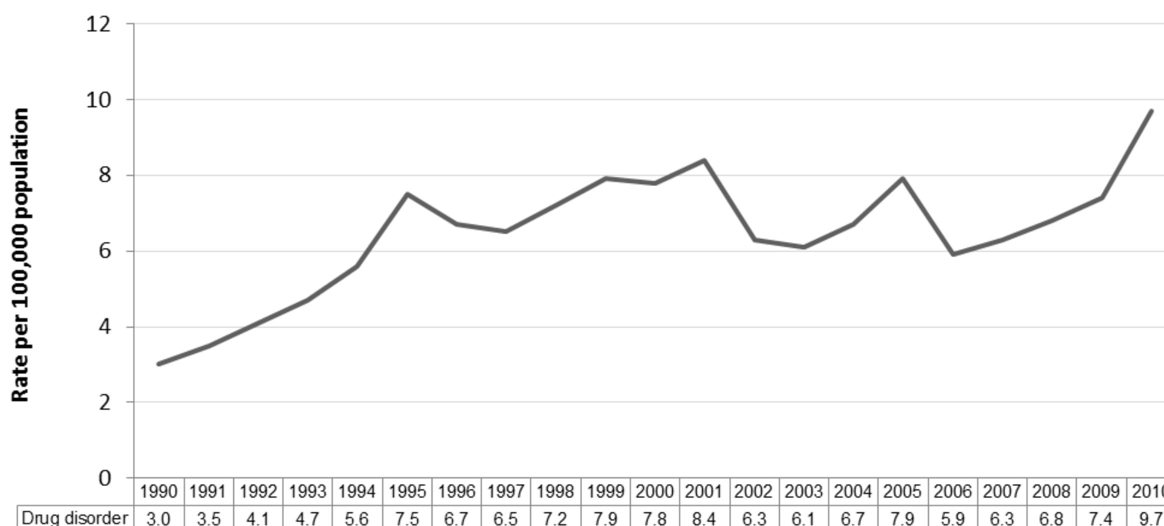
	2005	2006	2007	2008	2009	2010
	n (%)	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**
	5176	5475	5977	6576	6667	7878
Outpatient	3828 (74.0)	4094 (74.8)	4532 (75.8)	5061 (77.0)	5005 (75.1)	5565 (70.6)
Inpatient	817 (15.8)	987 (18.0)	1065 (17.8)	1156 (17.6)	1064 (16.0)	1232 (15.6)
Low threshold*	191 (3.7)	146 (2.7)	91 (1.5)	137 (2.1)	341 (5.1)	793 (10.1)
General practitioner	340 (6.6)	248 (4.5)	289 (4.8)	222 (3.4)	257 (3.9)	288 (3.7)

Source: (Bellerose*, et al.* 2011)
* Low-threshold services provide low-dose methadone or drop-in facilities only.

By comparison, in 2010 the NDTRS reported that 34% (n=3,227) of all cases treated for problem alcohol use were treated in inpatient/residential services (Carew*, et al.* 2011). This means that the majority of cases (72%) treated in residential care in 2010 in Ireland reported alcohol as their main problem substance.

Data on hospital in-patient drug treatment

In 2010, 966 cases were admitted to psychiatric facilities with a drug disorder as their primary diagnosis, of whom 412 were treated for the first time (Daly and Walsh 2011). Since 2006 there has been a continuous increase in the rate of first admission of cases with a diagnosis of a drug disorder. The report does not present data on drug use and psychiatric co-morbidity, so it is not possible to determine whether or not these admissions were appropriate. Additionally, only primary diagnosis is collected so there is no information on treatment provided, e.g. detoxification. Figure 11.2.1.1 presents the rates of first admission between 1990 and 2010 of cases with a diagnosis of drug disorder.



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Drug disorder	3.0	3.5	4.1	4.7	5.6	7.5	6.7	6.5	7.2	7.9	7.8	8.4	6.3	6.1	6.7	7.9	5.9	6.3	6.8	7.4	9.7

Figure 11.2.1.1 Rates of psychiatric first admission of cases with a diagnosis of drug disorder (using the ICD-10 three-character categories) per 100,000 of the population in Ireland, NPIRS 1990–2010
Source: (Daly and Walsh 2011)

Other notable statistics on first admissions for a drug disorder in 2010 include:

- The majority were to psychiatric units in general hospitals (259, 63%), followed by admissions to psychiatric hospitals (102, 25%) and to private hospitals (51, 12%).
- 6% were involuntary admissions.
- The rate was higher for men (14.2 per 100,000) than for women (5.2 per 100,000).

The majority of cases hospitalised for a drug disorder stayed just under one week (54%), while most were discharged within three months. Less than one per cent remained in hospital for more than three months.

Requirements for inpatient detoxification and residential treatment
In 2007, the *Report of the HSE working group on residential treatment & rehabilitation (substance abuse)* (Corrigan and O'Gorman 2007) calculated the requirements for inpatient detoxification and residential treatment for both problem drug and alcohol use in Ireland (Table 11.2.1.3, also see section 11.1.2 above). The authors concluded there was a deficit of 356.5 beds (252.5 for rehabilitation). The calculations were based on a population of just over four million. The model/type of residential treatment was not examined in this report. In the report, detoxification and rehabilitation are intrinsically linked as many centres require a person to be drug-free before they enter, therefore usually necessitating detoxification immediately prior to starting. The report also highlighted the need for residential services for under-18s.

Table 11.2.1.3 Current and recommended estimate of need for inpatient detoxification and residential treatment, 2007

Bed Type	Current Provision	Estimated Need	Deficit
Stabilisation Services	5.5	127 (IPU)	104 (64 for alcohol detoxification; 40 for drugs other than alcohol)
Community-based Residential Detoxification	15		
Medical Detoxification	17.5		
Residential Rehabilitation	634.5	887 (205+382+300)	252.5[29]
Step-down, Halfway house	155	296	141
General and Psychiatric Hospitals	79[30]	N/A	N/A

Source: (Corrigan and O'Gorman 2007)
IPU – Inpatient unit
[29] Includes the provision for under 18 year olds
[30] The Working Group note the evidence for treating people with drug and alcohol problems in these settings is not the best practice.

The report looked at substance abuse, including alcohol, illicit and licit drugs, and therefore it is difficult to separate out the requirements for illicit drug users. Of the 887 residential beds required, 205 were for problem drug users transferring from inpatient detoxification, 382 for problem alcohol users transferring from detoxification, and 300 for problem drug or alcohol users coming from inpatient services.

The report also estimated that there were 13 beds used for detoxification in general hospital settings and the equivalent of 66 beds in psychiatric hospitals.

A review of Tier 4 HSE funded services has been undertaken (Department of Health 2012b) recently. It aims to build on a number of previous reports in this area, including both detoxification and residential services (Corrigan and O'Gorman 2007) (Doyle and Ivanovic 2010, Working Group on drugs rehabilitation 2007). The objectives of the review are to:

- calculate the level of demand by local health office (LHO) area for Tier 3 and Tier 4 interventions;
- identify gaps and overlaps;
- make recommendations for better integration of HSE services and Tier 4 Voluntary/Community services (to include better integration of HSE services and Voluntary/Community services and will identify the best practice models for integration);
- assess existing funding models for HSE funding to the residential rehabilitation sector and recommend standardised models; and
- discuss with the residential services the potential for one service level agreement per agency.

The review is reported to be finished but has not yet been published (Department of Health 2012b).

Characteristics of those attending residential treatment

Keltoi, a residential therapeutic rehabilitation programme for problem opiate users, evaluated their service, using a cross-sectional survey of a sample of clients who had been discharged between one and three years prior to interview (Sweeney, *et al.* 2007). The treatment model used had been based on international findings that rehabilitation with a focus on developing new living skills produced more favourable outcomes.

Of the 485 clients referred to Keltoi between 2002 and 2004, 149 (31%) were treated. Ninety-five per cent of clients admitted to the treatment programme had severe opiate dependence problems, and a small proportion had severe cocaine dependence. To be admitted to the programme, clients had to be drug-free

for two to six weeks, depending on the individual case and the assessment of the team. Ninety-two participants (62%) agreed to be interviewed, with two dying prior to the interview date. Eighty questionnaires were completed. The final sample comprised 52 (74%) men, 18 (26%) women and 10 individuals whose gender was not recorded.

The study reported that a large proportion of those who started treatment completed it (83%, 58/70). Half (29/58) of those who completed treatment were drug-free in the month prior to the interview. The abstinence rate for men (50%) was higher than for women (39%). The proportion who committed at least one crime during the 30 days prior to interview was lower among those who had not used drugs in that time than among those who had, 15% compared to 30%. Five of the 29 who had used at least one drug in the last month had injected it.

The study was limited as there was no baseline data and drug-free status was self-reported. In addition, it is possible that other treatment interventions may have taken place between discharge from Keltoi and the study interview and these may account for some of the positive findings. Nevertheless, these findings indicated that the Keltoi approach to treatment for drug users could lead to favourable outcomes.

A follow-up study (White*, et al.* 2011) aimed to evaluate how effective the Keltoi programme had been in helping participants to remain drug free. Clients who had attended the programme between September 2002 and July 2004 were followed up. During the evaluation period, 149 clients had entered Keltoi, 94 had participated in the original evaluation, and 80 of these participated in the follow-up interview, which was based on the Maudsley addiction profile (MAP). The interviews started in May 2004 and finished in July 2009. The average time between discharge and follow-up interview was 1.9 years (range 1.2 to 3.0 years). Two participants in the original evaluation had died before the follow-up interview took place, giving a mortality rate of 2.1% for the 94 participants. There was no control group.

Half (51.3%) of the interviewees self-reported as fully abstinent (defined as abstinence from all substances including alcohol and prescription substitution drugs) in the 30 days before the interview. Most (88.1%) were still in contact with some type of drug treatment service. Those who were abstinent reported higher levels of well-being than those who reported that they were not abstinent. In the 30 days before the interview:

- five (6.3%) interviewees reported injecting;
- a lower proportion of those who were abstinent (3.8%) reported suicidal thoughts compared to the proportion among those who were not abstinent (18.8%);
- over two thirds (77.5%) of those interviewed reported no criminal activities; and
- half (50.0%) reported having undertaken paid employment.

Self-reported abstinence was recognised to be a limitation by the authors, but the level of self-reporting was felt to be reasonably reliable among this population as there were no negative consequences for the interviewees. Because of the methodology used it was not appropriate to undertake statistical analysis of the data looking for factors which might be associated with abstinence. The authors stated that, for the same reason, they were ‘wary of direct comparisons with the majority of current international literature’ in this area. This lack of comparability is an issue in many studies.

The authors found large gaps in outcome-based evaluations for treatment programmes in Ireland and recommended the introduction of a health outcomes monitoring system. They also concluded that the evidence from their studies and others done in this area showed that many of those who enter residential treatment do not have successful outcomes. They concluded it was important to find out what works and what does not work for different people.

The **ROSIE study**[49] reported on the outcomes of abstinence-based (Cox*, et al.* 2007). At baseline, the study recruited 404 opiate users aged 18 years or over entering treatment or, in the case of a sub-sample of 26 (6%), attending needle-exchange services. The participants were engaged in one of three different forms of treatment: methadone maintenance/reduction (53%, n=215), structured detoxification (20%, n=81) and abstinence-based treatment (20%, n=82). The abstinence cohort comprised 82 individuals, the majority

[49] The ROSIE (Research Outcome Study in Ireland) study was Ireland’s first national, prospective, longitudinal drug treatment outcome study. It aimed to ‘evaluate the effectiveness of treatment and other intervention strategies for opiate use’. In 2003/04, 404 opiate users who entered treatment were recruited, of whom 72% completed follow-up questionnaires one year and three years later. The reports on the ROSIE study are available at www.nacd.ie.

recruited from inpatient settings (85%, n=70), with the remainder being treated in outpatient settings (15%, n=12).

The abstinence modality was defined as ‘any structured programme which required individuals to be drug-free (including free from any pharmacological intervention) in order to participate in, and remain on, the programme’. Participants were required to attend a structured programme of daily activities and were given intensive psychological support.

Those recruited for the ROSIE study from inpatient settings were attending one of the three main types of residential rehabilitation programme identified in the international literature: 12-step/ Minnesota Model, Christian house, or therapeutic community. The abstinence participants were typically male (89%), had an average age of 27 years and were largely dependent on social welfare payments (70%). Just less than half (47%) had children but the majority (77%) of these did not have their children in their care. Most had spent some time in prison (72%) and 16% had been homeless in the 90 days prior to treatment intake interview.

The treatment completion rate was high, with 66% of participants successfully completing their abstinence programme (n=37). Just over one-quarter of the cohort (27%, n=15) dropped out of treatment; 2% (n=1) transferred to another treatment type before completing the programme; and the remaining 5% (n=3) were still engaged in their treatment programme at one year.

In addition to those still engaged in their abstinence treatment programme one year after treatment intake, 64% (n=36) reported that they were in some form of drug treatment. Less than one-quarter of the cohort (23%, n=13) were on a methadone programme, 23% (n=13) were attending one-to-one counselling and 37% (n=21) were attending group work (Narcotics Anonymous [NA] meetings, aftercare programmes and structured day programmes).

The number of participants who reported using heroin, non-prescribed methadone, non-prescribed benzodiazepines, cocaine, cannabis or alcohol in the 90 days prior to interview decreased between treatment intake and the one-year follow-up. The most substantial reduction was in cocaine use, both in terms of the proportion of participants using the drug (46% at treatment intake compared with 14% at one year), the frequency of use (an average of 10 out of 90 days at treatment intake compared with an average of 2 out of 90 days at one year) and the quantities consumed (an average of 1 gram per day at treatment intake compared with an average of 0.3 grams per day at one year).

Overall, the proportion of participants who reported no involvement in crime had risen considerably at one year (76%) compared to treatment intake (43%). There was a reduction in the percentage of participants involved in acquisitive crime, from 35% (n=19) at treatment intake to 13% (n=7) at one year.

There was a non-significant reduction in the number of participants who reported injecting drug use. There were no changes in participants’ injecting-related risk behaviours. The proportion of participants who reported an overdose within the previous 90 days remained at 4% (n=2) over the two time periods.

There was an increase in participants’ contact with general practitioners and with employment/ education agencies. The authors stated that the findings demonstrated that participation in an abstinence-based treatment programme was followed by positive outcomes in relation to drug use, involvement in crime, and physical and mental health symptoms. The outcomes for ROSIE participants in abstinence-based treatment compare favourably with the outcomes reported in other international outcome studies.

Information at the 3–year follow–up showed that 69% of those who entered abstinence-based treatment completed the treatment (Comiskey, Catherine *, et al.* 2009). The authors noted that completing treatment can be a good indicator of successful treatment and felt that the high treatment completion rate for this modality in the ROSIE (which was very similar to detoxification) was a very positive outcome.

Coolmine is currently undertaking a longitudinal study of their clients with follow-up at 18 months, two years and three years. The results are not yet available (Coolmine Therapeutic Community 2012).

11.2.2 Types and characteristics of residential care units

Information on all residential centres recorded on the NDTRS contact database is compiled to give an overview of the types and characteristics of residential treatment units in Ireland. It should be noted that the NDTRS contacts database is designed to record contact data only and was never intended to be used for

analysis purposes. Therefore this section does not give a complete overview of all residential treatment units in the country although every effort is made by the NDTRS team to keep the database up to date. Additionally, not all those included on the database comply with the NDTRS. Services were contacted to attempt to confirm/complete information but not all services responded so Table 11.2.2.1 is incomplete. Services that treated clients for alcohol only or only provided detoxification were excluded, if that information was known. Information on hospital–based care has been taken from the most recent publication of the National Psychiatric In-patient Reporting System (NPIRS) (Daly and Walsh 2011).

Table 11.2.2.1 Overview of different types of residential treatment settings

	No. units	No. cases treated 2010	No. of beds/places	Minimum duration (no. units) 2010				Range
				< 3mts	3 < 6 mts	6 < 12 mts	>12 mts	
Hospital based	67*	966*	66†	Not available	Not available	Not available	Not available	<1 week to 1 year* §
Residential treatment‡	28	871	Not available	8	5	0	0	28 days to 'no set period'
Therapeutic community‡	13	223	Not available	3	3	2	0	6 weeks to 6 months

* Source (Daly and Walsh 2011) 2010 data
† Source (Corrigan and O'Gorman 2007) 2007 data
‡ Source NDTRS unpublished data
§ Median length of stay 6 days; 54% stayed less than 1 week; 1 person stayed between 1 to 5 years

11.2.2.1 Common approaches

Of the 41 non-hospital services where information was supplied, 15 stated that their philosophy was the 12 Step/Minnesota Model and 13 services stated that they were therapeutic communities.

11.2.2.2 Typical mix/integration of services

This section only deals with (where the information is available) the 41 non-hospital based services known to the NDTRS. All but four treated both problem drug and alcohol use. A number (not specified) also treated other problems, for example gambling. Many would have HSE–funded beds. Entry criteria were based mainly around gender as some services took only one gender. There were two services which only accepted adolescents. There were other criteria depending on the service: clients to be drug free on admission (16); clients stable on methadone (4); clients stable on other prescription drugs (3); specified catchment area (2); funding (2); appropriate referral (2); registered homeless (1). Most services only had two or three criteria for entry.

Typical interventions provided by all services included: individual counselling, group counselling, social and occupational reintegration, complementary therapy, education awareness, family therapy and aftercare.

11.2.2.3 Integration of OST in residential care

The Central Treatment List reports on opiate substitution treatment (OST) in Ireland. Their figures on continuous care (i.e. the number of clients in OST on 1 January every year) show that very small numbers, ranging either just over or just under 10 clients per year between 2005 and 2010, received OST in residential services (unpublished data, Central Treatment List, February 2012).

11.2.2.4 Typical levels of collaboration and networking

Many services refer clients on, to aftercare, back to other types of drug treatment or to other social services as appropriate. There are no national published studies or data available that show typical levels of collaboration or formal (or informal) networks.

Analysis of NDTRS data shows that in 2010 the highest proportion of cases (37%) self-referred *to* a residential treatment service (either therapeutic community or 12-step) (Table 11.2.2.4.1).

Table 11.2.2.4.1 Source of referral to residential treatment services, NDTRS 2010 (1,094*)

Source of referral	%
Self	36.8
Other drug treatment centre	17.3
Court/probation/police	11.4
Family	10.9
Social services	8
General practitioner	3.4
Prison	2.8
Friends	2.7
Outreach worker	2.5
Hospital/medical agency	2.4
Other/not known	1.9

* Excludes those treated for alcohol as a main problem substances and detoxification-only services

The NDTRS collects information on where a case is transferred to, if applicable, once they have left the residential treatment service. However, the NDTRS only collects information on services relevant to the NDTRS, so does not collect information if cases were transferred to a centre, for example that provides only social care such as housing. In 2010, information was available on 145 cases who were transferred: most were transferred to either another residential service or an outpatient drug treatment programme.

A good example of complex levels of collaboration and networking between all the difference services comes from the list of partnerships included in the most recent strategy document of the Coolmine Therapeutic Community (Table 11.2.2.4.2) (Coolmine Therapeutic Community 2012).

Table 11.2.2.4.2 Coolmine Therapeutic Community Partnerships, 2012

Contact and Assessment	Primary Treatment	Integration	Aftercare
Anna Liffey Drug Project	Visiting Medical Officer	Focus Ireland	Arbour House Cork
Hartstown/ Huntstown Community Drugs Team	Barnardos	Peter McVerry Trust	Merchants Quay Ireland
Irish Prison Service	ASKES	YMCA	FÁS
Probation Services		Homeless Agencies	
Arbour House Cork		Threshold	
HSE Addiction Services and Maternity		Fingal County Council	
Homeless Agencies		Various county & city councils	

Source: (Coolmine Therapeutic Community 2012)

11.3 Quality management

11.3.1 Availability of guidelines and service standards for residential care

There are no national guidelines available for residential care (Irish Focal Point (Reitox) 2011) and no local guidelines were provided.

The *Report of the HSE working group on residential treatment & rehabilitation (substance abuse)* (Corrigan and O'Gorman 2007) identified issues and recommendations in relation to quality assurance for inpatient and residential services, as follows:

6.1: The working group fully endorses the concept that the quality of the residential facilities, the organisation, the delivery and evaluation of services, and also of the staff involved in the delivery of the service must be of the highest possible standard. It is vital, therefore, that all three components be subject to regular auditing using recognised benchmarks and targets.
6.2: The group therefore recommends that a national quality assurance scheme for all four tiers of the alcohol and drugs services be established following the necessary consultation, negotiation and training.
6.3: We recommend that the Quality in Alcohol and Drugs Services (QuADs) suite of organisational standards and the companion Drug and Alcohol National Occupational Standards (DANOS), as developed for the UK by Alcohol Concern and Drugscope and by the Management Standards Consultancy for Skills in Health respectively, should be adapted for use by drug and alcohol services in Ireland.
6.4: The group also recommends that there must be standards for the quality of the residential facilities themselves and believes that the HSE should enter into discussions with the Health Information and Quality Authority (HIQA) about the inclusion of residential services for drug and alcohol users within the range of services to be regulated by HIQA's social services inspectorate. This would help avoid duplication of effort when quality audits are undertaken.
6.5: The group also recommends that the HSE put in place an Internal Quality Audit function within the drugs and alcohol services in order to assist both HSE-funded and HSE-provided services to prepare for and respond to external audits of the facilities, organisation and staff.
6.6: There was particular concern expressed by the group about the need for relevant stakeholders to ensure that all detoxification procedures meet the highest standards of clinical governance, care and patient safety.
6.7: The group highlights the need for ongoing staff training and support to assist in role development. Managers and those who lead rehabilitation teams should ensure that staff are clear about their role definition and purpose, and that they possess or are actively working towards he required qualification(s).

The NDS 2009–16 endorsed these recommendations and concluded that they should be progressed (Department of Community Rural and Gaeltacht Affairs 2005).

QuADs, the quality standards framework created in the UK, has been endorsed by the HSE Addiction Services in Ireland.[50] Eight residential services are currently involved in QuADs (Personal Communication, Caroline Gardner, Progression Routes, 1 October 2012). Of those services known to the NDTRS, a further 10 residential treatment centres run by voluntary agencies reported that they were accredited with another UK-based company.

In 2010 Cuan Mhuire won the international CHKS Quality Improvement award which recognises significant improvements in patient care and patient experience as well as staff welfare, safety and morale (Galvin 2010).

11.4 Discussion and outlook

Starting in the 1960s, the factors influencing the recognition and development of residential treatment services in Ireland included both the example set in the UK, which the Irish health services followed, and also the interest of voluntary groups, which established residential treatment centres. In the 1980s, Jervis Street/Trinity Court drug treatment centre (outpatient) combined well with Coolmine (residential) in providing a range of treatment services for those with drug problems.

In the 1980s and 1990s, support for residential treatment declined as competing demands attracted attention, including:

- local communities demanding to be involved in policy development and policy implementation, especially around issues such as the 'heroin epidemic' in the early 1980s;
- the emergence of health-related risks of intravenous drug use from the late 1980s onwards leading to priority being given to harm reduction measures such as methadone maintenance through primary healthcare workers; and
- the need for prison-based services, services for under-18s, harm reduction services, and services across the country.

[50] http://www.progressionroutes.ie/index.php?page=quads-support-project

In the 21st century the recognition of the need for range of responses and alternative drug-free approaches for those with problem substance use brought the role of residential treatment to the fore again. This included specialised inpatient services for those with specific medical problems such as liver disease or dual diagnoses, detoxification and drug-free residential treatment. The 2007 report of the HSE working group on residential treatment and rehabilitation (substance abuse) endorsed the 4-tier treatment model. The adoption of this 4-tier treatment model and integrated care packages in the NDS 2009–16 as the framework for the provision of all health, including addiction, services means that the role of residential treatment is now officially acknowledged.

In Ireland, detoxification and rehabilitation are intrinsically linked as many centres require a person to be drug-free before entering, therefore usually necessitating a detoxification immediately prior to starting in a residential centre. It is very difficult to separate residential detoxification and residential treatment in this context or in the available documentation.

There is very limited information on the types and characteristics of residential services and unfortunately the results of the most recent review of Tier 4 are not available at this time (Department of Health 2012b). Therefore there is no update on residential treatment services since the 2007 report of the HSE expert working group on residential treatment and rehabilitation. That report estimated that there was a deficit of 252.2 beds for residential treatment (including both drugs and alcohol) (Corrigan and O'Gorman 2007). From the NDTRS data it is clear that the number of cases entering inpatient treatment has increased (see Table 11.2.1.2). This increase may be due to several reasons – an increase in the number of residential centres participating in the NDTRS, an increase in the number of residential places available or a true increase in the number of people being treated in residential care. In 2010 in Ireland, the majority of cases in residential treatment, as recorded in the NDTRS, had alcohol as a main problem substance. The number of people receiving treatment for drug disorders in psychiatric hospitals has also increased over the past years, but the length of stay in those facilities is usually less than 1 week.

11.4.1 Outlook

The economic climate is affecting all drug treatment services, including residential services. For example, in September 2012 the only residential mother and baby service run by the Coolmine Therapeutic Community faced {Lally, 2012 #410}

The recommendations of the HSE expert working group on residential treatment and rehabilitation specifically mentioned the challenges faced by problem drug users when accessing residential care (Corrigan and O'Gorman 2007).

New initiatives such as community detoxification programmes have proved a successful alternative for those who require detoxification and where a stay in an inpatient facility is not always the best option (Lyons, Dr Suzi 2008a) (Irish Focal Point (Reitox) 2011). However as endorsed by the2009–16 NDS, there will always be a need for Tier 4 residential treatment which provides the individual with another choice of treatment which may be most appropriate and beneficial option for them at that time.

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GREECE

CHAPTER 11. RESIDENTIAL TREATMENT FOR DRUG USERS IN EUROPE

11.1. History and policy framework

A brief history of drug treatment in Greece

The 80's decade at international level is marked by the psychiatric reform and de-institutionalisation which lead to the questioning of the, strong until then, system of therapeutic communities as another mechanism of social compliance (Poulopoulos 2011)

The 80's decade in Greece is characterised by a constant social debate, with often controversial positions, on the drugs problem and the treatment of dependence. The supply reduction is still mostly dominant. Although the extent of the problem remains unknown, as there is no monitoring system of the drugs' situation, the impression created mainly by the Media is that of a serious and increasing problem in the Greek society. The most reliable data come form the two nationwide epidemiological surveys in 1984, conducted by the UMHRI (one on the general and the other on the school population) which can only give a vague picture on use and not of dependence.

Law 1729 of **1987** is considered the first attempt for a global consideration of the drugs problem in Greece. The Law clearly identifies drug dependent people as patients and puts emphasis on destigmatisation and on motivation for treatment.

Since then, emphasis has been put in the creation of treatment services of various types (detoxification units, inpatient and day-care) to meet the diverse needs of individuals with drug use problems. **The first drug treatment programme in Greece was a therapeutic community – ITHAKI,** established in 1983, amidst a global questioning of the therapeutic community model.

Until **1994** the number of treatment programmes in the country (outpatient and inpatient) amounted to 12.(NR 1997)

All these therapeutic programmes were drug free. Until **1995**, abstinence from drug use through drug free treatment was the only policy in the treatment field. Methadone was prohibited by the Greek Constitution.

The establishment of OKANA (Organisation Against Drugs) in **1994**, as the coordinating body in demand reduction, marks a substantial change in drug treatment and coordination. Largely due to the growing concern on the HIV epidemic, OKANA given by law the exclusive right to administer substitution treatment, starts in 1995 the first two pilot methadone substitution units in Athens and Thessaloniki. The policy underlying substitution programmes and their aims are that of a progressive abstinence from drug use rather than maintenance.

In **1997,** with harm reduction policy gradually gaining ground, the first low threshold programmes are created, but it is not until 2003 that the substitution programme (Ministerial Decree 104741/03) is legally recognized as a harm reduction programme as well as a treatment one.

Until **2003** substitution treatment units were vastly outnumbered by the drug free programmes. Today they are represented in mostly equal numbers: in **2011** there are 47 drug free programmes in Greece and 42 substitution.

11.1.1. History of residential treatment

As mentioned above the beginning of drug treatment in Greece coincides with the establishment of ITHAKI, in 1983, the first therapeutic community.

This is the first systematic attempt to treat drug users and it coincides with, first the increase in heroin use, and, second, the accession of Greece into the European Union (EEC then) and the subsequent changes in public health and mental health concepts, policy and legislation.

Ithaki *(Itaca), an island in the Ionian sea, the kingdom of Odysseus (Ulysses), who, after the end of the Troyan war, punished by the Gods for his hybris, wandered for10 years trying to return to his island. Odysseus adventures are the object of Homer's epic poem Odyssey.*

ITHAKI fell administratively and financially under the National Welfare Organisation and the Children's Hospital of Attica. Its premises are in a Thessaloniki suburb, Sindos. Drug dependent people who participated in ITHAKI were assessed in two counselling centres, one in Athens and the other in Thessaloniki. ITHAKI was in fact the "nursery" of the KETHEA (Centre for Therapy for Dependent Individuals), which is the largest drug free treatment centre in Greece today and where ITHAKI belongs today.

In 1989 ***KETHEA*** establishes the **PAREMVASI** (in English: "intervention") residential programme which includes the PAREMVASI alternative therapeutic community in Pafina (Attica). In the same year the **EXODOS** (in English: "exit") a therapeutic community is established in Larisa (region: Thessaly, central Greece). In 1993 KETHEA establishes the **NOSTOS** therapeutic community covering Pireus, the Aegean islands and sountern Greece. The community's premises are in Salamina (island in Attica). Only 3 years ago, in 2009, KETHEA establishes the **KITARO** (in English: "tissue cell") therapeutic community in Kalamata (Southern Peloponnese)

Nostos *is a homeric word which means "homecoming". Nostalgia, nostos + algos (pain) is the yearning for the past.*

Residential treatment programmes are also founded by ***18 ANO*** treatment centre of the Attica Psychiatric Hospital. In 1995, 18 ANO establishes the **Department A for Psychological Dependence** , followed by the **Departments B** and **C** in 2004 and 2005, respectively. In-between, in 1997, 18 ANO creates the **Specialised programme for dependent women** and in 2006 the **Specialised programme for dependent mothers and their children**.

The Thessaloniki Psychiatric Hospital establishes the therapeutic community at **KARTERES** (a Thessaloniki suburb) in 1992 and the residential detoxification treatment "**DETOX- CHRISTOS ROGOTIS**" (which is the only detoxication programme in Greece) in 1996. Both these programmes are part of the IANOS Rehabilitation Department for Dependent Individuals.

IANOS (Janus) *Roman god of beginnings and transitions.*

In short, Greek therapeutic communities belong to KETHEA, while 18 ANO has residential treatment programmes.

Changes

The Greek therapeutic communities of KETHEA follow the hierarchical model. Unlike therapeutic communities in other parts of the world, in Greece there was not a strong public reaction of the local community against the first therapeutic community. ITHAKI. Public reaction emerged at a much later stage and peaked in the early 2000's against both residential and outpatient treatment programmes.

Even in the absence of overt reaction, the stigma and the social exclusion of the drug users were prominent in the Greek society. The first therapeutic community had a twofold role: to provide a stable and secure therapeutic environment for its members in a protective closed space, while, at the same time, they had to convey the message to the local communities for tolerance and social acceptance, as well as to prepare the society for inclusion of the former drug dependent people who had completed the reintegration phase.

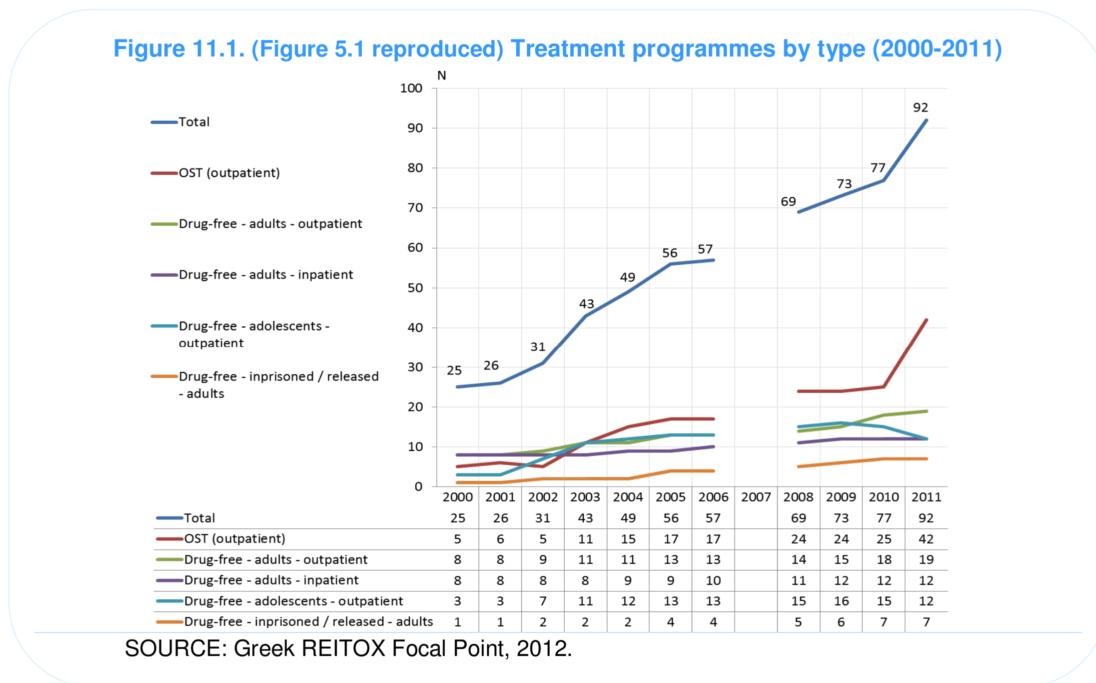
This latter role was (and still is) much assisted by a specificity encountered in Greece: all treatment agencies have formed family associations, which function in parallel, yet autonomous, way with the programme their children/relatives participate in. The families of KETHEA participants have been, and still are, active in coming forward to the community and talk about the problem openly, breaking myths and quite often demanding from the State better support for drug treatment (Poulopoulos 2005).

The therapeutic communities and the other residential treatment programmes have always been alert to adapt to social changes and to avoid institutionalisation of the members. Over the years they became more open to the society and increased their collaboration with the local communities, organising events and interventions on various issues (human rights, support of vulnerable groups or environmental issues). A good example is the PAREMVASI Alternative Community (see 12.2.2.1 *Common approaches*).

Another major change is that the main therapeutic phase is reduced to the benefit of the social rehabilitation phase, which has increased.

Although residential treatment is very much alive in Greece (the most recent therapeutic community being founded as late as 2009), through the years, the number and the rate of increase is much lower that that of the drug free outpatient and the OST programmes; while in 2000 residential treatment comprised 47% of all treatment programmes, the percentage gradually drops to 16% in 2008 and to 13,5% in 2011 (Figure 11.1).

Figure 11.1. (Figure 5.1 reproduced) Treatment programmes by type (2000-2011)



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Total	25	26	31	43	49	56	57		69	73	77	92
OST (outpatient)	5	6	5	11	15	17	17		24	24	25	42
Drug-free - adults - outpatient	8	8	9	11	11	13	13		14	15	18	19
Drug-free - adults - inpatient	8	8	8	8	9	9	10		11	12	12	12
Drug-free - adolescents - outpatient	3	3	7	11	12	13	13		15	16	15	12
Drug-free - inprisoned / released - adults	1	1	2	2	2	4	4		5	6	7	7

SOURCE: Greek REITOX Focal Point, 2012.

11.1.2. Strategy and policy framework for residential treatment

In the National Plan against Addictions, there is no distinction between any kind of treatment in terms of policy, funding and accreditation. OST is a unique case, as, according to the law only OKANA has the right or implement OST programmes and administer substitution substances.

Residential treatment programmes follow the policy and the funding of their agency, KETHEA, 18 ANO, or IANOS. The residential programmes of 18 ANO and IANOS, of the Attica and the Thessaloniki Psychiatric Hospitals respectively, are public programmes and they are financed by the Ministry of Health and Social Solidarity through the hospitals they belong to. KETHEA is an NGO, funded primarily by the Ministry of Health and Social Solidarity and by private donations.

All officially recognized drug treatment in Greece (out or in-patient) is free of charge.

The policy for residential treatment is more or less the same in all agencies: the user contacts the agency, enters the counselling centre phase and there he/she is assessed to continue to the next phase, the main treatment, which might or might not be in a residential facility. There is no compulsory referral. (for further details on referrals, see 2.2.4 *Typical levels of collaboration and networking*)

11.2. Availability and characteristics

11.2.1. National overall availability

The existing 12 residential treatment programmes function within their capacity there are no waiting lists in any of the programmes. Geographically, they cover few Greek cities, but since the programme offers residence, moving from other areas does not seem to create major problems.

Trends in the number of clients entering or receiving residential treatment are presented in 4.1 *Outlook*.

11.2.2. Types and characteristics of residential treatment

Common approaches

Residential treatment and therapeutic communities have a different therapeutic approach and this is described below. Nevertheless, they share very similar structure and activities.

Aims of counselling centre:
a) Assessment of the user's state and planning of the therapeutic intervention or referral, b) Information on detoxification and treatment issues, c) Motivation and preparation of users for admission to therapy, d) Decrease in use, and e) Systematic treatment of health problems.

They are all 3-phases programmes: counselling centre, main treatment and rehabilitation phase. The user contacts the agency, enters the counselling centre phase, becomes oriented and continues to the residential phase but also possibly referred to outpatient programmes or even to other agencies - always with the user's agreement.

The main phase of the treatment includes medical tests, primary heath care, school (for the school dropouts), family support, and participation in various groups and activities.
Rehabilitation in all residential programmes and therapeutic communities includes vocational counselling and training, relapse prevention, support for their legal problems.

All residential treatment is drug-free (no substitution substances) and the user is supposed to have completed detoxification before entering. Only in the DETOX – Christos Rogotis programme, detoxification is offered.

Duration of the programmes is also very similar: less than a year for the main treatment and almost a year for the rehabilitation phase.

Typical mix/intergration of services (specificities and differences between residential treatment and therapeutic communities)

Residential treatment of 18 ANO – (Attica Psychiatric Hospital)

18 ANO treatment (outpatient or inpatient) is based on the principle of therapeutic pluralism, with programmes of different modalities, where the dependent individual can choose the one suitable to them. The philosophy of 18 ANO is that dependence establishes when a personal (psychological) crisis meets a

social crisis; this meeting is always mediated by a crisis in the dependent individual's family. The main therapeutic tools are psychotherapy, art and participation in the social process. (18 ANO 2010).

The philosophy of the 18 ANO residential programmes is quite different form a therapeutic community, as they operate on the basis of equity among the members; i.e. old and new members have the same rights and obligations towards themselves and the programme.

Residential treatment is the second phase of treatment, the first being the counselling centre. The duration of residential phase is 6-7 months (depending on the programme), during which he/she is obliged to urine tests twice a week and any contact with the outside world is not permitted. The rehabilitation phase follows.

Apart form psychotherapy, the client is obliged to participate in is all therapeutic activities. These are: occupational therapy group, drama therapy group, group of art and expression, organisation group, sports team, working out group, health group, photography group. pottery group, administration group, group of social speculation, and book and cinema group.

The third phase of the treatment is social reintegration. It lasts 10 months and it is an outpatient phase.

Specialised residential treatment for mothers and their children. This is the only specialised residential treatment for mothers, where they can stay with their children. Pregnant users are also admitted. The mothers follow the same phases as in the other residential programmes of 18 ANO described above (counselling centre, treatment, rehabilitation). There is medical and psychological care for the children, who can participate in the public local day nurseries or kindergartens.

Therapeutic communities (KETHEA)

Although many aspects of the rationale under which ITHAKI functioned in the 80's have changed since then, the main principle is the same: a self-help drug-free therapeutic community model, aiming at psychosocial treatment and reintegration.

The philosophy of the KETHEA therapeutic communities is similar to that of therapeutic communities all over the world. It maintains that drug dependence is a symptom of other problems of the individual, which they can learn to recognize and tackle in a healthy manner. The goal is to encourage the individual to adopt a new way of life, new behaviours and a new value system, as well as providing them with the necessary skills to become a full member of the society. (www.kethea.gr, www.kethea-exodos.gr. www.kethea-kyttaro.gr).

Treatment comprises of three phases. Phase 1 is the counselling centre phase. All users who contact KETHEA, join first the counselling phase which lasts 2-3 months on average (the time can be extended according to individual needs). Following the assessment in this phase the user is placed either in one of the KETHEA programmes (in or outpatient) or referred to another more suitable agency. The main treatment phase is in the case of residential treatment the therapeutic community, As mentioned earlier, the time allocated to treatment and rehabilitation varies.

The common features of the KETHEA therapeutic communities are:

- Referral of drug users for medical tests
- Motivation and preparation of drug users for admission to therapy
- Counselling to drug users and their families
- Individual and group therapy
- Relapse prevention and crisis intervention
- Aftercare services
- Counselling on legal problems

- Family therapy
- Vocational guidance and occupational training
- School lessons (schools for adults are called “School of Second Chance” in Greece) for those who dropped out of school

Members can join groups such as sports, theatre, literature, photography, etc.

The *ITHAKI community* operates 4 production units:

- Printing house **Schema & Chroma** (shape & colour) =graphic arts, publishing.
- The **Farm** covers ITHAKI’s need in agricultural products and sell to the local community, and operates in 130 acres of cotton, barley, clover and a kitchen garden.
- The **Carpenter’s workshop** covers the therapeutic community’s furniture need and sells to the community.
- The **Ceramics workshop** for the ITHAKI’ pottery utensils needs, for selling and forms part of a local authority network for training on pottery crafts

The *alternative community PAREMVASI* presents differences in relation to the rest of the therapeutic communities. A particular feature of the Alternative Community is its strong social orientation and the alternative model for living it represents. The community endeavours to interest its members in current social issues, and encourages them to become active in organising environmental, humanitarian and cultural activities. Its focus is therefore to foster co-operation and interaction between the participants in the therapeutic programme and the general social environment, with a view to their developing closer ties with citizens, municipalities, associations and other entities. (www.kethea-paremvasi.gr).

IANOS Rehabilitation Department for Dependent Individuals - Thessaloniki Psychiatric Hospital

DETOX – Christos Rogotis. Only one specialized detoxification structure operates in Greece, within IANOS Rehabilitation Department for Dependent Individuals (Thessaloniki Psychiatric Hospital). Its operates since 1996 with a capacity of 35 slots. The mission of DETOX is to provide pharmaceutical assistance to (mostly but not exclusively heroin) users, in order to manage the physical withdrawal symptoms. It also provides information and health awareness, relapse prevention, as well as motivation and preparation for the main treatment phase through psychotherapy groups. The scheduled duration of the programme is 21 days.

Therapeutic Community of Karteres. A residential facility which operates since 1992 within IANOS Rehabilitation Department for Dependent Individuals in Thessaloniki Psychiatric Hospital. In order to be admitted, users have to successfully complete the DETOX programme, and participate in the counselling centre of IANOS for a month. The therapeutic community phase lasts 9 months, its capacity is 34 slots, and its main goal is to promote psychological rehabilitation from substances through compliance with a drug-free programme based on Millieu Therapy. In the course of the treatment process, therapeutic emphasis is placed chiefly on group therapy, as well as on therapeutic activities, mandatory (groups of “personal growth”, personal psychotherapy sessions, and activities such as literature, music, farming, climbing, hiking, cooking and sports) or voluntary (art, photography, film and computer groups) while preparing for the next stage of the treatment process, social reintegration. There is also a “School of Second Chance” for the school drop outs (http://psychografimata.com/6298/tmima-apokatastasis-exartimenon-ianos , IANOS 2011).

Family support

18 ANO provides family therapy for families of users, irrespective of whether the user participates or not in the 18ANO programmes. There is also an association of parents, which functions independently from 18 ANO.

In KETHEA there are two types of involving and/or helping the family of the therapeutic community member: a) meeting of the family where the member and their families meet together engaging in family therapy techniques, and b) each programme (and therapeutic community) operates a Family Support Unit offering support, counselling and therapy to family members. And, of course, the family associations mentioned in 11.1.1 *History of residential treatment*.

OST and residential treatment

Substitution Treatment in Greece is exclusively outpatient. Substitution substances are, by law, only administered by OKANA.

Typical levels of collaboration and networking

Users who follow drug treatment in a residential facility or therapeutic community have entered this phase of treatment via mainly two routes: they, either have contacted the counselling centre of that particular facility, or they may have been referred to it by the counselling centre of an outpatient programme, of the same agency. In particular a user who contacts the counselling centre of a therapeutic community or a residential programme, after he/she completed this phase, i.e. when the therapists decide that the user is ready to proceed to the next phase (main treatment) may be accepted into this residential facility or be referred to an outpatient programme of the same agency, or even he/she can be referred to another agency, if it is deemed appropriate (eg. Specialised treatment for mothers with small children). This assessment of the therapeutic team is discussed with the user and it is the user's decision to follow that recommendation.

Referrals are also in place in the cases of psychiatric comorbidity. Most residential treatment programmes accept users with a diagnosed psychiatric problem. Three of the KETHEA therapeutic communities (EXODOS, PAREMVASI, KITARO) do not accept them and have to refer them to other programmes (IANOS, 2011)

The DETOX – Christos Rogotis of the IANOS Rehabilitation Department for Dependent Individuals - Thessaloniki Psychiatric Hospital is the only detoxification programme in Greece and accepts referrals from all residential or outpatient programmes all over Greece. Users who after completing the detoxification phase go back to the initial agency and are placed in the main treatment phase. The DETOX also refer users who have successfully completed detoxification, apart from the Karteres therapeutic community, which belongs to the same hospital, to other in or outpatient programmes of other agencies.

11.3. Quality management

11.3.1. Availability of guidelines and service standards for residential treatment

Guidelines

National guidelines for residential treatment do not exist. KETHEA is a member of the World Federation of Therapeutic Communities and applies the Federation's code of ethics, which includes the "Standards and goals for the therapeutic communities". The code is provided to all substance users and their families participating in KETHEA programmes, as well as to the staff. It has been published in Greek, Russian, Albanian, German and English (KETHEA). The guidelines are cited at the end of this chapter.

KETHEA also has a permanent ethics committee within the organisation charged with, among other things, the presentation of an annual report and the elaboration of regulations regarding ethics for each individual KETHEA activity (research, professional education, etc.) (www.kethea.gr) .

Training

There is no centralised training system for drug professionals. Each agency employs professionals with the necessary qualifications and has its own training system.

I8 ANO provides training to its staff inside and outside the agency and has a policy of using ex-users as “special therapists” in the treatment programmes, who undergo special training.

KETHEA in collaboration with the IC&RC (International Certification & Reciprocity Consortium) established in 1981 the first Scientific Committee for the Certification of Drug Addiction Counsellors in Greece, Cyprus, Malta and Bulgaria with the participation of distinguished scientists from those countries. This Committee examines applications and provides certification for professionals from these countries according to international standards and the specific cultural conditions of each country. Certification through the IC & RC is international and recognized in all the countries in which it is active (Germany, Greece, UK, USA, Canada, Cyprus, Malta, Sweden, Bulgaria etc).

Apart form this, KETHEA employs qualified staff, who undergo a several months training inside the various treatment programmes. The agency also gives scholarships to its staff members for post-graduate studies to institutions abroad.

Evaluation

In 2001 **KETHEA** conducted an external evaluation of its therapeutic communities. It was designed as a follow-up study to measure the effectiveness of the therapeutic communities. Quantitative (EuropASI) and qualitative (semi-structures interviews) methodology was employed. The target population were all the KETHEA clients who entered any one of the existing therapeutic communities in the period between 1994 and 1995, irrespective of the time they spend in the programme. Results are based on a sample of 388 individuals. The study showed that the percentage of ex-clients who abstained from heroin or had reduced their heroin use increased in proportion to the time the spent inside the programme: from 11% of those having stayed inside the community up to 3 months, to 76% for those who had stayed one year or more. The same pattern was observed for cannabis and psychoactive pharmaceuticals use. In relation to legal problems, 10% of those having stayed inside the community up to 3 months still had legal problems, compared to 64% of those who had stayed one year or more. In terms of occupational status, the possibility of having a job increased by 157% for those having stayed inside the community up to 3 months and 227 for those who had stayed one year or more (KETHEA 2001)

In 2005 **18 ANO** conducted an evaluation study based on a follow-up of a representative sample of all the clients who completed treatment (in and outpatient) since 1990. The study aimed at identifying the current living conditions, use status and leisure time activities and employed qualitative (unstructured interviews) and quantitative techniques (structured interviews with EuropASI). The final sample consisted of 188 ex-users. According to the results, the vast majority of the respondents 73.1% were not using any substances at the time of the study, while 10.7% were using heroin. More than half (57.5%) of the respondents declared not having a chronic health problem. 81.8% had a full time job (40% of them as a lower clerk) 90% had no pending legal problems, 90% had not used any psychoactive medicines for a psychiatric problem during the 30 days prior to the interview, 80% and 84%. Respectively, declared being satisfied with their family conditions and their living conditions,. Improvement in their relationship with their partner was shown by 45.8% and with their friends 35.5% (www.18ano.gr/ereyna.html)

11. 4. Discussion and outlook

11. 4.1. Outlook

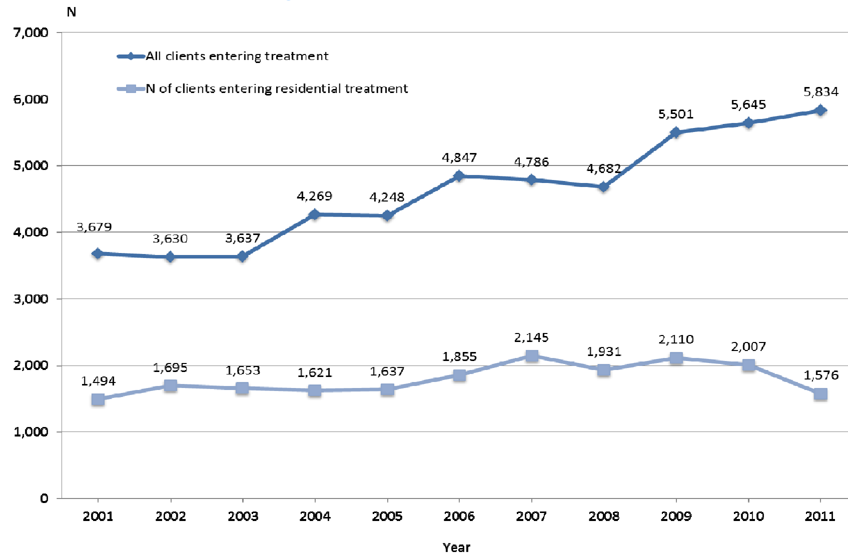
Residential treatment, as all drug free treatment, is available to all users; there are no waiting lists.

In 2011 there were 12 residential programmes out of the 89 treatment programmes in total (13,5%). The overall capacity of treatment in Greece was in 2011 7,883 and the capacity of residential treatment was 460 (5.8%)

Figure 11.2 presents TDI data and, as far as residential treatment is concerned, refers to the clients addressing the counselling centres of the residential programmes; these clients do not necessarily continue to the residential programme as they may be referred to other types of programmes or even to other agencies. It is considered, therefore, more appropriate to talk about “requesting” residential treatment.

The number of clients requesting residential treatment has been almost stable in the past decade. Nevertheless, they represent a decreasing percentage of the total population of users treated in any type of treatment in Greece –from 20% in 2002 to 9.5% in 2011 (Figure 11.2).

Figure 11.2. Trends in the number of clients entering all treatment programmes and those entering residential treatment (2001-2011)

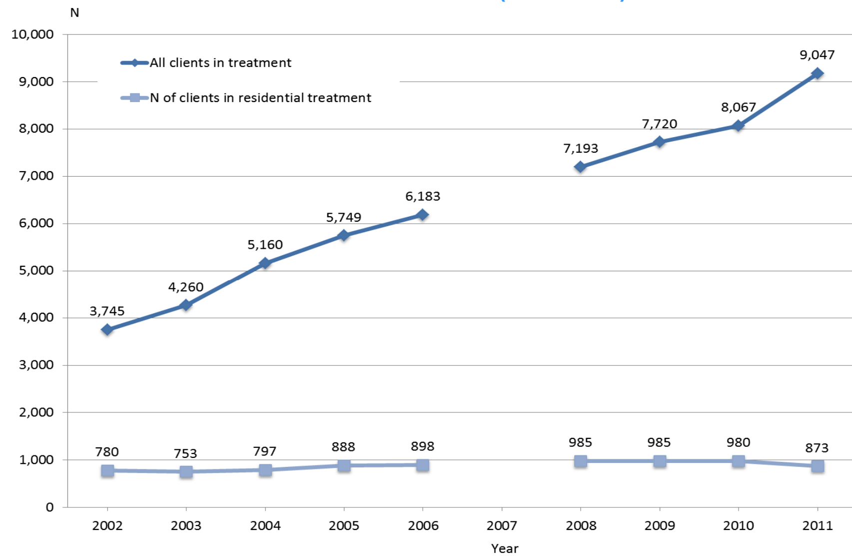


SOURCE: Greek REITOX Focal Point, 2012.

The number of clients requesting residential treatment has been almost stable in the past decade. Nevertheless, they represent a decreasing percentage of the total population of users treated in any type of treatment in Greece –from 20% in 2002 to 9.5% in 2011 (Figure 11.2).

Figure 11.3 presents treatment prevalence, i.e. the number of clients in treatment within the reference years. A similar pattern to that of Figure 11.2 can be seen: although the number of residential treatment clients remained relatively stable since 2001, their percentage among all the total number of clients in treatment has dropped –from 41% in 2001 to 27% in 2011.

Figure 11.3. Trends in the number of clients in all treatment programmes and those in residential treatment (2002-2011)



SOURCE: Greek REITOX Focal Point, 2012.

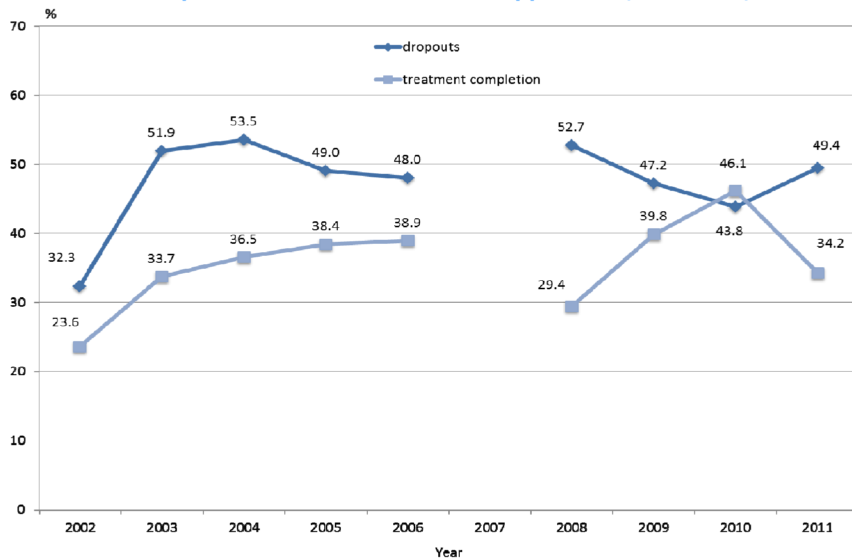
The only detoxification programme in Greece, the DETOX Christos Rogotis, also presents stable numbers of clients in the past 6 years: in 2006, 217 clients were reported, in 2007 -359, in 2009 -273, in 2010 -260 and in 2011 -280.

In relation to treatment completion, as seen in Figure 11.4 the number of clients who successfully completed residential treatment had been gradually increasing from 2002 until 2010. In 2011 a substantial decrease is observed, in combination with n increase in the number of dropouts. In the coming years data will show whether there is downward trend or an one-only event.

The same pattern is observed in all drug-free programmes (see Chapter 5.*Drug related treatment*)

Professionals in the field claim that the economic crisis plays an important role in the motivation and the determination of the user to comply with the treatment obligations, particularly when they are aware that during or after the rehabilitation phase finding a job would be very difficult.

Figure 11.4. Trends in the percentages of clients of residential treatment who successfully completed treatment and who dropped out (2002-2011)



SOURCE: Greek REITOX Focal Point, 2012.

In Greece, it is understood, by both policy makers and professionals that all types of treatment programmes should exist, as users have different profiles and needs. Therapeutic pluralism always been promoted in the Action Plans and in the country's drug strategy. Therefore, residential treatment was never "threatened" and programmes continued to being established in the last 30 years.

Nevertheless, in the last decade, the substation programme gained ground, as policy makers make it a priority, during the early 2000's as a means to reduce the number of drug related deaths and nowadays to control the HIV/AIDS rising epidemic. The last Action Plan 2011-2012 clearly put an emphasis on the establishment of new substitution treatment units.

Due to the fiscal austerity, cuts were effective in all drug treatment agencies, but up to now the agencies have managed to sustain their programmes.

Over the years, residential treatment clients occupy a smaller percentage in relation to the total of clients in treatment in Greece, but their actual number remains relatively stable. One reason for this might be that their effectiveness. Another reason might be that since coverage of any type of treatment programmes is not high in Greece, users who live in cities or areas where there is no programme, might not be able to afford to move from their place of residence to join an outpatient programme; entering a therapeutic community, where accommodation and subsistence costs are covered, might be a preferable solution.

Whatever the case, residential treatment does not seem to "suffer" financially more that the rest under the economic crisis.

World Federation of Therapeutic Communities –standards and goals for the therapeutic communities

1. The therapeutic communities make up a model for treatment aimed first and foremost at recovery from drug addiction through personal development of the individual whom requires him to abstain from mood-altering substances (including drugs prescribed by physicians but which are used illegally).

2. The members of the World Federation of Therapeutic Communities are called upon to:

(a) Recognise that all individuals involved in their therapeutic community have human and civil rights, and to clearly declare the rights, the benefits, and the responsibilities of all members and staff.

(b) Recognise the right of every individual in the therapeutic community to enjoy protection from the improper use of authority on the part of any individual or group.

(c) State the philosophy and the goals of the programme.

(d) Establish rules for their therapeutic community which will provide protection in the event of the apparent or actual abolition of relevant local or national laws.

(e) Operate in an environment which will provide the greatest possibility for physical, spiritual, emotional and aesthetic development and which will guarantee the safety of all.

(f) Facilitate the formation of a society/community, which will be based to the greatest possible extent on the integrity, good will, and compassion of all its members, within which human dignity will be the primary element.

(g) Provide training and proper supervision to personnel.

(h) Answer to an external Board of Directors that will meet at regular established intervals within the year, in order to supervise and be responsible for the activities of each unit's programmes.

(i) Present, following audit, a yearly financial report that will be approved by the Board of Directors.

3. The Board of Directors of the World Federation of Therapeutic Communities will demand compliance with the Standards and Goals each time it examines an application for issuance or renewal of membership. They will also demand active compliance with the criteria established by the World Federation in its Articles of Incorporation, article III, entitled "Determination", and article VI entitled "Membership" (with special reference to paragraphs A1, A2, B1, B2 and C3).

KETHEA. Code of Ethics, Athens

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SPAIN

11. RESIDENTIAL TREATMENT FOR DRUG USERS IN EUROPE

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INTRODUCTION

This report conducts an analysis of residential treatment for drug users in Spain. A description is provided of residential treatment within the context of the care provided for addictions in our country, the different extant resources, its quantification and main numerical figures, the positioning of residential treatment within the care network, the conceptual models having a bearing thereon, the current perception of their usefulness and the challenges facing this treatment in the near future.

The following methodology was employed for preparing this report:

- All those responsible for the care provided for the individuals using drugs in the different Autonomous Communities were requested to complete a questionnaire. This questionnaire was sent to the 17 Autonomous Communities (the Autonomous Cities of Ceuta and Melilla do not have any residential facilities providing care for drug users).

- In-depth individual interviews were held with four of the aforementioned people in charge of these services (Andalusia, Catalonia, Valencia and Murcia), and with three people in charge of major entities in the care-providing sphere ("Fundación Salud y Comunidad" ["Health and Community Foundation], "Asociación Proyecto Hombre" and Spanish Red Cross).

- A discussion group of clients of residential treatments facilities was held, in which ten people took part.

- Many queries were placed with those responsible for residential treatment facilities managed by the RAIS Foundation (RAIS Foundation is an NGO created in 1998 for the main purpose of providing support for different groups in at-risk situations for their social incorporation. This Foundation manages activities including 4 centres in various Autonomous Communities in Spain).

- All of the above was rounded out by way of analysing numerous documents furnished by those requested to do so or those documents available in documentary or online databases.

HISTORY AND POLITICAL FRAMEWORK

1.1. History of residential treatment

Therapeutic communities have been and currently continue to be the reference facility for providing residential care for drug dependence. To familiarize oneself with the history of residential treatment, one must refer back to the past history of therapeutic communities, which had their beginnings in self-help groups of a major ideological, religious or charismatic nature, combined with a peer support methodology entailing a highly regulatory, hierarchical setup. In Spain, this was to a great extent the very beginnings of care being provided for drug dependence which sprang up during the 1980's heroin epidemic, before the public network came into being. In due course, entities such as "El Patriarca", "Proyecto Hombre" or even the "Church of Scientology" were of leading importance. This configuration currently remains in

place solely in some therapeutic communities to be discussed at a further point in this document, which have nothing to do with the public network for the most part, having their own funding and care-providing systems, although they are still playing a minor role in providing care, especially regarding some profiles in certain territories.

The therapeutic communities underwent a professionalization process from the 1980's through the 1990's in Spain which differed to different degrees in different territories. The first regulations governing their operation came into being around 1985, they having been integrated into the public network for providing drug dependence care as of the point in time at which the National Plan on Drugs (1985) was first implemented, at all times as part of a care-providing network where the reference outpatient centres continued to be those mainly responsible for the treatment.

In the 1980's, the network of communities was set up under the "Proyecto Hombre", an entity inspired on the Italian Solidarity Centre, with a global social-educational and treatment programme which placed a major degree of importance on group work and one's time being occupied revolving around carrying out activities. During that same era, different professionals came together to form the Association of Drug Addict Therapeutic Community Professionals in 1986, a set of homologation criteria being set out ten years later for the therapeutic communities serving as a reference for the official accreditations which are currently in force for the most part.

The therapeutic communities were progressively configured as a care-providing resource and not as the basic resource, likewise being confined to an initial point in time of the intervention requiring conditions involving it being necessary for the individual in question to abandon their regular surroundings so as to be able to undertake a treatment process. Hence, the therapeutic communities were located mainly in rural environments, away from the urban environment, which, on one hand, favours the intensity of the treatment process and guarantees conditions of constraint and abstinence, but which, on the other hand, hinders undertaking a reinsertion process and working toward objectives of a social nature having to do with social relations, family relations and transition into work, etc. In addition to the professionalization of the therapeutic communities, the 1990's gave rise to another type of residential care-providing resources coming onto the scene, the treatment support and social reinsertion living facilities. The first versions of these facilities were the "reinsertion flats" in urban environments as an alternative to the rural environment in which the therapeutic communities had normally been located.

Throughout the first ten years of the 21st century, the therapeutic communities and all of the other residential treatment resources have been progressively adapting to the changes in the pattern of use which has been progressively taking shape in Spain, with different client profiles, despite a different image at times on the part of some professional sectors and the difficulties of adapting sometimes quite rigid structures. The growing use of cocaine, the major degree of poly-drug use and the use of other drugs in a recreational type of setting have had a major influence on the residential care-providing programmes.

It is important to point out the fact that when the therapeutic communities first came into being and then went through their subsequent configuration process, most were promoted and managed by entities of a social nature, what is currently known as the "Third Sector of Social Action", which, at the time, were mostly organizations of users, ex-users and their family members. The Public Agencies gradually having taken responsibility gained momentum as of the National Plan on Drugs having been put into practice, the funding falling almost always

exclusively or mostly to the Public Agencies, although with different approaches for managing the therapeutic communities on the part of private entities. There have been very few cases in which these communities have been completely publicly managed.

Over the last fifteen years, according to official sociological studies, the social perception Spanish citizens have of drugs as being a problem has remarkably declined, such that this issue is now being considered to be of progressively lesser importance.

On the other hand, as previously mentioned, the client profile has also changed, there therefore being a less pressing need at this point in time to provide care for individuals who have a strong addiction to heroin at such specialized centres as the therapeutic communities. This has all led to the Autonomous Communities having worked more intensively over these years toward improving the care-providing network in overall terms and on the reference care-providing facilities (which are the outpatient centres), as well as on the implementation of drug use prevention plans and programs.

1.2. Strategy and political framework of residential treatment

According to Spain's Constitution of 1978, "the State is organised territorially into municipalities, provinces and the Self-Governing Communities that may be constituted. All these bodies shall enjoy self-government for the management of their respective interests".

The Spanish State is currently comprised of 17 Autonomous Communities vested with a high degree of political and administrative autonomy. In all of these Autonomous Communities, there is a president and a parliament or legislative assembly of their own. The Autonomous Communities are vested with legislative and management powers of major importance concerning different matters, including all that which has to do with health, education, social services and the care provided for drug dependence. Each one of these Autonomous Communities has its own Statute of Autonomy which is configured as the basic institutional norm.

In addition to these 17 Autonomous Communities, there are two Autonomous Cities, Ceuta and Melilla, the degree of political and administrative autonomy of which is lesser than in the case of the Autonomous Communities, although they are vested with authorities over the care provided for drug dependence.

Generally speaking, the funding of the health services is the responsibility of the Autonomous Communities. Nevertheless, as far as the health care provided for the drug users in some of Spain's larger cities, the treatment resources are funded and managed jointly, to a greater or lesser degree, by the competent bodies of the Autonomous Community and Municipal Government in question.

All of the Autonomous Communities have their own law (at the Autonomous Community level) governing aspects related to drug dependence-related prevention, care and reinsertion. Similarly, the Autonomous Communities have prepared strategies and/or plans for action on drugs which are updated periodically.

These laws, strategies and action plans set forth the duties and powers falling to the Autonomous Communities proper and to the municipalities (in keeping with their populations), as well as the organizations coordinating between the Autonomous Community Government

and the municipalities for greater efficiency and effectiveness of the measures to be carried out with regard to drug dependence. Thus, it has been set forth on an overall basis that the preventive and social reinsertion area falls to the Municipal Government, whilst the care-providing aspect falls to the Autonomous Communities.

Some exceptions exist in two realms. Firstly, as a result of the Municipal Government taking authorities upon itself, one of the most significant cases is that of the Municipal Government of Madrid, this being a situation which is referred to as “unvested powers”[51]. Also worthy of special mention is the authorities taken upon themselves by the provincial councils (Local Government) in the Andalusian model and in the Municipal Government of Barcelona. The data related to these unique individual situations are reflected numerically in the data furnished by the Autonomous Communities for this report, as is normally the case, in the data collected by the Government Delegation for the National Plan on Drugs.

The other major exception lies in some residential treatment facilities being considered social reinsertion resources. The boundary line between social assistance and social reinsertion is not the same throughout all of the Autonomous Communities, although, in principle, social reinsertion comes under the authority of the local government, it has been undertaken at least partially in many cases through the Autonomous Community administration, some housing as support for social reinsertion of drug dependent individuals being available therein. However, in practice, the differences in operation between these dwellings and other dwellings for social support for treatment (clearly under the authority of the Autonomous Communities) are quite nebulous, being operated at other times under care-providing and not social reinsertion departments.

Residential treatment falls within the care-providing area and therefore comes under the authority of the Autonomous Communities, which has given rise to broad-ranging specialization of the facilities, their configuration and their scope in each one of these Autonomous Communities.

The most innovative Autonomic Plans on Drugs in Spain have all included other addictions from a broader-ranging perspective within the care provided for drug dependence. The first step in this regard from a public health-oriented standpoint was the integration of care provided for individuals who have problems involving the use of legal drugs such as alcohol and tobacco. Another subsequent yet significant step was that of incorporating care for behavioural addictions (mainly compulsive gambling), where, in recent times, the phenomenon of the addiction to the new technologies, from internet to cell phones, has arisen, with variations evolving as fast as their use is evolving. The result thereof is that, in some autonomous networks, a commitment has been undertaken of referring to addictions in general and of trying to guarantee the care for these addictions, regardless of whatever type they may be, addictions to: new technologies, sex, work, certain emotional relations, etc.

Lastly, through the Central State Government, all of the drug policies which are carried out at the different territorial levels (central, autonomic or regional and local) configuring the National Plan on Drugs (Spanish Plan on Drugs) created in 1985 are coordinated. A Central Government Minister heads the National Plan on Drugs, the Government Delegation for the National Plan on Drugs operating under the authority thereof. This Delegation is responsible for

[51] For more information, please see the Selected Issue on “Drug Policies in Large European Cities”.

the executive management, promotion, general coordination and supervision of the services in charge of updating and carrying out the National Plan on Drugs.

All of the foregoing has configured a very complete network for providing drug care which is reference point at the international level in some aspects. Therefore, the possibility exists throughout Spain of undergoing residential care within the public network when a person is experiencing a problem of addiction.

2. AVAILABILITY AND CHARACTERISTICS

There are two main facilities involved in residential drug dependence treatment: the therapeutic communities and the supporting homes or flats. There are some others which are also detailed despite their being on a completely minor plane than the therapeutic communities and the treatment support and social reinsertion flats, especially regarding the number of places. There are highly-specialized resources normally providing care for the specific needs of the individuals for whom they are providing care.

In all cases, the essential aspect of residential treatment is that of providing a controlled environment affording the possibility of progressing in the treatment process that will assure abstinence and will provide accompanying psychotherapy treatment as well as daily living habits and organization in daily life.

2.1. Types and characteristics of the residential treatment units

2.1.1. Types of residential treatment units

2.1.1.1. The therapeutic communities

The therapeutic community is resource provided for those patients lacking basic family or social support or for whom this support, although in place, is considered as being a hindrance for the patient's proper progress in the treatment due to the existence of dysfunctional relations, due to lacking a possibility of basic constraint or even encouraging drug use for some reason, such as the existence of family members or friends who use drugs. The therapeutic communities may also be suitable in certain situations in which, there not being any special problem in the social or family network, the drug user in question lacks self-control and skills for maintaining abstinence within their regular surroundings.

While residing in the therapeutic community, the professional relationship with the reference outpatient centre is discontinued, full responsibility for the treatment falling to the professional team of the therapeutic community. Therefore, the therapeutic communities must avail of a range of professionals capable of maintaining the treatment intervention as a whole, including healthcare professionals (physicians, nurses, and psychiatrists), professionals from the social field (social workers, social educators, employment counsellors, occupational therapists…) and psychologists, as well as auxiliary personnel at times.

Although currently only to a very small degree, the professional teams sometimes include individuals who have a past history of drug use, this having made it necessary for them to meet some minimum qualification requirements for the job position they hold.

2.1.2. Treatment support flats

In addition to therapeutic communities, there is treatment support housing and flats in several autonomous networks (at least six according to the provided information). These flats are residential facilities where the treatment is not centralized, but rather is carried out through the reference outpatient centre providing care for drug dependence. These outpatient centres are manned by a multi-professional team which sets out and manages the treatment, whilst added professional care is provided by way of the flats in a context making it possible for the treatment to be carried out as an alternative to the patient's social environment in an initial or intermediate stage. These flats are located in the urban environment, given that their function is not mainly that of confining patients within an isolated space, but rather that of making headway in a treatment process.

Just as in the therapeutic communities, this resource is provided for the patients lacking basic family or social support or for whom this support, although in place, is considered as being a hindrance for the patient's proper treatment-related progress.
Unlike the case of the therapeutic communities, the professionals who work in the flats do not have full responsibility over the treatment, but rather support the treatment under the indications of the reference outpatient centre. These teams are configured in many different ways depending on the requirements and characteristics of each facility. Thus, there may be a minimal-level configuration, in which the professionals do not possess any special professional qualification, in which case they confine themselves to keeping the rules for peaceful living amongst all and the relational guidelines for occupying time and leisure time set out through the reference centre, as well as keeping a check on the possibility of alcohol or drugs being used.

At the opposite end of the scale, there are resources manned by professional teams comprised of a number of professionals from the social field (social educators, social workers, occupational therapists…), the field of therapy (psychologists) or the health care field (mainly male nurses). In any case, although the professional team in the flat is trained to carry out a treatment programme on their own, their intervention is always under the coordination set out by the reference outpatient centre.

2.1.1.3. Social reinsertion flats

These are homes or flats located in the urban environment and are of a configuration and characteristics very similar to the treatment support flats. They differ from the treatment support flats in that they provide care for individuals who are in the final period of the treatment process, therefore meaning that the professional teams are comprised to be oriented more toward supporting the social reinsertion processes and the return to the initial social environment or achieving an alternative environment. In these flats, the intervention in the area of counselling and integration into employment become more highly intensive among those individuals who have difficulties due to lacking qualification or experience, as well as dealing with both the use of money and the relations within the working environment, especially if this environment has had a bearing on the drug use-related problems of the individuals in question.

The relations with the outpatient centres and the configuration of the professional teams are quite similar to those specified with regard to the treatment support flats.

2.1.1.4. Other facilities

This section has to do with residential facilities of certain specific characteristics, independently of whether they may be therapeutic communities, treatment or social reinsertion support homes or even hospital bed spaces. These facilities are being mentioned here given that their essence does not lie in their being located in a rural or urban environment or in the architectural shape or size of the centres (flats or therapeutic communities), but rather in certain characteristics which have to do with the individuals for whom the care is provided, by socio-demographic profiles of use, etc.

By specific substances

As previously mentioned, in the beginning, the residential facilities were focused mainly on providing care for a group of heroin users. Over the last twenty years, numerous studies confirm a change in the profile among drug users, a very strong trend toward poly-use and a clear-cut advancement of cocaine use having been noted which has progressively balanced out and modified the profile of the clients using these facilities. Most of the resources have progressively adapted to this changing situation by suiting the individual treatments to the individuals admitted to the resource regardless of the main drug used and incorporating any possible organic and psychological complications resulting from the same. However, some specific facilities have been found for providing care for cocaine addicts which specialise in the possible psychiatric complications resulting from this addiction.
The greatest degree of specialization of resources based on the substance used has to do with alcohol, which, being an element for exclusion in this report, is therefore not discussed herein.

By specific types

In some Autonomous Communities which have an extensive care network as regards both the number of facilities and places, some highly specialized drug dependence treatment centres can be found which have been implemented to a highly limited degree or to no degree at all in the rest of the Autonomous Communities. In some cases, this specialization is not formal, but rather solely progressively comes into being in a more or less planned manner without however being specified in the description of these facilities. In others, however, such as is the case of the Autonomous Community of Madrid, there is a high degree of specialization. In this Community, which includes the municipal network of the Municipal Government of Madrid's Addiction Institute, there are facilities for the homeless, for providing care for highly-deteriorated chronic clients, for dual diagnosis patients, for self-management, for autonomy, etc.

The facilities for individuals with dual diagnosis-related problems are especially significant, being the paradigm of resource specialization (not only residential) and being highly valued by the individuals for whom care is provided and of major significance also when the drug care network is situated within the mental health field.

The Autonomous Community of Andalusia provides housing for drug-dependent individuals who have AIDS, although those heading this service entertain certain doubts as to it being advisable to consider these facilities as residential treatment facilities.

In the Autonomous Community of Catalonia's network, there is a special facility known as a "crisis centre""[52], based on an experience carried out in the Netherlands, in which the patient is admitted due to a subjective crisis episode, although there be no evident social, organic or psychiatric emergency involved, but rather a combination of several factors. This type of facility could replace the detoxification units at some point in the future. On being admissions involving very short stays (maximum seven days), the intervention plan must be organized by the centre to which the referral is made.

Facilities for minors

There are specific residential facilities for minors who have drug use-related problems in different Autonomous Communities, there being a certain degree of specialization on the part of some organizations (Dianova) in this type of care. Along general lines, the intervention with minors can be said to divert the focus from the addiction to place it on the personal plans, placing great relative importance on the development of the person as a whole so as prevent the use or addiction from taking hold.

Minors and adults living together has been considered as being a problem for minors, given that they consciously or unconsciously take adults as a point of reference, this being a major problem in their treatment process.

Facilities for females, couples or women with children

Information has been gathered on the existence of some residential resources provided exclusively for females, which ensures, on one hand, the existence of a sufficient number of places for females in the network and, on the other, affords the possibility of dealing with aspects specific to the females who have problems of addiction. In the case of the Andalusian network, mention is made of facilities for women with children or couples with drug use problems. Information exists as to the presence of females in some therapeutic communities not having been properly managed, emotional relations coming to bear at a point in time of great far-reaching importance in the life of the individuals affected having interfered in the treatment processes, giving rise even to their dropping out of treatment.

2.1.1.5. Admission criteria

The admission requirements are usually set by each care-providing network, the main requirements having to do with the profile of use and the diagnosis, socio-demographic aspects, social environment, health status and obviously the degree to which the admission is voluntary.

Past history of use

The prime requirement for admission to a residential facility is the existence of a problem of drug use, drug dependence or drug addiction. In some cases, the profile of use is defined formally or by way of a distinction being made in practice, in the direction of a certain type of drug in particular, although most of the residential facilities have opened up their range of care to include any type of drug (even including alcohol in some cases). Similarly, there are some cases in which the residential facilities are likewise open to providing care for behavioural

[52] No data have been provided; therefore they are not included in this report.

addictions not involving the use of drugs or in which drug use is not the main reason for admission. In these cases, compulsive gambling, addiction to sex, to the new technologies (videogames, internet, cell phone…), to work, to emotional dependence, etc. are included.

Socio-demographic aspects

Most of the residential facilities are for adults, although there are some residential facilities for minors only. Adults and minors living in the same facility has been identified years ago as a risk factor in the prognosis of the younger individuals, who, as previously mentioned, need a treatment in the residential facility which is more focused on defining their personal plans than on specifically treating the addiction.

Apart from the above, gender may likewise be a decisive factor in an admission to a residential facility. Most of the facilities have the number of places available for males and for females regulated, being in many cases exclusively for males, especially in the case of small-sized facilities (support and reinsertion flats). In this regard, there are two factors to be taken into account. On one hand, the architectural configuration proper of the centre, which determines the number of rooms set aside for each gender. The number of individuals for whom care is provided in the drug dependence care-providing network in Spain, care being provided for 83% males compared to 17% females. This has meant that the vast majority of centres are for males, although there are some facilities for females only. The second factor is taking sexual relations within the residential facilities into consideration and the regulation thereof in terms of different criteria and especially the incidence on how the patients' treatments evolve. At some centres, relations with one's spouse/partner are even limited during the treatment period. With regard to the gender perspective, there are professionals who have set out different aspects concerning the male-focused configuration of the drug dependence care-providing system proper.

Social environment

One fundamental criterion for admission to a residential facility is that of not having the basic social environment and family support necessary. This lack is considered in different ways in certain cases, although it is normally determined at the judgment of the reference centre team and mainly that of the social worker.

However, there are some cases (mainly on the part of some social entities which base their decision on a criterion differing from that of the Government Agencies) in which family support is considered, to the contrary, to be a fundamental requirement and a factor for the success of the treatment, the non-existence of which may be a criterion for exclusion ("Proyecto Hombre" may be one example in this regard, although their position has been changing over the past few years).

Health status

Practically all of the residential facilities require a health status affording the possibility of peacefully living together with others and adapting to the dynamic of the facility on the part of the individual proper and on that of the rest of the patients. This means the non-existence of infectious diseases in the active stage, when they entail a risk for the other clients, the non-existence of a physical disability preventing the self-dependence required at the facility, as well as the non-existence of psychiatric disorders. This last-named aspect is usually one of the main reasons for discrepancy at times in the process of adapting the criteria for inclusion among

those responsible for the residential facilities and those responsible for the reference centres processing the referral.

Voluntary admission

Admission being voluntary is a fundamental requirement for being admitted to the residential facilities. This is a basic human right governed under Spanish legislation on patient autonomy, as well as a result of being considered a determining factor in the progress of patient's treatment. In this last regard, the evaluation of the patient's motivation as a criterion for success is at times reason for discrepancy between those responsible for the centres making the referral and those responsible for the residential facilities, where there is usually a more highly demanding criterion on the part of the latter. The degree to which admission is voluntary is usually determined in a document known as the "informed consent form" in those facilities which have progressed in recognizing patient rights, whilst being solely an undocumented practice at others.

The possibility of forced admission is quite limited in Spain and when carried out is always determined by way of a court decision, but does not take place regarding just simply drug users, but rather is for severe psychiatric disorders. This is accomplished by means of admission to hospitals or psychiatric centres for adults (normally persons legally incapacitated) or by means of court convictions as a result of behaviours governed by the penal system, in which case the prison system (which has two psychiatric hospitals) takes charge.

However, there are circumstances in the prison system which govern ways of serving sentences alternative to incarceration on the part of individuals who have drug dependence-related problems, in which the degree to which the individual's admission is voluntary could be considered to be conditioned.

Lastly, mention must be made of the times prior to admission to residential facilities. Although complete information is not available, there are sometimes waiting periods of up to two or three months for admission. This waiting period has been a source of controversy regarding its perhaps not being the best way of proceeding with regard to improving client motivation at the point in time of their admission, although this argument is being put forth by a minority at present.

2.1.1.6. Release from facilities

Whilst admission to the residential facilities is determined by the referral from the reference centres, patient release takes place independently of these centres in the case of the therapeutic communities, which take charge of the treatment process from beginning to end of the patient's stay. However, in the treatment support and social reinsertion homes, this aspect continues to come under the authority (normally shared) of the outpatient treatment centres. In both cases, the stay reaches an end for any of three main reasons: the time periods or objectives have been met, voluntary release or expulsion. All of the releases of individuals for whom care is provided involve the documentation of the process by means of a report issued at the end of their stay.

The analysis of these reasons for leaving the facilities is, in conjunction with the ex-post evaluations, the fundamental criterion of efficacy and efficiency of these facilities, being determined in terms of the percentage of treatment releases.

Being released from the residential facilities does not imply the end of the treatment process, treatment still being continued through the reference outpatient centres, which may refer the

patient to other residential or outpatient resources or continue the intervention exclusively through the outpatient centre until final release.

2.1.2. Approaches

The role which the residential treatment facilities play in the care-providing network in Spain is conditioned to a great degree by the past or current opinion of those heading the different Autonomous Communities as to the functions and benefits of these facilities. An assessment is provided in following as to the different approaches to the care provided for drug users and its implications in the configuration of the residential facilities.

2.1.2.1. Addiction as a mental health problem

The approach which has taken hold to the greatest degree over the past few years is that of positioning the care provided for drug dependence within the mental health network as a result of considering dependence on drugs to be a mental health-related problem. By way of this approach, a great deal of importance is placed on the residential facilities as isolation centres, with the implications thereof in a context set apart for the intervention and also for confinement. However, the classification of mental health services does not easily fit in well with the classification of the residential treatment facilities. The objectives of isolation, confinement and separate environment for the intervention seems to be achieved more readily in the larger residential facilities than in those smaller in size (support flats or housing in urban areas).

The mental health approach maintains a different professional opinion toward the professionals of the reference outpatient centres than toward the residential facilities as a result of their being responsible for the treatment. Although the role of the residential facilities is generally subsidiary to the role of that outpatient centres (and thus their teams of professionals), when the intervention is designed from the mental health perspective, the top-priority role is played by the psychiatry professionals and, to a lesser degree, by healthcare professionals, positioning the psychosocial intervention teams at a level of lesser importance.

This effect is on the rise due to the fact that there are currently very few psychiatry professionals in Spain, there being a scant likelihood of their being located at residential facilities. Generally speaking, the degree of specialization required in the field of mental health had not as yet made its way to the residential facilities nor does it have any possibility of doing so due to the conditions in which these facilities are funded.

In terms of organizational functionality, placing the care provided for drug dependence within the mental health network is not usually done on a full-fledged basis nor is this always done, in practice in terms of equality with the rest of the mental health facilities. The care provided for drug-dependent clients is carried out operating hierarchically under organizational units which act in parallel to all mental health activity as a whole, within any homogeneity of protocols for taking action or for outfitting and workloads being achieved. The trend toward integration into standardized networks has been confined, in practice, to simple organizational coverage, meaning that many times the residential treatment is not always one of the managing entity's priorities.

The mental health approach devotes special care to the "treatment", understood as overcoming the mental disorder in question, in a process ranging from detoxification to habit cessation, entailing a major involvement of pharmacological support in the individual intervention in

conjunction with individual psychotherapy greatly focused on the clinical aspects, which is some communities is quite markedly psychoanalytical in nature. And all this may lead to lesser importance being placed on the social insertion phase in comparison to that placed through other approaches.

From the perspective of actual complete rehabilitation of some patients being impossible to a certain degree, the mental health approach considers the residential facilities for drugs to be partial rehabilitation spaces during an acute episode of a mental disease. It also considers this period, regardless of the prognosis, as a physical recovery and timeout in very tough vital processes, not only for the patients for also for their families and close social networks.

This gives rise to a certain contradiction in view of the impossibility of care from a more social perspective, but also due to the impossibility of the abandonment of certain patients, some minimum resources therefore sometimes being managed in view of the non-existence of other facilities of an exclusively social type. Some managing entities advocate a hypothetical "socio-sanitary space" as an entity for referring patients who have chronic, irremediable disorders for the purpose of being able to free resources and professionals for the purpose of providing more effective care.

2.1.2.2. The social-educational model

One approach of major importance on the part of the therapeutic communities in Spain is the social-educational approach in response to considering the problem of addictions as being a bio-psycho-social problem. From this standpoint, the interrelationship among factors, consequences and biological and social symptoms is taken into account in the care provided for drug users.

This model is aimed at integrating these three health-related perspectives, there however being a major difficulty involved in drug care being administratively positioned in the social and health systems, these being systems with are dissociated from one another, whilst those defending this approach stress the coordination and collaboration among the different networks. The staunchest supporters of this approach tend to position the care provided for drug dependence in the social welfare system, the top reference point of which might be the Autonomous Community of Andalusia.

This approach has been employed for configuring a line of therapeutic communities which have been termed social-educational communities versus those of a psychotherapy-oriented line. The therapeutic communities stress the work of acquiring or recovering living habits and relations with others, placing great importance on the organization of structured and unstructured activities and social interactions which are carried out in formal and informal situations and environments affording the possibility of acquiring personal responsibility and decision-making skills. In this model, group intervention is of greater importance than individual intervention.

In some Autonomous Communities, the social welfare system and the health system come under the authority of one same Department, which could facilitate communications and coordination among different care-providing systems, however, in practice, no major differences are found to exist in comparison to other models: the strongest sub-system (health system) always taking precedence over the lesser system (the social system).

2.1.2.3. The psychotherapy intervention approach

With respect to the socio-educational approach, there is another approach committed to quite an in-depth psychosocial intervention. This approach is not predominant at this point in time in the care being provided for drug dependence in any Autonomous Community, but was indeed predominant throughout a time in which psychological intervention was more highly valued than medical intervention.

From this perspective, the length of time spent in a residential resource is a privileged intervention space for working on personal factors having a bearing on the use in question, especially the emotional factors, where the patients can learn to interact socially, consolidate their own identity and learn to maintain social relations, also being aimed at a behavioural and motivational change and, in greater depth, a true process of "redoing" their lives.

The active involvement in the residential facilities can be noted in the treatments being more highly structured, entailing a great deal of individual and group intervention and practically all the time is taken up with therapeutic interventions, predominantly devoted to the psychological aspect

Although no Autonomous Community is known to have adopted this approach as essential to its network, the "Proyecto Hombre" social organization, highly important in this sector, could be said to be the entity most intensely maintaining psychosocial intervention. This organization acts within a framework of collaboration with the public network, although also maintaining its own individually-defining features and even its own model if its additional funding so allows. Through this model of the predominantly psychological as a preferred intervention context, this organization is committed to configuring highly well-rounded multi-professional teams, long stays and a strongly-structured intervention.

2.1.2.4 Public health approach

One important approach during the 1990's which is still in place is some autonomic networks is the public health approach. This approach places prime importance on the harm which the use in question causes, whatever the harm in question may be. A major degree of importance is placed on the residential facilities by way of this approach by encouraging their being made more flexible, promoting a certain revamping of the residential care provided and allowing for objectives other than abstinence. This is an approach used to a great deal in the case of those patients who are using opiate substitutes or in the process of making the strict demands on meeting objectives more flexible. This pre-eminently clinical perspective incorporates social insertion objectives into the treatment to a lesser degree due to its not having a direct, quantifiable effect on the disorder.

Significant headway has been made by way of this model in opening up the therapeutic communities to new client profiles, to admitting patients undergoing methadone treatments and making the more rigid models which existed when therapeutic communities first came into being more flexible. This has also afforded the possibility of bridging gaps by way of the different models to reach a consensus regarding the methodologies, systems for evaluating and monitoring the activity in terms of health objectives to be achieved. This has also been a model which has contributed a great deal to the processes of planning the care-providing network by being provided with and investing all of the experience of other public health processes and services. In some aspects, the care-providing network of the Municipal Government of Madrid's "Madrid Salud" Addiction Institute would be a fine example of the advantages of this approach.

2.1.3. Mix or integration of services

There are two opposite trends in residential care in different autonomic networks: those which are committed to the integration of all addictions and all profiles of use in the same facilities, regardless of what their characteristics may be; and those which are committed to the specialization of the different facilities in terms of different types of users, by substances (alcohol, cocaine), by specific disorders (especially dual diagnosis) or by social or demographic profiles (females, minors, immigrants…).

Some Autonomous Communities which avail of greater capabilities for planning, homologating the portfolio of services and training professionals are inclined toward integration with a perspective of universalizing the care provided (Andalusia would be a reference point in this regard), which also affords the possibility of a greater efficiency of the resources. This is likewise the trend which will likely be having the best prospects in a budget-cutting situation.

On the contrary, especially in autonomic networks which have sufficient resources and whose territories are not widely spread (the reference can be the Autonomous Community of Madrid) teams of professionals with a high degree of specialization are sought with the prospect of incorporating methodologies, techniques and teams which are advanced in each field. In this regard, one can hardly negate the need of specialized facilities, for example, facilities for females or for dual diagnosis patients.

Some of the trends which have come into being over the past few years for improving the care provided for profiles for which sufficiently high-quality care is not provided in the network according to their specific requirements (and which would require efforts for the improvement or specialization of the residential facilities) are in jeopardy of being suspended. This may be the case of homeless individuals addiction-related problems, mothers with children who cannot be provided with care by family members or other services, some groups of immigrants whose health is deteriorated to major degrees associated with highly problematic uses or profiles of users who have a long past history as users and who require a degree of care and assistance that, despite their stability, are excluded from the network of residential facilities for the elderly, in some cases due to the refusal to continue prescribing opiate substitutes (mainly methadone).

The Delegation for the National Plan on Drugs is working on a further expansion upon the portfolio of services which could be definitive for providing a solution to these opposing trends.

2.1.4. Integration of patients with opiate substitute treatment into residential treatment

In the 1990's, the opiate substitute programs, mainly methadone programs, became widespread in Spain. According to the data on patients for whom care was provided in methadone maintenance programs in Spain collected by the Delegation for the National Plan on Drugs, there was a relatively constant rise from 1993 to 2002, from 15,398 patients to 90,488 patients, there having been a slight decline in the following years, down to 83,374 patients in 2005, having remained stable over the past few years, the latest data available being for 2010, totalling 81,022 patients.

Just as for the vast majority of the services providing care for drug users, the residential facilities encountered major difficulties on undertaking the admission of drug users from methadone maintenance (opioid substitution treatment) programmes. However, the presence of

these individuals is currently a situation accepted on a widespread basis throughout all of the facilities, there being extremely few residential facilities currently refusing to admit this type of patients. In fact, at many facilities, healthcare professionals having been incorporated into residential facilities has evolved along with the need for prescribing and dispensing this pharmaceutical drug.

Nevertheless, the professionals at some residential facilities have put pressure sometimes openly or covertly on the clients and the professionals in charge of prescribing (the physicians at the reference outpatient centres) to lower or discontinue the prescribed doses. This attitude on the part of some residential facilities is becoming progressively less frequent. It is also true that this pressure is more exerted than by the conviction of the professionals as a result of the conditions required by the Government Agencies. The widespread use of methadone in the programs for drug users has also contributed to this situation. Around 40% of the patients for whom care is provided within the care-providing network make use of this network without there being any difference among profiles and prognoses justifying, in practice, the existence of a criterion for the exclusion of the patients in relation to the use of opioid substitutes.

2.1.5. Levels of collaboration and relations among networks

2.1.5.1 Positioning and relations with the care-providing network

The residential facilities in Spain are considered as being second or third-level facilities within the public network. On analysing the drug care-providing network as a network within another more general network (normally the health or social welfare network); the facilities providing drug care would be a second-level facility. However, admission to the residential facilities is always through the first-level facilities in the drug network, the outpatient centres providing drug dependence care, addictive behaviour units or those termed similarly. Despite their being termed differently within the different autonomous networks, these centres are configured similarly throughout all of these networks and are manned by multidisciplinary teams generally including professionals from the fields of psychology, social work and medicine, which are usually rounded out with other health care professionals (nursing, psychiatry…) or social care professionals (social-employment counsellors, monitors, social educators, occupational therapists…).

The outpatient drug care centres are considered as being the first level in the drug dependence care-providing network and are those responsible for referring the patients to the residential facilities, the residential facilities being second-level facilities within the drug care-providing network. In relation to the health network (or social network in some Autonomous Communities), the outpatient centres would be specialized or second-level resources, whilst the residential treatment centres would be third-level resources.

The residential facilities operate under the authority of the reference facility in drug dependence care in Spain. Some minor difference being involved with regard to the system by which this care is carried out, the reference centres (outpatient drug dependence care centres, addictive behaviour units or similar) determine whether it is best for a patient to be admitted to a residential facility, they therefore being those responsible for determining the admission, without any spontaneous admission or admission at the decision of the residential facility proper being regulated.

This referral system usually works under single-list systems centralized within each one of the autonomic networks, although there be some exceptions in which this is regulated spontaneously through the reference centres proper, with a greater degree of autonomy. Referrals are made by means of referral reports which are issued through the reference centre, although the possibility exists in most cases of refusing to provide a place for the patient if the patient is considered as failing to meet the admission requirements.

Sometimes, a certain degree of discrepancy may exist in this regard between the reference outpatient centres and the residential facilities, the reference outpatient centres usually urging the admission (at times even due to being pressed to do so by the patients or their families), whilst the residential facilities are more demanding in some aspects. This is a strain which has also been found to exist in the subsequent communication among the professionals from both of these facilities during the stay in the case of treatment support housing (in the case of therapeutic communities, this does not come to bear because these contacts do not take place).

2.1.5.2. In sectorial dependence: Health versus social welfare

A general consensus exists as to drug addiction entailing certain aspects, in its origin and in the way in which it is approached, which come under the heading of health care and other aspects which come under the social welfare network. However, on having been configured as a specific network in Spain, it has always been positioned in one of these two networks. Throughout the last fifteen years, different changes have come about in the positioning of the drug dependence care system, situating it within the health network. Funding aspects may possibly have had some influence being the health system the most high-powered, best equipped and administratively best organized.
The technical implications of the drug dependence network being positioned within the health network have meant an increase of professionalization, some major advancements with regard to scientific evidence being taken into consideration in the treatments, an increase of listing of the interventions and all that has to do with evaluation. These implications have however been more difficult to apply to residential treatment, where the heterogeneity of the facilities, the lesser degree of homologation on the part of the teams of professionals and the interventions and the lesser presence of healthcare professionals thereof have meant fewer advancements having been made.

Similarly, the care-providing network has sometimes been perceived on the part of those responsible for health care as being a group of facilities difficult to understand and to place, without any orderly planning or this network has been updated or eliminated. However, during the previous years of economic growth, there had been a heightening in professional qualification and in the practices of the residential facilities, although not always having been due to planning but more as a result of the dynamics proper of this sector.

In the processes of integrating the drug dependence care-providing network into the health or social welfare departments, we often come across aspects “inherited” from the prior organization as a result of the impossibility of undertaking, in standardized management, the specialities of this network and therein primarily the needs for planning and leadership. This has sometimes meant the management of the services being turned over to certain units whilst the responsibility for the coordination and planning of the services is left to others. Despite this type of administrative organization being hard to position within the civil service system, it affords the possibility of maintaining a greater degree of care provided and dynamism in the care-providing

network, which has some major implications, in turn, on the residential centres when this is the case.

2.1.5.3. Administrative management: Services agencies versus the socio-sanitary space

The care-providing network being integrated into the different Autonomous Community Ministries has led to this network being added into the respective administrative organizational charts. The evolution of the health network (the major network in the case of drug care) tends to be organized into a service provider network, one of the priorities of which is the application of efficiency and profitability-related criteria, as well as the classification of the care by means of drafting portfolios of services. Positioning the drug dependence resources in the respective organizational charts has entailed some difficulties regarding equating the existing organizational systems and modifying the prior practices. This process if giving rise to different management-related approaches in the residential treatment facilities which may be having some major repercussions for this network in the future on being facilities easily within the existing systems.

The socio-sanitary space, which pursues integral individual-oriented care and which is often called upon (appealing to the organized coordination among systems) to provide a response to unfulfilled needs which do not obviously fit into any of the services in each network, may possibly be affected to a greater extend in this process, possibilities of coordination and planning of services providing responses to these situations being lost.

2.1.5.4. The relationship with the third sector as promoters and providers

Regardless of whatever management model may be implemented (the approaches used the most for funding with the private sector are agreements, contracts and subsidies, where each Autonomous Community goes by its own individual system), the vast majority of the residential resources are managed by private entities placed in charge thereof by the Government Agencies. The vast majority of these entities are entities which pertain, in turn, to the Third Sector; NGOs, associations, foundations and, in some cases, religious entities. Within the scope of the foundations, some are public or semi-public however dealing, in practice, with residential facilities involves dealing, in parallel, with the management of the third sector entities, and the perception that the public authorities have of these facilities is conditioned mainly by their view of the management carried out by the social entities.

In many cases, the third sector entities contribute by supplying volunteer personnel for managing the residential facilities, thus lowering the cost of these facilities. Nevertheless, a certain degree of debate exists as to it being best to incorporate volunteer personnel, due to the difficulties of assuring the necessary qualification requirements and violating the volunteering-related agreements which rule out volunteers taking the place of paid personnel.

In the information gathered to write this report, some of those in charge have been found to be of the opinion that these entities are innovative, realizing and adapting to the changes more readily and being comprised of committed individuals, whilst in other cases they are perceived as entities set up to defend individual interests related to self-employment, lacking professionalism and suitable management criteria. In the information gathered, the perception which the public authorities have of the residential facilities and the not-for-profit entities is noted as being quite similar. It is for this reason that some aspects related to the Third Sector will be dealt with in further depth herein in following.

2.1.5.5. The management model: From subsidy to contract

Over the past few years, a trend has been being noted toward a change in the management model of the residential facilities, which is in some way a change which the Third Sector proper has been making overall. The coming into being of the services carried out by the Third Sector and clearly that of the residential treatment services have been funded for the most part through the Government Agencies and, to a small degree, by the clients and their families proper and to a negligible degree by other sources of private funding (religious faiths and savings and loan bank benevolent funds, for the most part). This public funding has been done under the legal convention of the subsidy. Subsidies imply granting financial resources to an entity for carrying out a certain social purpose in particular, the entity in question being under the obligation of justifying the expenditures made. The obligations and the possibilities of planning and controlling the activity on the part of the Administration in this legal convention (due both to its legal regulation and the dynamic which has taken hold in practice) is limited to and aimed much more toward the justification of the funds provided having been spent for the planned purpose and not so much at achieving specific results. The subsidy approach is usually carried out on a small volume of funding, at least when done in terms of competition. This has given rise to a special approach which has been the signing of agreements between a Government Agency and a Third Sector entity, which has been the legal convention under which the residential facilities have been maintained on numerous occasions. However, due to the intervention of the Government Agency control and intervention systems, a limitation has been being placed on this funding system, given that it is not guaranteed that this funding is done under circumstances of transparency and equity, but rather by way of a subjective decision on the part of public authorities in charge of certain bodies.

It is for this reason, as well as due to the growing public responsibility over the planning and control of this activity and in undertaking the residential activity as something of its own, that the funding by means of subsidies has progressively evolved toward conventions regulated under the legislation governing public contracting. This is a mechanism which has been progressively coming to bear in parallel to the participation of the private sector in providing public services, the residential facilities being found to continue to be massively provided by Third Sector entities.

Within this context, there is a growing trend toward services being purchased on the part of the Government Agencies within a context of competition, transparency and equality of conditions in accordance with the legislation governing government contracting, which, in any case, will hardly modify the composition of the entities which are providing services in this regard, given that the residential care market requires major investments and a high degree of specialization whilst entailing very little or no economic profitability in most cases.

2.2. Availability and accessibility at the national level

The data provided in following is rather a precise approximation regarding the quantification of the residential resources currently existing within the Spanish State, it however being necessary to take some clarifications into account in the quantification. The diversity of residential resources, its different classification and the difficulties involved in obtaining complete, homogeneous information all make it difficult to determine an exact figure for the data on the extant resources, the number of places, facilities and individuals for whom care has been provided.

Another factor which may give rise to imprecise information is the converging data for 2010 and 2011. Despite the data requested referring to 2011, in some cases, some information is for the year before, which may give rise to some minor deviations, which, in any case, do not alter the fundamental information, given that all of the data on number of places and individuals for whom care was provided is for 2011. Similarly, it has also been necessary to modify some of the information provided in order to homogenize the criteria set out by the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA). The data related to exceedingly short stays as well the stays exclusively for detoxification have been excluded, it also having been ruled out to include those cases in which treatment was provided only for alcohol addiction. Nevertheless, the interpretation of this data has included a subjective criterion in some cases in the classification of the centres, which would entail, in turn, changes in other care-providing-related data[53].

2.2.1. Distribution of centres, places and clients

The following Table provides all data distributed by total number of places, the number of clients for whom care was provided, the number of centres and the ratio between the number of clients and number of places per population[54]. There were a total of 4,506 places in residential facilities in Spain in 2011, care having been provided for a total of 9,312 individuals.

[53] Some of the information from the Autonomous Community of Madrid may be imprecise, given that this Autonomous Community uses a somewhat different system for classifying facilities. The referring data includes the places from the Municipal Government of Madrid's Addiction Institute (more than half thereof).

[54] Data taken from the official municipal register of residents at January 1, 2011.

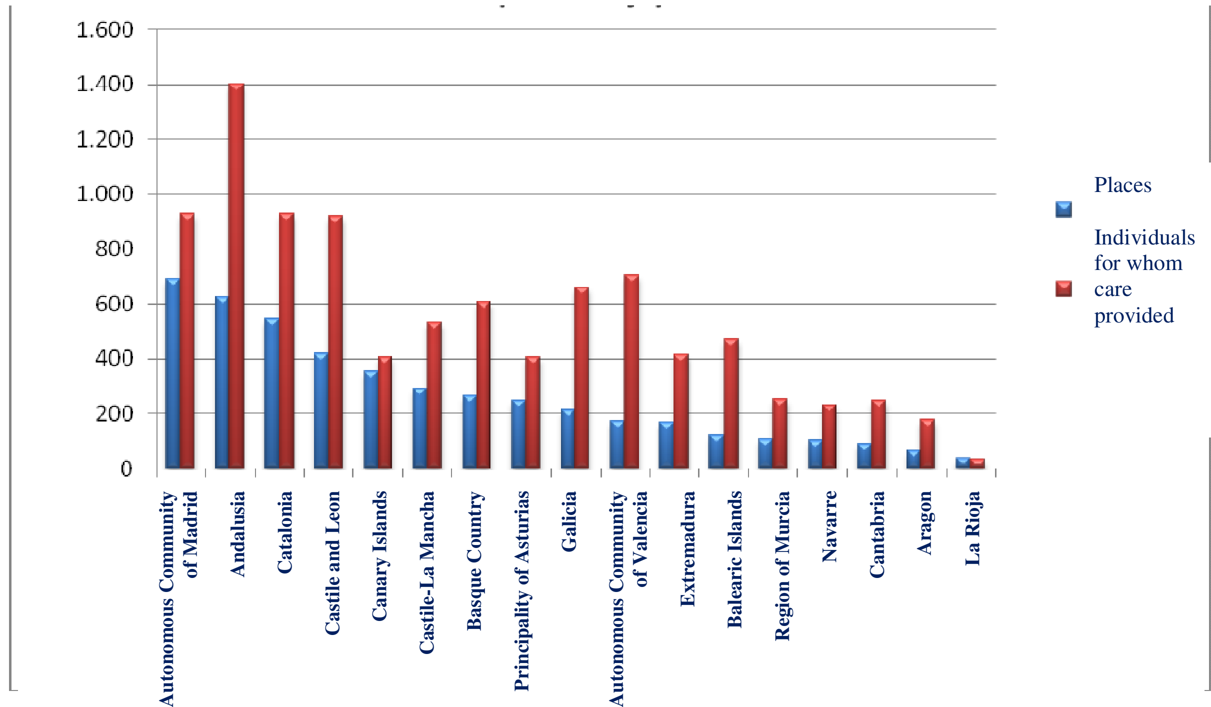
Table 11.1 Total places, clients for whom care was provided, centre number and clients/places ratio and places/population ratio.

Autonomous Community	Places	Clients for whom care provided	Centres	Clients/places ratio	Places/ inhabitant x100000	Population
Andalusia	623	1,402	46	2.25	7.4	8,424,102
Aragon	63	178	2	2.83	4.7	1,346,293
Cantabria	90	247	2	2.74	15.2	593,121
Castile and Leon	417	919	9	2.20	16.3	2,558,463
Castile-La Mancha	293	530	12	1.81	13.9	2,115,334
Catalonia	547	928	18	1.70	7.3	7,539,618
Ceuta	0	0	0		0.0	82,376
Autonomous Community of Madrid	689	926	54	1.34	10.6	6.489,680
Autonomous Community of Valencia	173	702	9	4.06	3.4	5,117,190
Extremadura	169	415	10	2.46	15.2	1,109,367
Galicia	211	659	10	3.12	7.5	2,795,422
Balearic Islands	122	470	3	3.85	11.0	1,113,114
Canary Islands	352	407	11	1.16	16.6	2,126,769
La Rioja	35	32	1	0.91	10.8	322,955
Melilla	0	0	0		0.0	78,476
Navarre	101	231	3	2.29	15.7	642,051
Basque Country	266	608	7	2.29	12.2	2,184,606
Principality of Asturias	249	406	4	1.63	23.0	1,081,487
Region de Murcia	106	252	7	2.38	7.2	1,470,069
Total	**4,506**	**9,312**	**208**	**2.07**	**9.5**	**47,190,493**

2.2.1.1. Number of places and clients by autonomous communities

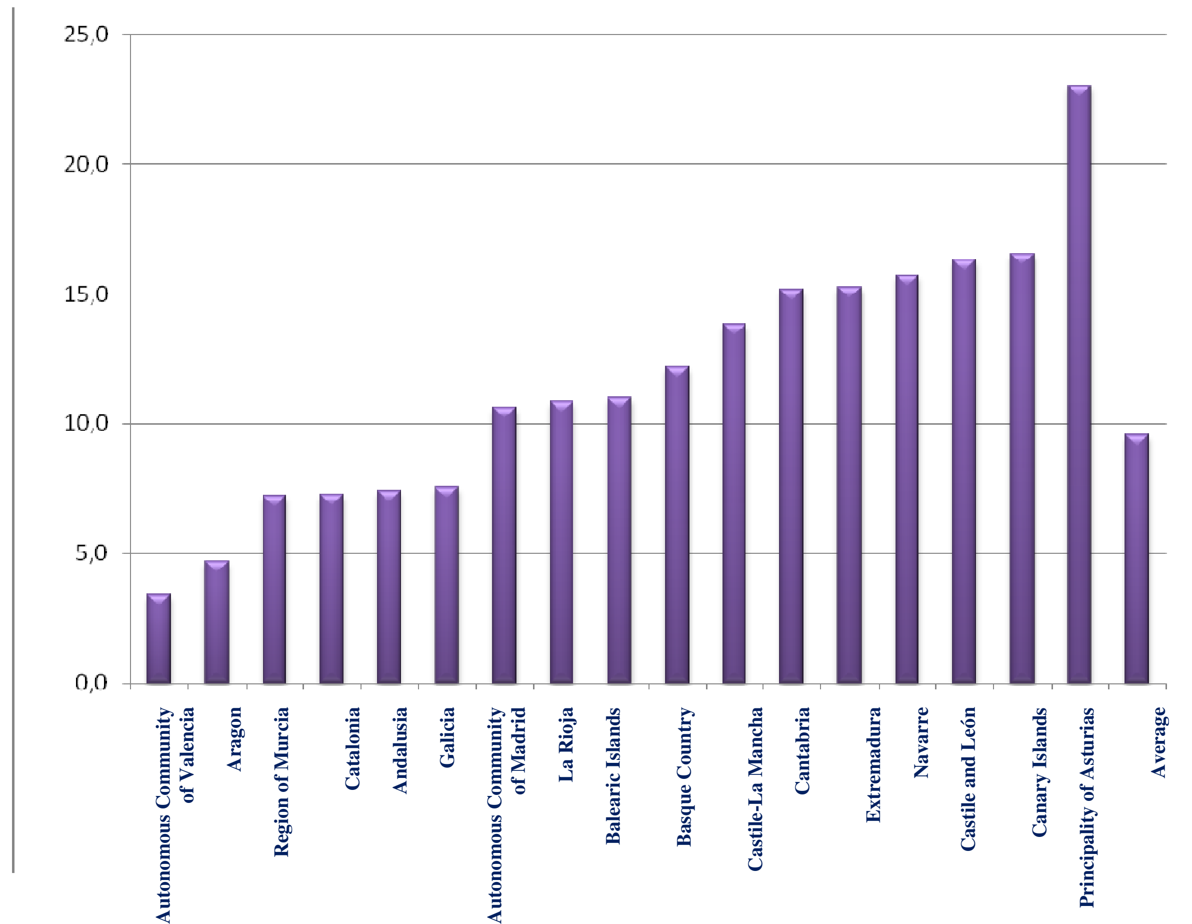
The largest number of places is in the Autonomous Communities of Madrid (689), Andalusia (623) and Catalonia (547). These are the three Autonomous Communities which have the largest absolute number of inhabitants, thus affording the possibility, in an economy of scale, to apply greater planning and specialization criteria without it being possible for us to be able to give more details regarding this study.

Figure 11.1 Breakdown of number of places and individuals for whom care provided



On calculating a ratio of the number of places available per inhabitant (per 100,000 inhabitants), 9.5 residential treatment places are found to exist in Spain for every 100,000 inhabitants, thus meaning one place for approximately every 5,000 inhabitants. Some major differences however exist with regard to the availability of places depending on the Autonomous Communities in question. The Autonomous Community which has the largest number of places per inhabitant is the Principality of Asturias (23 places per 100,000 inhabitants), followed by a major group of Autonomous Communities having a small number of inhabitants, ranging from half a million to two and a half million inhabitants. The most highly-populated Autonomous Communities are situated at around the average or slightly below, with the exception of the Autonomous Community of Valencia (3.4 places per 100,000 inhabitants), the fifth-ranked of the most highly populated Communities (not including the two Autonomous Cities of Ceuta and Melilla, which are not large enough to develop residential resources and are ranked in last place).

Fig. 11.2. Places per inhabitant x 100,000

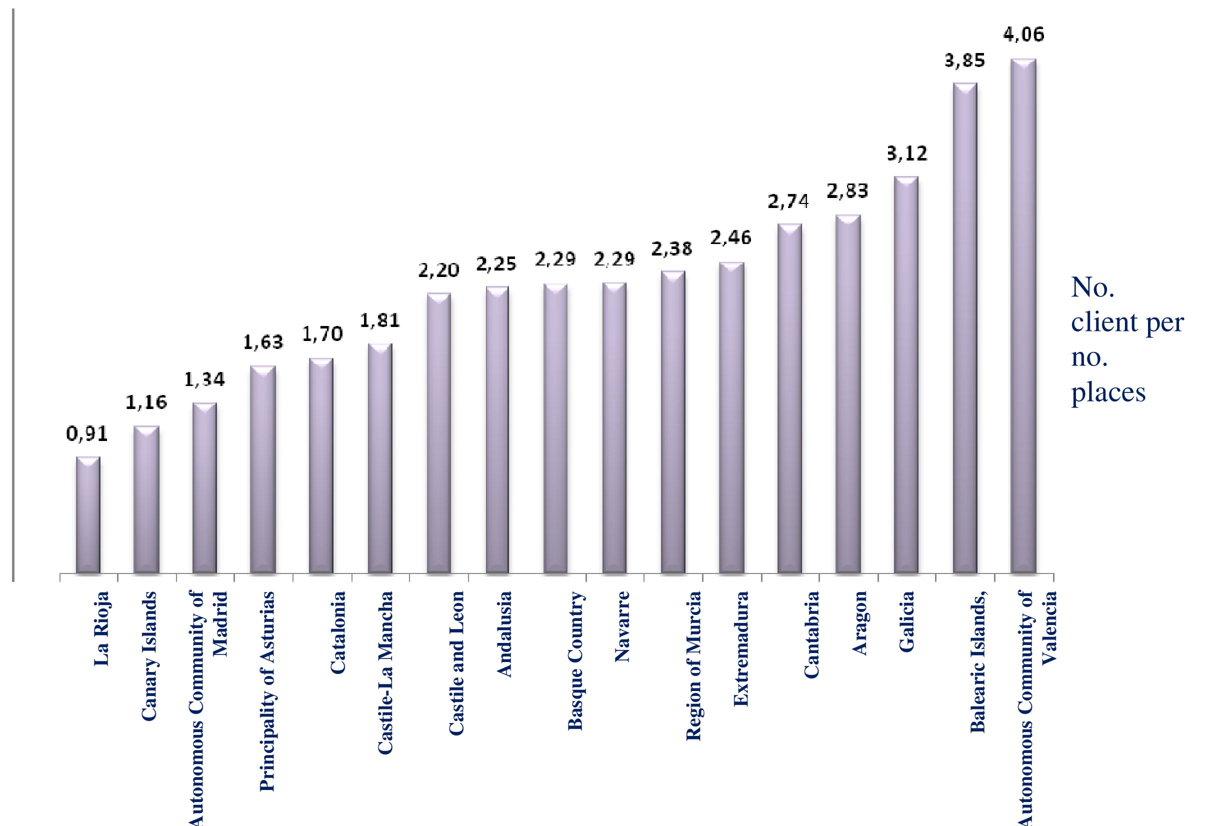


A marked difference exists on the part of the Autonomous Community of Asturias, with 23 places per 100,000 inhabitants, which is nearly 150% higher than the average (9.4), whilst the second-ranked position held by the Autonomous Community of the Canary Islands could be due to the fact of this being an island chain, a fact setting this Autonomous Community apart from others which would justify the importance of the therapeutic community due to the need for isolation within a context of highly limited geographic dimensions. In fact, the Canary Island Government has made an effort to expand the therapeutic communities in order to be present on almost all of the islands. This is a hypothesis which is not confirmed in the case of the Balearic Islands, although in this case, the presence of residential facilities of a private type, to which reference will be made at a further point herein, is particularly significant. The fact that this Autonomous Community has a noticeably higher per capita income might explain the difference.

2.2.1.2. Ratio between the number of places and the number of clients

On analysing the ratio between the number of individuals for whom care has been provided in relation to the number of places available in each Autonomous Community, the data is found to vary, ranging from a number of clients lower than the number of places in La Rioja, implying that care was provided for a lesser number of individuals than places available, to the Autonomous Community of Valencia, which has provided care for more than four times the number of individuals than the number of places it has available.

Fig. 11.3. Ratio of individuals per place



Two opposite indicators having a bearing on this factor: the ratio of occupancy of the resource and the number of days of care provided. The diversity of the information available has not made it possible to process these two indicators. The range of days of care provided for one same patient determined as optimum for the different resources could fall anywhere within a range of three to fourteen months. Some information has been furnished indicating that, in some cases, the budget cuts are affecting the maximum number of days a resource can be

used, so that care may be provided for a larger number of individuals at the same cost. This would therefore be an efficiency-based criterion. On the contrary, the largest number of days could be said to be an indicator of the facility functioning well, with the ability to achieve adherence to the treatment on the part of the individual admitted and therefore with a lower degree of dropouts and expulsions from the programme, increasing the number of treatment releases and the subsequent ability to maintain abstinence.

2.2.1.3. Breakdown by types of centres

In relation to the types of centres which are determining in the section on availability, a list is included in following showing the number of centres, the number of individuals for whom care was provided and the number of places available according to the types of centres detailed (2011 data).

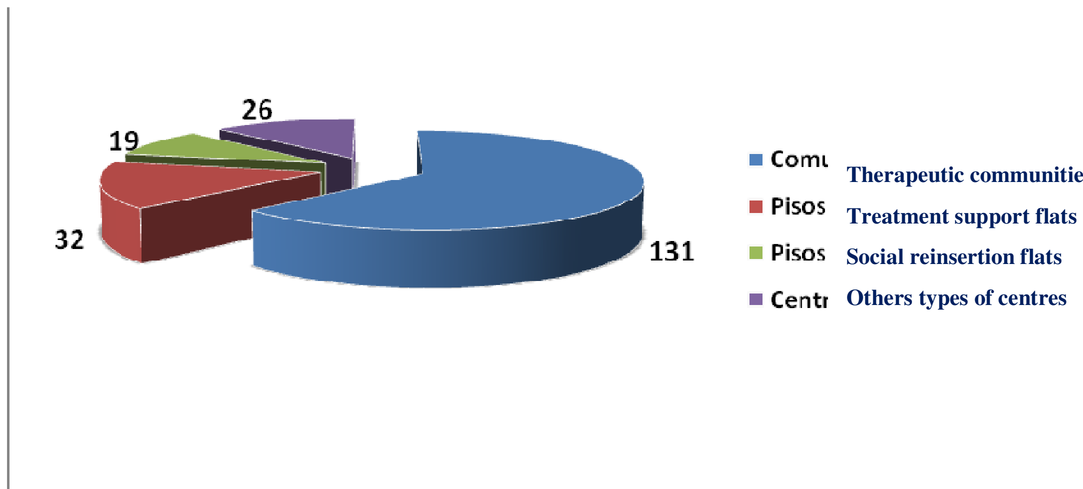
Table 11.2. Ratio number of centres, individuals for whom care provided and places available

Type of centre	Centres	%	Clients	%	Places	%
Therapeutic communities	131	62.98%	8,075	86.72%	3,568	79.18%
Treatment support flats	32	15.38%	961	10.32%	373	8.28%
Social reinsertion flats	19	9.13%	224	2.41%	165	3.66%
Other types of centres (*)	26	12.50%	52	0.56%	400	8.88%
Total	**208**	**100.00%**	**9,312**	**100.00%**	**4,506**	**100.00%**

(*) 1 cocaine users treatment centre located in a hospital, 5 support flats to any users with AIDS, 1 short treatment centre and 19 resources difficult to classify (flats or centres supporting the stabilization, personal autonomy or other care) are included. Some of the centres are specified in section 2.1.1.4 (Other facilities).

As shown in the Table above and on the graph below, the majority of the residential treatment facilities in Spain (more than 60% of the centres) are therapeutic communities, providing nearly 80% of the places available and providing care for more than 86% of the clients.

Fig. 11.4. Number of residential treatment centres. Spain, 2011



2.2.2. Residential treatment funding

2.2.2.1. Cost of residential treatment

Regarding the cost of the treatments and the way in which funded, these treatments are funded publicly for the most part, regarding both the percentage of expenses to be paid as well as the number of cases in which applicable, as previously stated. Regardless of the management model, two different ways exist for the residential facilities to obtain income:

- The proceeds from public income determined by the **quantification of places** available and occupied which are placed under contract, officially arranged or subsidized. In these cases, the information furnished is found to vary greatly, ranging from around 20€ per day up to around 100€ per day for each place.
  In some cases, the funding provided to the managing entities by the Government Agencies depends on the intensiveness of the treatment in question, as in the Catalonian model, entailing three degrees of intensiveness in terms of the ratio of professionals (in terms of the hours of treatment per week, 128 € - 243 €), giving rise to different amounts of public subsidy (approx.. 30€ - 60€ per day). In other Autonomous Communities, this is not quantified so precisely, but the public funding is indeed conditioned to the professional intervention which is provided.

  Whether or not the places available are occupied is a criterion many times determining the funding with which the entities managing the facilities are furnished on the part of the Government Agencies. Many management contracts stipulate a cost per place occupied and a percentage per place unoccupied (usually around 80%, given that the fixed costs of the facilities are quite high and cannot be modified depending on unforeseen deviations).Another factor which has a bearing in this regard is the existence of a single list for referral to places at different facilities, which is centralized through the care-providing network. This is the most common system employed. There are some significant exceptions however, such as the case of Catalonia, in which the referrals are made through

the reference outpatient centres, whilst the treatments are not totally free of charge, which may mean that the economic differences among the different services may condition the choice made by the patients based on criteria totally unrelated to the treatment.

As previously mentioned, the diversity of the information and the fact of no shared information system existing would require a much more in-depth investigation in order to be able to precisely state this information.

- The public income determined by the **total cost of the facility**. Information is provided on the total cost of the facility without any reference to the cost per individual place. To find this item of data, the fitting operations must be performed. This is usually the case of the publicly-managed facilities. In this case, the figure is usually above the previously-mentioned general maximum range.

- The income provided by way of annual **subsidies** from different sources. In this case, widely-varying processes for the filing of applications for subsidies may be found on the part of different Administrations (autonomous communities and municipal) and on the part of private bodies. In most cases, the income from the subsidies is usually rounded out through other ways of funding and even by way of other subsidies from different sources.

- The income provided by the **clients** depends on their ability to make a contribution (and that of their family members) and on the system set out in their Autonomous Community. This is normally always a minor part of the total cost of the treatment, although sometimes not being the case, clients contributing different amounts or others who contribute nothing sometimes living together in one same facility and undergoing one same treatment. In most of the Autonomous Communities, the cost for the patient is free of charge in all of the residential services. Similarly, in some cases, the care-providing network proper facilitates there being individual subsidies indirectly or from other Government Agencies for those cases in which the patients have no income or family support. In the Autonomous Communities in which economic contributions are made, these contributions usually range from 200€ to 800€ monthly.

Except in the case in which the resource is funded in full, as mentioned in the second case (total cost of the facility), the different channels of income do not usually rule out one another, but rather, on the contrary, progressively round out one another, likewise giving rise to the variations in certain ones having a bearing on the rest.

The factors having the greatest influence on the cost of the resources are their size and the personnel costs, which depend, in turn, on whether the teams or more or less complete, that they be comprised of more highly-qualified and specialized professionals (the psychiatric resources are the most costly, following by the general medical practice resources) and whether or not the professionals be public service employees (noticeably higher cost). The larger size of the facilities makes it possible to organize professional teams comprised of a greater number of higher-quality professionals compared to the small-sized facilities.

Despite the difficulty and imprecision of providing a figure for the annual cost of residential treatment, a projection could be made on the basis of the number of places currently existing according to the information furnished. Thus, taking as a reference which could be the average cost per place of 50€-70€ per day, the 4,506 extant places would render an annual cost within the range of 82 million euros to 115 million euros annually. By dividing this figure by the 9,312

individuals for whom care was provided in 2011, this would mean a cost per residential treatment within the range of 8,800€ and 12,300 € annually.

2.2.2.2. Publicly and privately-managed facilities

On the questionnaires sent out to the Autonomous Communities, information was requested as to whether the residential facilities were public or private. This question regarding terming them as public or private has not always been answered based on the same criterion, but, generally speaking, the publicly-managed facilities are considered to be those facilities under the ownership of the Government Agency or a foundation of a public nature which holds the rights and obligations regarding the installations and the personnel of which is subject to the civil service legislation. To the contrary, privately-managed facilities have been considered as being those in which a private entity, whether a not-for-profit entity or a company, holds said ownership. For the most part, the facilities are privately-managed and, save a limited number of exceptions, are managed by not-for-profit entities, mostly foundations and associations, although also by religious institutions in some cases.

According to the foregoing, one must therefore bear in mind that all of the data which is included in the following sections refers to residential treatment facilities and places which are funded by the Government Agencies, are included in their care-providing offer and are recognized thereby, as a result of which they may be considered, in many aspects, to be those ultimately responsible from the legal standpoint.

However, a different criterion is employed in some of the information furnished, public places being considered as being those furnished with funding by the Government Agencies under different approaches, private places being those not receiving this funding. Thus, public and private places may sometimes be found co-existing with one another within one same facility. This is the case, for example, of the Region of Murcia, where most of the entities have “public and private” places. This is likewise the case of Catalonia, where there is no total funding of places, therefore leading to the places (normally) funded in part as being public and those for which this partial funding is not provided as being private.

The following Table shows more than 90% of the centres to be privately-managed and, by a slightly lower percentage, also the number of places and clients[55].

[55] Please note that the total number of clients provided with care does not tally with those of previous tables for the reasons previously stated.

Table 11.3. Types of centres, number of clients, places and clients/places ratio

No. centres			No. clients			Places			Client/places ratio		
Public	**Private**	**Total**	**Public**	**Private**	**Total**	**Public**	**Private**	**Total**	**Public**	**Private**	**Total**
18	190	208	824	5745	6569	603	3903	4506	1.37	1.47	1.46
8.65%	91.35%	100.00%	12.54%	87.46%	100%	17.62%	82.38%	100%			

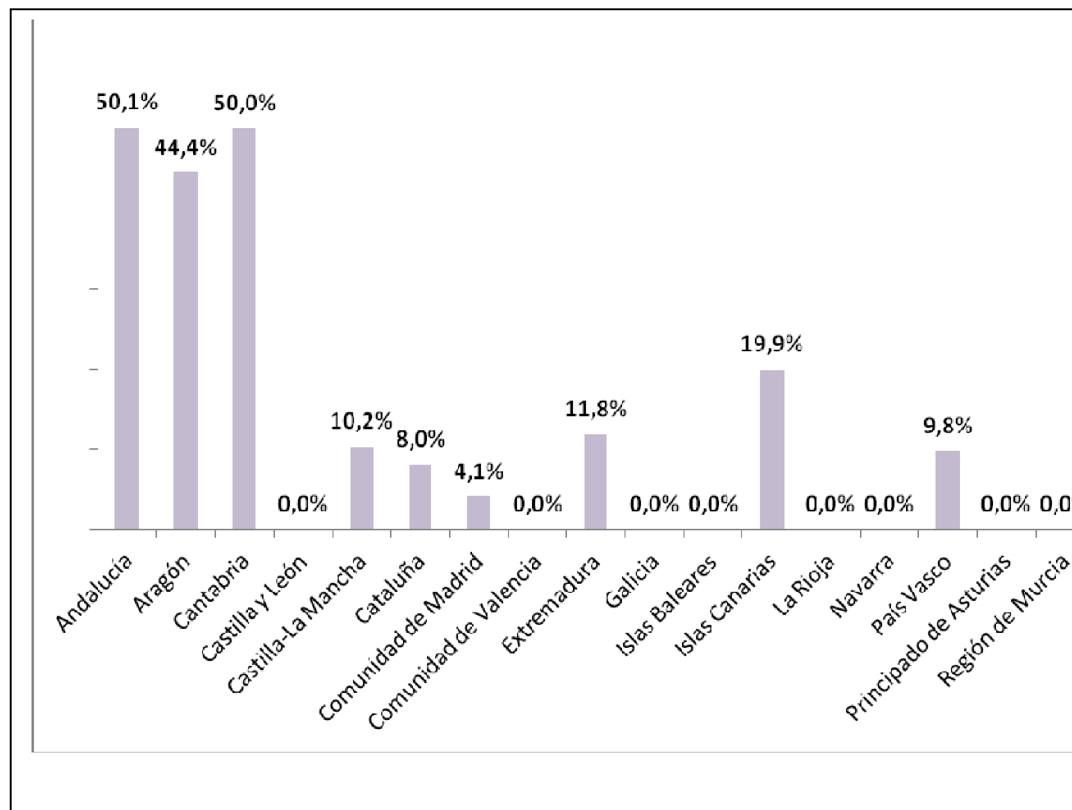
The differences in the percentages between places and centres is due to the fact that, whist there are some public therapeutic communities, no case is known of any publicly-managed flats or homes with a much smaller number of places.

In the entire residential treatment network, the ratio between the number of individuals for whom care was provided and the number of places available is 1.46 individuals/place/year. However, whilst care was provided at the publicly-managed centres for 1.37 individuals in each place in 2011, care was provided for 1.47 individuals at the privately-managed centres. As previously discussed, in order to be able to interpret this information, it would be necessary to avail of a breakdown of ratios of occupancy and percentages of success in the different places, as well as determining maximum times in the different facilities (usually stays of around six months, but these differ in the different autonomic networks and types of facilities).

When distributing these publicly or privately-managed places by regions, more than half of the Autonomous Communities are noted as not having any publicly-managed centre and the rest, with the exception of Andalusia, having one or two therapeutic communities publicly-managed compared to all of the privately-managed resources. The graph provided in following shows the percentage of publicly-managed places compared to the total number of all those places existing within each Autonomous Community[56]. The Autonomous Community of Andalusia is that which has the largest number of publicly-managed places in the entire network, the publicly-managed places totalling more than 50% compared to those privately-managed.

[56] In some cases, projections have been made based on the number of centres as a result of lacking precise information.

Fig. 11.5. Publicly-managed places (percentage)



Over the last few years, partly following the guidelines set under the 2000-2008 National Strategy on Drugs and partly as complaints put forth by the professionals, a trend has arisen of including the care provided for drug-dependent individuals in the standardized health system. In this regard, some case (Cantabria) has come to bear in which a therapeutic community was turned over to be managed by a public foundation. This trend has been much more intense in the case of the reference outpatient centres, but was always a slow process entailing some major complications with regard to meeting all of the requirements set forth for functioning at the administrative level, especially in the employment-related aspect. Quite a major wage gap often exists between the professionals in the public sector and the professionals in the privately-managed therapeutic communities, which has posed a problem with regard to making further headway in this process and may possibly have put it on hold under the current economic circumstances.

Generally speaking, the aforementioned data includes only those places which are funded through the Administration, which leaves two large groups outside of our ability to for analysis:

the non-professional therapeutic communities[57] and the “private clinics” (the cost of which is paid in full by the patients in both groups).

The non-professional therapeutic communities are usually managed by evangelical religious entities and lack, at least in part, the professional teams and accreditations required by the Government Agencies in order to be considered healthcare establishments, their activity however being allowed without any existing guarantees of professionalism. They have been criticized for contributing more to indoctrination than to therapeutic intervention. These communities are more similar to the first self-help therapeutic community model, where individuals with a past history of addiction were turned into therapists albeit lacking professional training. Their main advantages, as is widely known, is their being completely willing to immediately take admissions of individuals who do not meet the necessary conditions at the accredited facilities due to a lack of prior processing, not having the documentation available, lack of fitting assessments, etc. The limitations in the services and conditions they are have sometimes given rise to the intervention of the Government Agencies.

The latter of these two types of facilities, referred to in this report as the “private clinics”, are facilities accredited as healthcare centres manned by different teams of professionals who provide their services exclusively to the patients and their families, without requesting any type of funding from the Government Agencies. Far from being a hindrance, the lack of public funding is precisely their main appeal, on targeting a sector of the population possessing high purchasing power preferring to go to centres offering a certain degree of exclusiveness. They therefore avoid contact with individuals with many different habits and problems, keeping complete secrecy as to the existence of a drug use-related problem and demanding a number of services unrelated to the treatment and closer to high-quality hospitality services. Generally speaking, this type of establishments are completely unrelated to the public treatment network, are registered as general healthcare centres or centres of another type and although their existence be known, they provide no data concerning the care they provide and are therefore not included in this report. In some case, they are mentioned but no specific data is provided.

Along general lines and according to the information gathered indirectly, these treatments include medical and psychological aspects, although they are usually less demanding regarding the latter of these two aspects as far as what is required of the patient and minimize the social aspects. Their cost may vary within the range of 1,000 to 5,000 euros monthly.

At an intermediate level, there are many residential facilities combining the existence of public places funded in full or by a very large percentage by the Government Agencies with private places which are paid for in full by the clients or their families. Some information exists as to the trend toward the decline in the public contributions sometimes being equated with the private places.

[57] Their number does not total a significant volume.

3. QUALITY MANAGEMENT

3.1. Accreditation requirements

Along general lines, the residential facilities need twofold accreditation: as a health centre and as a drug care network centre. These accreditations are determined in all cases by the Autonomous Communities by means of their own legal and administrative regulations and may entail registration in the pertinent administrative registries following fulfilment of the respective requirements.

In the case of the therapeutic communities, who have more complete teams of professionals and always include healthcare professionals, the two accreditations are required.

However, generally speaking, the treatment support, reintegration or other type of flats or homes are not usually under the obligation of being registered in the healthcare centre registry, although they must sometimes register in an administrative registry for social centres similar to the healthcare centre registry although entailing different requirements.

For the accreditation required by the drug care networks, they usually set a number of minimum requirements, such as the existence of a treatment program, a professional team, adequate facilities, internal regulations governing rights and obligations of the individuals for whom care is provided and the positioning of the facility in question within the network treatment circuit.

3.2. Quality systems implementation

The process of quality systems being introduced into residential treatment facilities is still as yet in its very early stages in Spain, its implementation is normally carried out more out of the willingness and on the initiative of the managing entities that out of a planned choice of the drug dependence care-providing network. As previously explained, the care provided for drug users comes under the authority of the Autonomous Communities, in their respective health and social welfare departments, and insofar as these departments value and promote the implementation of quality systems, a certain correlation comes to bear in their being implemented in the residential treatment facilities. Thus, the possibilities and requirements for the implementation of a quality system throughout the drug network is going to depend upon the rate at which they are instituted in the health (or social) network of the Autonomous Community in which they are located and the decisions thereof in this regard.

Many of the facilities are positioned within a drug care network which avails of an advanced management and information system into which indicators are incorporated for analysing the activities carried out, the available structure and the results achieved, but which cannot in any case be considered quality management systems. The existence of satisfaction surveys and studies among clients or professionals is being promoted.

The preparation of documents stipulating portfolios of services in conjunction with the respective evaluation systems is standard practice in different autonomic networks, but the existence of these documents does not guarantee their being implemented in the network facilities.

In other territories, the incorporation of standardized quality systems, normally ISO 9000 or EFQM, for the management of the facilities funded thereby is considered a merit. This valuation may take the form of taking this aspect into consideration in awarding contracts or in granting subsidies, despite regulatory limitations existing hindering significant value being placed thereon. Normally, the implementation of quality systems in addiction care facilities in Spain does not depend on these incentives, but rather on a greater awareness as to the importance thereof on the part of the entities themselves.

Other actions found for promoting the implementation of quality systems, such as the funding of training processes (Autonomous Community of Andalusia), care process management guides or similar initiatives.

The most advanced case which has come to light is that of the Autonomous Community of Valencia, which has carried out a quality accreditation process for drug dependence prevention and care services and centres in 2011 through a public institute operating under the Autonomous Community of Valencia's Ministry of Health (INACEPS). However, from the information available at the point in time of the writing of this report, there is no knowledge of any residential facility which has been granted this accreditation, which must also be on the initiative of the entities and not demanded by the public authorities.

Over the past few years, a progressive implementation of EFQM and ISO 9000 quality systems and the adaptation of ISO 9000 for the not-for-profit entities under standard ONGCONCALIDAD [QUALITYNGO] (only in Spain) has been seen in entities which manage residential facilities, there being information from numerous entities which have fully implemented or are in the process of implementing the same and being granted accreditation. In the Principality of Asturias, the four extant centres possess accreditation of the implementation of one of the two main models (ISO or EFQM) on the initiative of the entities themselves.

3.3. Information and management systems

One of the main aspects of the care-providing networks is the existence of a unified information system. This system is based on criteria which vary greatly from one Autonomous Community to another, the most advanced are those which incorporate online management of the entire case record file in a manner shared with all of the other facilities in the drug care network (Valencia, Andalusia). Its existence and full implementation make it possible to improve the planning and management of the places available in the different facilities, to improve access times, shorten times for the professionals due to different reports and documents being issued automatically and the mining of care data. Similarly, depending on their evolution, subjective biases can be eliminated from diagnoses and interventions.

This type of management systems are often incorporated initially into the reference outpatient centres in the first place and then progressively into the rest of the resources in the network. In this case, the therapeutic communities are usually ranked at the top of the list in the order of incorporation into the system, far above the smaller-sized flats or homes.

At the opposite end of the spectrum, the systems which have evolved to the least degree solely send out documents for keeping up with the information but do not become involved in management, not even in the existence of a unified list of admissions (Catalonia).

3.4. The effectiveness of the residential facilities

It is a common practice among the therapeutic communities for their activity to be regularly measured and an annual report prepared providing an account of their main indicators. These reports usually include indicators related to the profiles of the clients for whom care has been provided (age, gender, patterns and past history of use, health status, by whom referred, socio-demographic variables…) and activity indicators. The activity indicators usually include total number of admissions, occupancy ratios, lengths of stay and releases, as well as its classification.

The percentage of satisfactory releases (known as "treatment releases") as a result of objectives or similar having been met is usually considered a factor of success. Based on the information furnished, the treatment releases usually fall within the range of 30%-75% of the releases. The varying data is conditioned to the objectives which are set by the different facilities for classifying a release as a treatment release, which may also be conditioned by the specialization in the access profiles, by the entity's management criteria and by criteria concerning the conceptual model employed. Therefore, it is quite difficult to draw a comparison among these items of data.

There are, however, various public and private entities which have tried to conduct research concerning the success of the residential facilities, normally the therapeutic communities or the care-providing programmes within which these communities are placed. This research includes post-release and longitudinal studies aimed at verifying the continuance of the changes in the clients several months or years after the fact, with different variables, one of which is logically abstinence. In this regard, studies have been carried out on the therapeutic success of their programmes on the part of organizations such as "Proyecto Hombre" or the "Fundación Salud y Comunidad". These studies find 30%-40% success rates per admission in addition to finding the programs in which the patients stay for at least eleven months to be more effective. However, the different conditions under which these studies are conducted and the difficulty involved in gauging the same and drawing a comparison among them make this a difficult and controversial issue. To make a rigorous approximation, it would perhaps be necessary to conduct a specific study on the evaluation and meta-evaluations of care-providing facilities.

4. DISCUSSION AND FUTURE PROSPECTS

4.1. Trends in the treatment demand since 2000

4.1.1. The impact of the crisis on patterns of use

To date, the available evidence shows no impact of any sort due to the crisis on the types and prevalences of use or in the care-providing profiles. One of the hypotheses being examined is a change in the patterns of use over the past few years with a rise in recreational use of drugs. The lesser availability of income in general in Spanish society may possibly reduce the recreational use and hence curb the rise in cocaine use. On the contrary, the rising unemployment rate could give rise to greater social instability and an increased degree of "escapist" use related to difficulties of managing one's own life. This type of use could lead to an increase in the needs for residential treatment or the modification of certain care-providing criteria in the future depending on these changes. Along this same line, if social-employment reinsertion has been difficult regarding certain patients, it is practically impossible in the current situation, which would require an in-depth analysis as to including employment insertion-related objectives in some individual treatment programs.

4.2. Challenges

4.2.1. The impact of the crisis

The main challenge coming to bear over the next few years in residential drug treatment is that of remaining in treatment under the conditions in which treatment has been carried out over the past few years. The uncertainties regarding funding affect the number of places, the professional services offered in the resources, the lengths of stay and the cost of these services for the individuals for whom care is provided. The challenge will be greater in the specific resources which have been started up in the network and in the treatment and reinsertion support housing in comparison to the therapeutic communities.

4.2.1.1. The reduction in facilities

According to the information furnished, more than half of the Autonomous Communities have made some type of cutback in the funding of residential treatment, although, generally speaking, this could be termed a freeze or slight decrease which, without having precise information, could be estimated at around 10% based on data from 2011. However, this reduction has not meant, in the vast majority of cases, a proportional decline in the number of places available, but rather that the average cost per plaza is being lowered. The reductions in the number of places have more of a major effect on the treatment support and social reinsertion housing and less directly on the therapeutic communities.

Mention has already been made previously of the fact that, in one case or another, information has been furnished indicating a limitation on the maximum length of time for staying at the resources, which hinders its analysis at this point in time. Another modality for cutting costs without reducing the number of places is the possibility of stays five days a week, on weekdays, allowing patients to return home on the weekends. This is a complicated initiative which, should it be carried out, must ensure that the patient's treatment process is not altered.

These reductions in the number of places would also have to include (in this case sufficient information has not been gathered to make any contribution, there solely having been 10%-20% estimates) the indirect declines which arise in those case in which the clients make part of their contributions, due to their inability of doing so in an overall decline in the incomes in Spain and especially due to the drop which has taken place in some Autonomous Communities in the minimum incomes, the only income which some of the clients and potential clients of these centres collect.

Based on the information obtained in different interviews, discussion groups, document analysis and information in the media, there has been little social response in view of the cutbacks in residential facilities. The existence of a social response in different Autonomous Communities has been made known, where different social entities or its professionals headed protest actions in view of the closure of drug dependence care resources, including different residential resources. This scant social response is due to the difficulty of organizing the group of individuals for whom care is provided, who, of everything, on being asked, are aware of the difficulty the closing of residential facilities involves, making statements of the type "… *the problem of being kicked back out onto the street…" or " … it's going to be real expensive getting hooked on drugs again or relapsing, because there's not going to be anywhere to go…",* admitting even that the residential resources provide *"… a certain degree of control and solution, (that) will cease to exist …".* This scant social response sometimes goes along with the perception of guilt and not being worthy of the care provided, on the part of the individuals themselves and on that of the general population.

The main doubt entertained is how far the impact of these reductions will go, whether this will go so far as to involve residential facilities ceasing to exist in some territories, some of the managing entities permanently closing (it is already known that many small-scale entities have ceased to exist) or whether they will solely be reduced in number and be put in a more precarious situation. Many of the social partners are of the opinion that it takes many years and many resources to create a care-providing network, whilst it takes only a very short time for them to disappear without considering all of the investment made.

4.2.1.2. Contribution to the service expenses on the part of the patient proper (co-pay)

The co-pay phenomenon which already exists in some of the autonomic networks, as has been discussed in the section devoted to costs and funding, might also be an approach used by some Autonomous Community Administrations to maintain the funding of the residential facilities despite this meaning that some patients who so require may not be able to gain access to these facilities.

Similarly, the existence of specialized residential facilities, such as those provided for minors with use-related problems or for the homeless, women with children and dual diagnosis patients run the risk of being those affected first and foremost by the budget cuts. These facilities ceasing to exist would require these patients being integrated into larger-scale centres having better possibilities of funding without their possibly being able to meet their specific care-related needs with the same degree of quality as the care with which they are currently being provided.

4.2.2. Trends toward improvement halted

One of the main trends which has occurred over the past few years has been the progressive professionalization of this sector. In most of the resources, the integration into the health network has meant an increase in the health services provided, in both general care as well as psychiatric or nursing care. An increase has also taken place in the specialization of the services of a psychosocial nature which are offered, entailing higher-level qualification of the different professionals which has afforded the possibility of including aspects related to integration into employment with the social relations or with specific psychological aspects.

The funding cuts will likely entail the professionalization process which has taken place in residential treatment over the past few years being halted to a certain degree or even backsliding. This decline will probably be progressive if the trend noted during these years of economic crisis continues, affecting mainly the makeup of the professional teams, the breadth of the range of disciplines, working hours and working conditions, with a reduction in working days, types of hiring and qualification required, in a certain way coherently with the way in which the employment market in Spain is evolving.

4.3. Added value of residential treatment

4.3.1. Usefulness of the residential resources

In the information gathered, different criteria can be established for determining the usefulness of the residential resources as perceived by different people with whom we spoke.

The main reason alleged for justifying the existence of the residential facilities is the inability to carry out the treatment on the part of some patients in their regular social environment. This inability is manifested by their drug dependence, the complete lack of self-control, serious deficits in behaviour and personal and social life, the lack of social-family support, as well as prior failures in other treatment modalities.

Other aspects which these facilities provide are a minimum “break” or “time out” for the patient (who has the benefit of a time of abstinence within a long past history of use) as well as for their families, basic needs of accommodations and upkeep being covered and the providing of basic and health care which would otherwise not take place.

4.3.2. The perspective of care-provided individuals

The clients of the residential facilities usually take part in the everyday life at the centres to some degree, where there are evaluation and planning meetings held, although it is not often at these meeting that the evolution of the patients is dealt with, which is kept within an exclusively professional framework (at least in the majority of cases).

Therefore, an attempt has been made to mirror the viewpoint of the individuals for whom care is provided at residential centres in a discussion group comprised of ten people of differing profiles and experiences. Some of the main conclusions reached are set out in following.

The patients resoundingly state the usefulness and need for this type of facilities. The essential aspect of their contribution is “*stabilization and recovery of coherence”*, saying that if these

resources were not to exist "*my life would be very different, much worse",* even going to far as to say that *"I would likely be dead"* or, referring to a fellow patient in a past experience, *"I saw him come back to life"* in the therapeutic community. Centres like these make it possible *"to grow, mature, to know the right way to behave, to get to know yourself better".*

The aspects which the clients value most highly at the residential facilities are the way they are treated by the professionals, their professionalism (the confidence and knowledge they convey), the method and the degree of demand and discipline. They do not place the same value on the social support among fellow clients or self-help (something which was characteristic of the initial therapeutic communities), nor the coverage of basic needs of accommodations and upkeep (they even criticise those who make use of these resources this way with explicit mentions of evangelical communities).

One of the aspects which clearly mark their classification of the resources lies in the existing degree of demand and discipline, opinions being found to be divided in the group among those who require an almost military degree of order and discipline and those who consider this type of resources to have "demoralized them more". This group's overall conclusion was that each type of resource serves different personal profiles. They say that there are many "downer" times and that it is very difficult to see a treatment through to the end.

They however stress that the resources are useless unless the patient has strong willpower and motivation, mentioning different positive and negative experiences, although they also acknowledge the professionalism of the treatment team when anyone "*comes in without any motivation and makes it".*

One of the significant resources named is the centre managed by the Brothers of the Order of San Juan de Dios, devoted to dual diagnosis patients, where they helped *"toward creating an awareness of this [mental] disorder"* and understanding the role which use played therein.

With regard to the differences among different residential resources, those who have been clients clearly perceive the disparity between the isolation-oriented nature of the therapeutic community and the social nature of the flats or homes. In their opinion, this disparity is justifiable in terms of the need for protection and for more personal than social work. However, they do not perceive any major differences between the different types of flats, not being able to name any at all on their own initiative. On being asked about specific classifications, they determined that one cannot look for work in the treatment support flats, but can do so in the reinsertion flats.

In regard to whether or not the facilities are for both males and females, those who have been clients of these resources acknowledge their preference for living with people of both genders, but also the difficulties which can arise on taking up relations as a couple at points in time of recovery given that "*they get you off track"*, as they mention having happened to some of them.

Most of the individuals who took part in this group had lived in more than one facility (this was a top-priority criterion for configuring the group), this being the reason why they could state their opinions regarding the effectiveness of the treatments. Generally speaking, they say that, despite the subsequent relapses, they have always been useful to them in their recovery, speaking of periods of several years without relapses and holding out hope against any relapse into drug use occurring in the future.

The negative consequence of a shortage of these facilities, according to care-provided individuals, is revealed more explicitly when the impact of the crisis is discussed.

4.4. Challenges for the future

4.4.1. Guaranteeing residential treatment

The top-priority suggestion which must be made within the current context is to establish the guarantee of access to residential treatment as a resource fundamental to providing addiction care. These facilities ceasing to exist or being significantly fewer in number could give rise to a collapse in the care-providing system and would involve many individuals with addition-related problems finding themselves in a situation of very marked social exclusion.

4.4.2 How broad the residential treatment range

All of the information gathered indicates that the care offer, specifically the residential treatment offer, is not uniform in its successes for all groups of patients. Therefore, it is necessary to guarantee a broad-ranging residential treatment offer for different profiles, which can be done by means of different degrees of intensiveness in the treatment care, by individualizing the care programs, by specialization of the facilities or by any other means.

The degree of demand for both accessing as well as staying in the treatment programs can and must be different for different profiles, and it is necessary to guarantee that this diversity of methodologies is maintained, whilst also demanding compliance with a number of standards regarding basic issues (installations, professionalism, rights and obligations, abiding by the legislation, etc.)
Establishing one single model of care as well as one single methodological model for all clients could mean treatment failures, in practice, for most of the clients due to the care being incapable of meeting their needs.

4.4.3. Care for specific situations and profiles

Independently of whether or not the trend is toward the specialization or the universalization of the residential facilities, it is necessary for there to be a broad range of possibilities in the treatment offer to guarantee care being provided for situations outside of the norm, such as those of minors with use-related problems, females, women with children, homeless individuals, immigrants in especially vulnerable situations, dual diagnosis patients and many other cases. Heretofore unknown profiles or those which may arise at some later time and different situations requiring a sufficiently broad-ranging care-providing offer and also as far a residential treatment is concerned must be provided with care in order to guarantee universal access to health at this level.

4.4.4. Stable residential alternatives for a certain group of patients

Reference has been made in this report to the contribution of a residential environment in carrying out a treatment program. However, there is a concern shared by many professionals regarding the non-existence of residential alternatives for individuals who complete a treatment process or who could stay on with professional support in situations entailing a certain degree of control although without any major alternatives for social reinsertion.

In this regard, one might think of low-demand living facility alternatives for individuals who have completed one or more treatment processes for whom there is no prognosis of improvement, although in whom a destabilization or worsening may arise if some basic conditions are not met.

In this regard, one group which does not have adequate residential care is that of the elderly people who have use-related problems, have survived many years of addiction and have reached a stable situation until the death of their parents. In these cases, it might possibly be necessary to deal with the idea of long-term residential centres for providing care for a now chronic, aged profile (some experience in this regard has been found to exist).

4.4.5. Innovation in the configuration of residential facilities

Independently of the conceptual and methodological models which are employed and which have been previously analysed, the architectural configuration of these facilities may condition the possibilities for patients making progress in their treatments. In this regard, small facilities provide for a greater ability to individualize and for professional supervisory, whilst the large facilities provide for a greater efficiency of the resources.

Therefore, architectural models should be explored which will make it possible to make the advantages of one configuration and the other compatible with one another and to make them flexible. One reference in this regard may be the buildings such as the Carmen Sacristán Centre managed by the RAIS Foundation with the support of the Municipal Government of Madrid's Addiction Institute, in which a large-sized building is divided into spaces facilitating individualization and cosiness of the facilities like homes, whilst crossing a quasi-concealed floor level guaranteeing homogeneous professional presence in each one of these "homes". Thus, the management-related advantages of a large centre are combined with the possibilities of efficiency in the provision of professional services which would not be possible in small-sized centres.

4.4.6. Advancements in scientific knowledge

The high cost of the residential treatment facilities, especially within a context of economic strife, requires the recognition of its usefulness based on scientific evidence and the discrimination of the variables (personal, social, health-related, use-related, moments in life and in the treatment circuit, etc.) making it advisable over outpatient alternatives. In this same regard, it would be important to make a greater evaluation of the efficacy and efficiency of these facilities within a medium and long-range framework.

A greater deal of agility and flexibility would likewise be necessary on the part of the residential facilities in adapting to the changing needs and to the demands which are determined by scientific evidence.

Although the advancements made over the past few years reveal a scenario differing greatly from that of twenty years ago, it is still important that science be what rules over the models of the residential facilities above and beyond any ideology or beliefs of the different managing entities.

Within the scope of scientific evidence, some major advances have been being made over the past few years in biomedical and neurobiological research which are not always implemented in the clinical and therapeutic approach and which may have not exclusively pharmacological implications.

4.4.7. Promoting social-employment reinsertion

It is common knowledge that there are large number of patients who have long past histories of use who have evolved positively in their use and health-related situation, but who have not done so in the social sphere. Although the therapeutic communities may possibly not be the ideal facilities for making headway in this regard, the social reinsertion housing would indeed be ideal and must delve deeper into the social reinsertion methodology and distinguish themselves more from the treatment support dwellings. Within the current economic crisis context, a review must be made as to what the best degree of intensiveness may be concerning the efforts which are devoted in the residential area to the employment insertion programs. Although having a job can be decisive in maintaining abstinence after leaving the residential facilities, devoting efforts to employment insertion in the treatment objectives in the current economic situation requires major efforts which, in most cases, would surpass the final outcomes achieved. A review should therefore be made of the range of employment insertion objectives which are feasible and suitable in each situation.

4.4.8. Setting out the portfolio of services

A common portfolio of services within the national health system may foreseeably be configured in the near future due, in part, to implications of the current economic crisis and in part due to the on-going debate concerning the differences in the services provided to people in Spain– especially however not only health services –in one Autonomous Community and another.

This possibility may be an opportunity for this portfolio of services to specify the type of addiction care facilities which must exist in the different autonomic networks. This portfolio of services being set out could have some major implications for the residential facilities. The reference facility, the therapeutic community, being included in the portfolio of services would serve for its consolidation and homologation in the services themselves which should be provided thereby as a facility.

4.4.9. Better coordination

Some of the experts consulted point out the need for better coordination between the residential facilities and the reference outpatient centres. In the case of the therapeutic communities, some of the top-priority aspect would include improvements in the continuity of the treatment process from prior to admission to after release, as well as the information which is conveyed throughout the entire process. In the case of living accommodations, the improvement must be focused on the professional interventions which are carried out in both types of facilities being complementary to one another.

4.4.10. Improvements in management

The implementation of unified management and information systems which has taken place in some of the autonomic networks has meant some significant advancement in improving planning, especially with regard to the timing and in the dimensioning of different resources in

the patients' treatment circuit. Similarly, these systems also implement quite some major improvements in the possibility of exploiting the information which can mean, in turn, improvements in research and evaluation.

Yet another further advancement would be that of instituting a unified care-providing activity information system making it possible to guarantee equity and an aggregate state-wide view, on the design of which work is currently being done.

BACK TO TOP

FRANCE

1. Residential treatment programmes for drug users

1.1. History and framework of public policies

1.1.1. History of residential treatment programmes

Since the 19th century, the attraction of residential treatment programmes for people addicted to psychoactive substances has been growing. There are several reasons for this: firstly, drug addicts need a protective environment during withdrawal and not all addicts have one; secondly, for the immediate post-withdrawal period, physicians recommend, where possible, that addicts rest in a pleasant environment that is sufficiently removed in time and space from the environment in which they previously consumed substances.
It is appropriate to state in later years, programmes specifically designed to treat either alcohol or drug addiction developed separately. The first of these programmes arose within the healthcare setting (sick alcoholics are in hospitals). Given the communal, countercultural spirit of the 1970s, subsequent programmes were characterized - until the 1980s - by their suspicion of the medical domain.

Drug addictions

The increase in numbers of residential drug treatment programmes appeared following the increasingly widespread use of illegal drugs amongst young people towards the end of the 1960s. The 31 December 1970 law was intended as a response to this upward trend in drug use. Various establishments became available to "drug addicts" in this period. For the most part, these “rehabilitation” programmes gradually became links in an increasingly large and varied therapeutic chain, in response to the growing nature and diversity of problems, including solutions such as therapeutic apartments and foster families. At that time, numerous establishments opened. As was appropriate at the time, these sites were often located in the countryside and founded upon an ideal of “getting back to healthy living” and encouraging the restoration of satisfactory human relationships. The goal was abstinence from illegal drug use, but these structures also occasionally helped with professional placement within a society that was close to full employment. The opening of such establishments was made even easier since budgets at the time were approved on a departmental level, and the government reimbursed 80% of these departmental budgets. The residential treatment structures were run by associations since the authorities considered associations to be more responsive than governmental services. In the absence of evidence on the effectiveness of treatments, it was decided to heavily fund experimentations, which disappeared for the most part due to an inability to maintain long-term relationships with their public or due to ideological or financial deviations.
After the euphoria of creating such programmes wore off, the 1980s can be characterized by the professionalization and organization of this sector. For example, there was the creation of the *Association nationale des intervenants en toxicomane* (ANIT, or the French national association of drug addiction professionals), the implementation of annual conferences throughout France and the first “*journées de Reims*” seminars with a strong psychoanalytical

focus. This is also the period during which AIDS appeared in the United States (1981) and shortly thereafter in France. This disease heavily affected injecting heroin users, who became the majority "clientele" of treatment programmes. As a result, the authorities began to question the system that was in place.
In 1987, a report by the *Conseil économique et social* (Economic and Social Council) described residential institutions (Sullerot 1989). Out of 30 aftercare establishments, 16 focused on “relational techniques” and 14 on “occupational techniques”, and three offered “semi-autonomous lifestyles” (therapeutic apartments). In addition to aftercare establishments, there were four major and 19 smaller foster-family networks in relation with treatment centres.
This report deplored the lack of sufficient numbers of residential programmes and also emphasised certain weaknesses by criticising the undermedicalisation of the centres, the underutilisation of certain measures, the inappropriateness of client personal development programmes and client selection, the distancing of families and the lack of communication between the residential centres and their local environment. Above all, the report challenged what formerly had been presented as a strong point of the French system, namely the diversity of available treatment methods. According to the report, such diversity is not effective for patients looking for treatment in centres: patients are referred based on affinities with caregiver ideologies, or in more simple terms, based on availability, which explains the short stays in such centres. “Variety is hardly a virtue if it does not provide choice” (Sullerot 1989).
In 1992, a decree[58] was issued on the missions of outpatient and residential treatment centres. To become a certified CSST (*Centre de soins specialisé aux toxicomanes*, or Specialised Care Centre for Drug Users), an establishment must be able to provide “at least 1) medical and psychological treatment for drug addicts, 2) drug addiction social support and education, which includes social integration and rehabilitation services.” If an establishment only fulfils one of these two missions, it must add the following services: “admitting, orienting and informing drug addicts and their families, and supporting them during withdrawal (…), providing family support”. This is accompanied by certain obligations: therapeutic, social and education treatment plans, like those that exist in the healthcare and medico-social sectors, along with activity reports. The plans must cover a period of no more than five years and prefects must be able to review these plans to assess the progress of the actions.
AIDS not only revealed the problem issues of access to treatment, equality of access to treatments and risk reduction but also France’s underequipped situation in terms of responding to drug use. However, it also called into question the very nature of the responses provided to these issues, and especially professional practices based solely on abstinence.
This led to a 1993 decree that aimed to double residential capacity specifically by developing "therapeutic apartment” programmes and by creating the first therapeutic communities. However, the decree also emphasised developing outpatient structures throughout France and the importance of city hospital networks.
Simultaneously, the authorities, motivated by numerous stakeholders, including those involved in the fight against AIDS, worked to redefine public policy by using several reports: the 1989 Trautmann report (Trautmann 1990), the Henrion report (Henrion 1995), the Parquet-Reynaud report (Parquet 1997) and the Roques report (Roques 1998). These reports provided the foundation for addiction treatment on the one hand and supported the development of a harm reduction policy and the use of opioid substitution treatments, on the other hand.
The territorial coverage of outpatient centres authorised to prescribe methadone, then in 1995 the launch of Subutex®, resulted in repositioning the role of residential treatment centres. These measures, which were crucial to drug addiction treatment, became an option along the treatment path. Moreover, such centres were forced to become medicalised, to accept users

[58] Décret n°92-590 du 29 juin 1992 relatif aux centres spécialisés de soins aux toxicomanes (NOR SANP9201106D).

receiving substitution therapies, and to work in networks, an aspect reiterated in a memorandum from the *Direction générale de la santé* (National Health Directorate) in 1998[59]. These changes led to the closure of several establishments, especially those functioning collectively, since such structures could not become medicalised and received little support from the authorities, who were busy establishing access to substitution therapies and harm reduction measures. Moreover, some people believed that substitution therapies would render these specialised programmes useless. Nevertheless, professionals regularly question the authorities about the need not only to maintain, but also to develop, the capacity for residential treatment programmes. It was quickly observed however, that although substitution therapies considerably improved the situation for drug users, medication alone does not resolve the complex and intricate medical, psychological and social problems inherent in many addictions. At the same time, drug use or practices had changed, and the use of cocaine (crack included) had risen. The polydrug use, including alcohol, had become the norm. For these more complex addiction forms, the services available in outpatient centres or in primary care settings seemed insufficient.

In order to improve the stability of these programmes, for which funding was instable, they were integrated into the medico-social sector in 2002[60]. This sector is not funded by the government, but rather, by the French national health insurance system. These centres then became known as CSAPAs and their missions were clarified in 2008[61].

It was not until 2006[62] that public policy relaunched the creation of residential treatment centres through the establishment of therapeutic communities. Changes in drug use habits, the need to offer longer stays (up to two years) for very socially isolated users coupled with the desire to rebalance therapeutic options, resulted in the drawing up of specifications or working guidelines for therapeutic communities. In particular, support for abstinence and socio-professional rehabilitation was proposed. Seven therapeutic communities with 35 beds opened their doors between 2006 and 2011, bringing the total number of community establishments to 10.

During this time, the 'housing group' of the addiction commission[63] of the French Ministry of Health examined housing needs and pointed out the difficulties encountered by certain populations in gaining access to therapeutic housing: women with or without children, convicts released from prison, young drug users, elderly drug users, people suffering from psychiatric comorbidities, people suffering from cognitive disorders related to neurological deterioration and "active" users, who were typically refused by the majority of medico-social and social programmes.

To take these unmet needs into consideration, the authorities launched calls for projects for certain of these groups, particularly women and convicts released from prison. Furthermore, residential programmes for active users began on an experimental basis.

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[59] Note de service DGS/SP3 n°98-659 du 5 novembre 1998 relative à la révision des projets thérapeutiques des centres spécialisés de soins aux toxicomanes (NOR MESP9830471N).

[60] Loi n°2002-2 du 2 janvier 2002 rénovant l'action sociale et médico-sociale (NOR MESX0000158L).

[61] Circulaire DGS/MC2 n°2008-79 du 28 février 2008 relative à la mise en place des centres de soins, d'accompagnement et de prévention en addictologie et à la mise en place des schémas régionaux médico-sociaux d'addictologie (NOR SJSP0830130C).

[62] Circulaire DGS/MILDT/SD6B n°2006-462 du 24 octobre 2006 relative à la mise en place des communautés thérapeutiques (NOR SANP0630464C).

[63] http://www.sante.gouv.fr/commission-addictions.html

Alcohol rehabilitation

"Modern" residential alcoholism treatment programmes developed shortly after the end of the Second World War: The first French alcoholism rehabilitation centre was founded in Alsace in 1932 at Château Walk. It was based on the therapeutic farm model. Inspired by this model, the 1950s saw the launch of several establishments. Some of these sites operated from within the healthcare sector and others from within associations in the social sector (rehabilitation homes), and opened gradually as projects and opportunities arose.

These two programme types, i.e., health and social, developed for alcoholics primarily during the 1960s and 1970s. Their treatment approaches were very similar, despite their different funding methods, since public policy was not well established in the area at that time.

The hospital reform act[64], and then the SSR (*soins de suite et de réadaption*, or rehabilitation) decree of 17 April 2008[65] modified these establishments, which were formerly medium-stay hospitals, transforming them into *Soins de suite et de réadaption en addictologie* (SSRAs, or addiction follow-up and rehabilitation centres).

This journey back in time highlights the current issues: SSRAs are still tethered to the healthcare system, residential CSAPAs remain embedded within the medico-social sector and addiction CHRS centres (*Centres d'hébergement et de réinsertion sociale*, or social housing centres) appear to be the passing fancies of history.

1.1.2. Residential treatment strategies and regulatory frameworks

Since initial legislation, public policies have remained focused on residential treatment measures for drug users. However, the missions of such measures have evolved over time to take into account changes in needs and the development of knowledge on the one hand and developments in available treatments and the subsequent diversity of residential treatment modalities, on the other hand.

Hence, the 1992 decree stipulated that outpatient and residential centres were required to offer at least: 1) medical and psychological treatment for drug addicts, and 2) drug addiction social support and education, which comprises social integration and rehabilitation services. This created a significant challenge for project sponsors.

The 14 May 2007 decree[66] regarding the missions of CSAPAs required these centres to be more specific regarding their missions:

1) "Admit, inform, provide the medical, psychological and social assessment of the person and guide the person and the person's family or circle

2) Reduce the risks associated with the use of psychoactive substances

3) Provide medical, psychological, social and educational elements in the patient's treatment programme. The mission includes diagnosing, providing healthcare services, ensuring access to entitlements and offering assistance in social integration or rehabilitation. The centres provide withdrawal facilities and support. They also prescribe and monitor medical treatments, including opioid substitution treatments."

The decree also stipulates that the team must be multidisciplinary and placed under the supervision of a director. A physician must be responsible for the medical activities performed.

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[64] Loi n°91-748 du 31 juillet 1991 portant réforme hospitalière (NOR SPSX9000155L).

[65] Décret n°2008-377 du 17 avril 2008 relatif aux conditions d'implantation applicables à l'activité de soins de suite et de réadaptation (NOR SJSH0803309D).

[66] Décret n°2007-877 du 14 mai 2007 relatif aux missions des centres de soins, d'accompagnement et de prévention en addictologie (NOR SANP0721630D).

Therapeutic communities, whose missions are stipulated in the 24 October 2006 circular regarding the implementation of therapeutic communities more oriented to abstinence, are exempt from the need to obtain prescriptions for the substitution therapies they provide. Appendix 5 of the circular of 28 February 2008 regarding the implementation of the CSAPAs and the implementation of regional medico-social addiction programmes defines the various authorised residential programmes which are grouped according to duration of stay:

- Short-stay (under 3 months), pertains mainly to emergency and transition structures

- Medium- and long-term stays, pertain to therapeutic apartments (stays of no longer than 12 months, stays can be renewed once), residential therapeutic centres (stays of no longer than 12 months), foster families ("from several days to several months") and therapeutic communities (12 to 24 months at most).

The recommended staff-to-patient ratios are only indicated for therapeutic communities. They must not exceed 0.5 to 1.

1.2. Availability and characteristics

1.2.1. Establishment types and characteristics

As CSAPAs, the following establishments are forced to undertake certain missions set forth by the 28 February 2008 circular. These missions include:

- Admitting: this mission entails opening the doors to any person who comes to or contacts the CSAPA, whether that person is the care seeker or a member of the care seeker's family circle. It involves listening, establishing initial contact to create the foundations for a relationship and providing initial responses to the demands and needs of people. Simply making an appointment does not constitute "admission".

- Informing: written or oral, information must be supported by leaflets or brochures and explained, whether this information concerns the user's rights or the treatment modalities.

- Providing medical, psychological and social assessments: this mission comprises assessing the needs of the patient and the patient's family circle. For patients, this involves determining their level of use, their social situation and any related difficulties in order to offer patients the treatment that is most appropriate for their needs. For the family circle, this means mainly assessing the psychological and social effects of the addictive practices of the person on the family circle, as well as the family circle's needs in terms of support and assistance.

The circular also outlines the content of certain, mandatory missions:

- Medical treatment, which comprises:
    - assessing the medico-psychological dimension of addiction
    - looking for somatic and psychiatric comorbidities
    - proposing different treatment protocols, including treatment for the withdrawal states inherent to addiction and for comorbidities
    - proposing therapeutic withdrawal, and if not directly provided by the centre, the CSAPA must accompany the patients.
    - considering the patient's health in a broader sense and not just from an absence of illness point of view
    - as part of their medical treatment offer, CSAPAs must provide prescriptions for all opioid substitution treatments (OST) and issue initial methadone prescriptions, as well as all other medications necessary for treatment.
- Psychological treatment: this is based on assessing the psychological dimension of use and addiction, and complements the medical assessment. It comprises psychological monitoring and support appropriate to the situation and the user's needs. It must provide for the possibility of referring users to psychiatric services in the event that psychiatric comorbidities are revealed.
- Social and educational management: it consists of socio-educational support to help the patient gain or regain independence so that therapeutic treatment can ensue. More precisely, it encompasses support to recover social entitlements and actions or referrals aimed at social rehabilitation.
- Harm reduction: its purpose is not only to limit the health and social risks related to psychoactive substance use, but also to contribute to the treatment process and to the maintenance and restoration of social ties. Any person treated by a CSAPA should be able to benefit from group information sessions and/or customised health education counselling (e.g., in hygiene, infection and overdose prevention). They are accompanied throughout their treatment and aided in the design and implementation of a customised harm reduction strategy.

These different missions are distributed among the establishments that shall be described below, in more or less detail, depending on the establishment's nature and project.

Transition and emergency housing structures:

Sleep-ins

Individual or collective (134 beds funded in 2001, source DGS – the National Health Directorate)
This "Sleep-in" programme offers housing at night for users awaiting treatment or requiring temporary shelter. They mainly target people with significant social difficulties, one of their aims being to help users rebuild social ties. The nighttime accommodation is followed up by consultations during the day with a social worker, a physician, a nurse, a legal counsellor and a host in order to advise, monitor, refer and support people in terms of medical, paramedical, social and legal needs.

Quick treatment and short stay centres

There are four of these centres, which accept drug or alcohol users and multi-relapsers as soon as they are released from custody. The recent opening of these establishments, which resulted from the transformation of CSAPAs with an existing residential capacity, illustrates the willingness of the authorities to orient a portion of the residential programmes towards the most excluded populations. Stays, which are limited to three months, offer intensive treatment to support ex-convicts in devising a care or rehabilitation plan. These centres focus on rehabilitating former detainees to help them reintegrate into a non-prison environment, to prevent relapse and to involve them with treatment and rehabilitation networks.

Individual housing:

Therapeutic/follow-up apartments:

This is a type of therapeutic housing in individual or shared apartments. Residents receive intense support from a multidisciplinary team. The therapeutic apartments available to users represent rehabilitative or maintenance support for a care plan based on outpatient assistance. They prepare residents for access to a social integration programme or, whenever possible, for direct access to a self-financed individual apartment.
Regular, mandatory meetings with team members are organized either at the reception centre or in the apartment. Some services accept couples and even people with children. For people with children, the parents must not have had parental custody removed. Participation in housing costs is often requested. This participation is comprised of a fraction of the income of the resident. If necessary, the implementation of the social assistance that helps fund this participation helps prepare the resident for paying real rental fees.
The maximal duration of stay has been extended to two years to take into consideration the difficulty residents have in gaining access to independent housing when leaving these programmes.
These programmes are accessible either directly or upon discharge from a group residential treatment programme. For people discharged from a group programme, therapeutic apartments enable people receiving treatment to try out living conditions that are closer to independent conditions while maintaining significant professional support. Users can enter directly into a therapeutic apartment if group housing is contraindicated (for people accompanied by children or couples, for example). This support, which implies regular visits to the apartment by professionals and appointments in the reception centre, targets social aspects to facilitate apartment upkeep, budget management, time management and craving management, and to prevent re-use so that it does not turn into a fully-fledged relapse. Medico-psychological support is systematically provided within the scope of this residential model.

According to the most recent data available, in 2008, 58 CSAPAs managed[67] therapeutic apartments that overall represented 488 beds.

Foster families:

These are families that agree to host, for several days, weeks or months, a person referred to them by a specialised centre (one must be referred). They offer a lifestyle punctuated by family life in a friendly environment that fosters contact.
All families are selected by the specialised centres and are reimbursed for the expenses generated by the extra person in the household. Foster family networks are often located away from cities (in big cities, people rarely have a spare room to host someone).
They are particularly beneficial for people who need structure (and who know how to respect it), but who do not want to live in a group or an environment that is too institutional. The person being hosted is still followed by the treatment centre and the family is supported by a social worker with whom the family can discuss any problems encountered.
The development of these networks is limited by the difficulties encountered in recruiting motivated families and, beyond expense reimbursement, by the issue of remunerating families. In 2008, six CSAPAs managed a foster-family network offering 47 beds.

Group housing

Centres thérapeutiques résidentiels (CTRs, or Residential treatment centres)

Residential treatment centres offer all the same services as CSAPAs, but within a group or fragmented residential framework. They aim to promote a dynamic of change in users, and to support this change through a therapeutic programme that may vary from one establishment to another. They are suggested when outpatient or individual programmes appear to be insufficient due to a deteriorated environment, somatic or psychiatric comorbidities or heavy social problems that prevent the person from fully benefitting from treatment, or when the person needs a secure, protective environment without needing hospitalisation.
Located in either an urban or a rural setting, residential treatment solutions provide a safe, drug-free environment. The activities offered aim to restore a rhythm to daily life and the ability to form satisfactory relationships for the person. They also promote the development of personal skills to prevent relapse. These establishments help implement life plans that include treatment.
These residential programmes offer a constant professional presence and generally provide psychological support (individual and/or group), psycho-educational support, medical support and rehabilitative social support. They must also be in contact with medical and psychiatric services and rehabilitative services as well as have access to housing to cater to the needs of patients.
Daily life entails therapeutic activities (individual and group meetings) and rehabilitative group activities. These activities may take place inside or outside of the establishment. After a while, it is often possible for patients to once again begin a professional activity while maintaining their housing and support. The family environment can be taken into consideration in order to prepare for a return to the family setting or enlist parenting support.
The duration of residential treatment, statutorily set at one year maximum, must take into consideration the time required for the patient to acquire sufficient autonomy in order to integrate into a more open treatment setting (such as therapeutic apartments and outpatient

[67] In France, therapeutic apartments are not independent units from a legal and budgetary point of view; they are generally supervised by an outpatient CSAPA and represent one of the services provided by the CSAPA.

treatment centres) or towards social and/or professional rehabilitation. Receiving therapy in a residential treatment centre can be anonymous[68], if the user so desires, and is free of charge to the user (funded by French national health insurance).
Certain residential treatment centres cater to specific populations: two establishments in France are especially designed to treat minors, and some have sections for women with children. Only one establishment employs the Minnesota model, working cooperatively with Alcoholics Anonymous and Narcotics Anonymous networks.
In 2008, 35 residential therapeutic centres offered a total of 440 housing spots. Approximately 1,500 patients were housed in these centres in 2008.

Therapeutic communities:

Therapeutic communities are defined as long-term residential centres open to people who are addicted to opiates, stimulants, alcohol or multiple drugs. These communities provide a safe, drug-free environment of community living with drug addicts who are more advanced in their rehabilitation process. These peers can provide support by acting as positive role models and by using positive peer pressure to help addicts rebuild their lives. This approach aims to help residents develop their ability to manage their stress and distress without using drugs, to regain self-confidence and to gradually move forward towards independence and resocialisation by taking on greater responsibilities.
These programmes currently cater to patients who are too difficult to be able to reap the long-term benefits of outpatient or "short-stay" residential treatment programmes: these difficult patients may have experienced numerous failed treatment attempts and/or be suffering from psychiatric disturbances or significant social isolation.
French therapeutic communities take the environment into consideration and represent a treatment method that complements existing measures. Less rigid than their Anglo-Saxon counterparts, therapeutic communities offer support to those drug users wishing to achieve abstinence, when medically possible. Given the frequent psychiatric comorbidities, psychiatric treatments can be pursued.
Therapeutic communities function based on four main principles:

- Organization of time: the stay is organized into phases of varying duration depending on the progress a person makes in managing the tasks entrusted to them, their relationship with peers and the supervising personnel and their ability to manage any “cravings”. Days are also structured into different therapeutic and/or organizational activities.

- The group: it is hypothesised that the group can resolve problems that arise while working and living together. The group is called upon to use mutual aid to provide support for each member. Most of the therapeutic activities are based on group situations (group therapy sessions of varying types).

- The emotional approach: this approach helps group members to express emotions they feel “here and now”, thereby facilitating emotional control and conflict resolution.

- Assuming responsibility: as users progress along their treatment path, they take on more responsibilities, whether this means helping users who are less advanced in their treatment or taking part in community decision-making.

[68] This anonymity is possible as the result of the criminalization of use.

Communities can also make use of workshops (such as occupational therapy) or rehabilitation services (government "*chantiers d'insertion*", or government certified occupational rehabilitation programmes that provide remuneration for participants). Therapeutic communities have both a cognitive-behavioural and a psychodynamic approach. They can work to develop specific programmes (e.g., relapse prevention, femininity) that are appropriate to their population. They undergo a special assessment process. There is a new therapeutic community being opened, and it is specifically intended for women with children.
In 2008, there were six therapeutic communities, which together had a 200-bed capacity. Since 2008, four new therapeutic communities have been launched. The total housing capacity of these therapeutic communities in 2012 is 350 beds.

Duration of stay and reasons for patients leaving residential treatment centres and therapeutic communities

In 2008, the patients living in residential therapeutic centres or therapeutic communities were mainly managed by specialised educators or activity leaders (56% of procedures) and by nursing personnel (33% of procedures). General practitioners, psychiatrics and psychologists carried out 22% of the procedures.
The average duration of stay in these centres in 2008 was approximately 100 days. For a little more than half of those patients who completed a stay in 2008, the duration was one to three months long, and for slightly over one quarter, the stay was three to six months long. Nearly one out of every five patients stayed for over six months. Approximately one out of every four patients completed their stay on the date that had been scheduled with the treatment personnel. Nearly one out of every 10 patients was referred to a structure considered more appropriate to their situation. Approximately two out of every 10 patients were expelled by the treatment centre and nearly three out of every 10 patients left the centre early of their own accord.
These data mainly depict the situation in residential therapeutic centres since there are many more such centres than there are therapeutic communities. Therefore, the figures do not illustrate the specificities of the latter type of residential programme, especially since such structures were only recently created and still under development at the moment the data was gathered.

CHRS Addiction centres (Centres d'hébergement et de réinsertion sociale)

As was previously mentioned, CHRS centres arose during an era when the authorities had just begun to consider treatment for people suffering from addictions. These CHRS centres (social housing centres) mainly receive people having trouble with alcohol, and most such centres aim to become SSRs (*Soins de suite et de réadaption*, or follow-up and rehabilitation centres) or CSAPAs. With a view to implementing addiction treatment for alcohol and illegal drugs, some of these centres are gradually opening up to illegal drug users.
The missions of the addiction-oriented *Centres d'hébergement et de réinsertion sociale* (CHRS) are:

- to admit any person presenting with an addiction to single or multiple substances and seeking to abstain from use
- to admit mothers with children and pregnant women within the scope of preventing foetal alcohol syndrome

- to provide these people with support for quality social integration with consideration for the somatic, psychological and social aspects

- to continue providing such support within the framework of follow-up care.

There are 11 CHRS centres originally geared towards alcoholics, representing some 448 beds (source: FNESAA-COPAAH). The way they function is very similar to CSAPAs with housing. Some CHRS centres plan to eventually become CSAPAs with housing, residential treatment centres or therapeutic apartments.

Health

Follow-up rehabilitation treatment programmes

Originally alcohol treatment centres, these centres are gradually opening up to other addictions. *Services de soins de suite et de réadaptation en addictologie* (SSRAs or Addiction follow-up care and rehabilitation) aim to prevent or limit the functional, physical, cognitive, psychological and social effects of people with addictions to psychoactive substances and to promote their rehabilitation.
The treatment targets achieving abstinence, preventing relapses and avoiding the risks related to substance use. In addition to providing medical care, such programmes ensure individual and group psychotherapy and a socio-educational programme intended to promote social rehabilitation.
Based on the complications and deficiencies caused by addictions, these measures can specifically target managing somatic complications, psychological or psychiatric disturbances and neurological or cognitive deficits as well as promoting social rehabilitation.
SSRAs are just one of the components of hospital-based addiction structures. They host patients who severely abuse and who are often dependent after withdrawal, or patients who have undergone complex residential treatment.
The areas of expertise of SSRAs include addiction to psychoactive substances, which may or may not be associated with other behavioural addictions.
There are currently 70 addiction follow-up and rehabilitation services, with a total capacity of 2,305 beds. Until 2010, these services almost exclusively treated patients with alcohol problems.

1.2.2. Methods of intervention

Operating in a network

Establishments are encouraged to enter into agreements with partners who are crucial to their activities. Subsequently, there are agreements with outpatient CSAPAs to ensure subsequent treatment, with hospital addiction services to provide the support needed for simple and complex withdrawal, with medical and psychiatric services to provide better management for people with dual diagnoses, with child welfare services when residents are minors, with CAARUDS to provide support for any relapses and harm reduction or to take part in a CSAPA harm reduction mission, or with prison administrative staff for residential programmes open to convicts.
In all cases, stays in residential establishments are designed to be a step in the treatment process, allowing patients to become aware of the totality of treatment options available to them.

Since the causes of addictions are multifactorial, the related treatments usually involve several approaches: pharmacotherapies, psychotherapies, physical therapies and rehabilitative assistance. It is the combination of these approaches, which are all of interest, as well as the concurrent observations by different professionals, that seems relevant.

1.3. Quality management

All CSAPAs and therapeutic communities are medico-social establishments and are therefore regulated by French law no. 2002-2, which stipulates the assessment modalities for establishments and imposes a certain number of standards and tools, especially with respect to user representation.
In particular, each establishment must:

- have a brochure that presents the establishment
- have policies and procedures
- establish a residential contract or individual treatment document with each user
- inform users of their rights and their possibilities for recourse
- display the charter for residents in the establishment
- organize a "Council for social life". This acts as a body through which users of the establishment can express themselves; the Council should also have members from outside of the establishment.

Furthermore, each establishment must have an establishment plan validated by the inspection authority and be part of a quality improvement process, which implies the establishment of regular internal and external assessments. Such assessments must occur before the renewal of the authorisation to operate.

1.3.1. Availability of the framework and standards

The *Agence nationale de l'évaluation et de la qualité des établissements et services médico-sociaux* (ANESM, National agency for the assessment and quality of social and medico-social establishments and services) produces frameworks[69] with which establishments must comply as well as good practice guidelines.
Some guidelines apply to all of the medico-social establishments, such as "*bientraitance*" (Welfare: definition and references for implementation)[70], or those related to the internal and external assessment of establishments[71]. Others are more specific, such as "*la participation des*

[69] The complete list of ANESM frameworks is available on the Internet: http://www.anesm.sante.gouv.fr/spip.php?page=rubrique&id_rubrique=10

[70] Agence nationale de l'évaluation et de la qualité des établissements et services médico-sociaux. La bientraitance : définition et repères pour la mise en œuvre (Welfare: definition and targets for action), Saint Denis, ANESM, 2008, 47 p.: http://www.anesm.sante.gouv.fr/spip.php?page=article&id_article=128

[71] *Fédération nationale des associations d'accueil et de réinsertion sociale*. *Évaluations internes et externes* (French federation of treatment and social rehabilitation, Internal and External Assessments).

usagers dans les établissements médico-sociaux relevant de l'addictologie" (The participation of users in addiction-based medico-social establishments) (ANESM 2010).
La Fédération addiction, an NGO that groups the majority of addiction medico-social establishments, prepares good practice guidelines for CSAPAs with housing using the support of the authorities and an approach that incorporates the participation of all relevant establishments[72].

National and local frameworks

La Fédération addiction has also developed a framework for its members[73], to support them in performing self-assessments. It helps analyse the different operational areas in establishments:

- Appropriateness of the response to the needs of the population
- Partnerships and the place in the environment
- Compliance with the rights and duties of the users and their participation
- Management of human resources
- Administrative and financial management
- First contact
- Information
- Medical, psychological and social assessment, orientation
- Support
- Harm reduction
- Housing and methods.

Other frameworks that integrate the ANESM's directives were created, sometimes by the establishments themselves and sometimes by groups of establishments.

Results, documentation and assessment

Each establishment is required to submit an activity annual report to the territorial delegation of its regional health agency. However, the diversity of the populations seen and the modes of operation for the establishments (do they accept users with severe psychiatric comorbidities?

Summary sheets written from experience with the FNARS network, Paris, FNARS, 2010, 95 p :http://www.fnars.org/index.php/ressources-documentaires-evaluation/125-ressources-documentaires/2371-un-outil-pour-le-reseau-fnars

[72] *Fédération addiction*. *Guide méthodologique* "*Mener l'évaluation interne* : *pas de panique*!" (Methodology guide, "Conducting internal assessments: don't panic!"), 2008: http://www.federationaddiction.fr/guide-methodologique-mener-levaluation-interne-pas-de-panique/

[73] *Fédération addiction*. *Un référentiel d'évaluation interne pour les CSAPA et CAARUD* (A framework for CSAPAs and CAARUDs on internal assessment), 2012: http://www.federationaddiction.fr/un-referentiel-dauto-evaluation-pour-les-csapa-et-caarud/

unstable users? etc.) makes it difficult to globally assess their results, which do not take into consideration the baseline situation of users.
It is appropriate to point out that the most recent calls for projects (e.g., therapeutic communities, mother and child housing, persons just released from prison) incorporated the need to implement an assessment procedure into their specifications for these measures.

Relationships between funding and reporting

The report submitted each year to the territorial delegation of the regional health agency puts into perspective the use of the budget that was allocated and the activity of the establishment. Moreover, a national system for information collection has been in place since 2005. This system is called "RECAP" (*Recueil commun sur les addictions et les prises en charge*, or Common Data Collection on Addictions and Treatments), and it provides an analysis of the major trends in populations and use. This knowledge helps guide the activity of establishments and authorities whenever necessary.

1.4. Discussion and perspectives

1.4.1. Trends in demand for access to treatments in the last decade

The last decade was characterised by several striking events. We will mention three here that had an impact on the development of residential treatment measures.
The first is the advent of the treatment of addictions, which groups problems with alcohol, tobacco, illegal drugs and non-substance related addictions all under the same heading. The distinct histories of these areas have left traces that are fading very slowly: the sector of alcohol addiction treatment, which was primarily managed in the hospital sector, is gradually opening up to illegal drugs, but the needs for alcohol addiction treatment remain tremendous. CSAPAs with housing still mainly accept illegal drug users, but are also open to alcohol users since alcohol is often the last substance used after the use of other substances has stopped. Nevertheless, the residential treatment of illegal drug users occupies a less central place than before since the possibilities for outpatient treatment have largely developed, particularly since the launch of effective substitution treatments. Outpatient CSAPAs have medico-social technical platforms that provide long-term support for drug users. Many physicians in private practice are also involved, since they can treat many addictions through networks as long as the addictions do not present with significant complications.
The second significant event was the change in use habits, with the use of cocaine, and crack in particular, moving to centre stage. This led to a rethinking of treatment models, which up until then had essentially catered to heroin addicts. However, cocaine use also revealed "festive" use, particularly of psychostimulants, which sometimes got out of hand and required strong support. Users are also of different ages. There are still numerous young users, but there are also older users confronted with significant health problems for which professional rehabilitation no longer seems appropriate.
The third significant event to take into consideration is the economic crisis, which has made already-vulnerable populations even more susceptible: homeless young people and elderly people, ex-convicts, women, and especially women with children, sick people, particularly HIV- or HCV-infected people, and foreigners whose papers are not in order.
This difficult context has been evidenced through a major change in the place and operation of residential solutions: previously a solution of first resort, they are now part of a treatment course with a network of partners both upstream and downstream. They are becoming more technical,

proposing complex treatment programmes including pharmacotherapies, psychotherapies and sociotherapies, and address populations requiring more resources, since residential solutions cater to heavier cases. Since the 2006 launch of therapeutic communities, some of these populations, which are often those furthest from integration, have been helped. However, there are still significant, and sometimes unmet, needs, as was shown in two surveys (Coquelin *et al.* 2009; Palle Non publié) conducted within the scope of a "housing" working group of the addiction commission of the French Ministry of Health. The surveys revealed the need to develop diverse responses to meet the therapeutic housing needs of drug users.
At the confluence of the health and social sectors, medico-social residential establishments must nevertheless take current trends into consideration: the development of health responses, and follow-up and rehabilitation services in particular, on the one hand and the “radical reform” of the social sector on the other hand, with experiments that aim to achieve unconditional housing access (“Housing first”).
This leads to a continuation of the effort in several directions: on the one hand, it is necessary to work to improve the acceptance of people suffering from addictions through “common law” measures to open up the field of housing and integration. On the other hand, it is necessary to continue developing residential measures for "over-excluded" populations, i.e., those who cannot directly access health, social and medico-social programmes, by including them in large partnership networks. Finally, it will be necessary to continue efforts to identify profiles of users who could benefit from the different residential structures so that these users can be better oriented.

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ITALY

11. RESIDENTIAL TREATMENT FOR DRUG USERS IN EUROPE

EMCDDA Foreword

Residential treatment has historically been a substantial component in the range of treatment and rehabilitation options for drug users in many European countries. Although today, in an era of rationalism, residential facilitates are being closed, the interest is still alive as to what they can offer to the population of dependent users who seek treatment and recovery. Partly, the dwindling availability of residential services can be seen as a result of recent efforts across Europe to contain drug treatment spending, among other public pay. A fuller explanation can be gained for these changes by turning to the history of drug treatment and examining any prominent influences and preferences in relation to treatment philosophies, which in different countries would have shaped unique drug treatment provision landscapes.
Today there is a need to examine residential treatment facilities. Outpatient treatment and rehabilitation is not always a realistic option, particularly for a select group of drug dependent clients, who need the safety, care and structure that residential settings provide. The aim is therefore to provide a Europe-wide overview of residential treatment, including country specific features of its history and current role in the wider drug-treatment systems, as well as exploring the availability and diversity of residential treatment programmes.
As proposed by the EMCDDA, this chapter provides an overview of the Italian situation with regard to existing regulations in the sphere of rehabilitation and social reintegration of drug dependent clients, national strategies, the types of facilities and treatments available and, finally, treatment demand in terms of clients.

Sources and information flows

Concerning information sources, flows regarding social-rehabilitation facilities and their clients are collected by the Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources of the Ministry of the Interior, while classifications of social-rehabilitation facilities, in accordance with the criteria laid down in the State-Regions Accord Act, are gathered by means of the information flow from Regional Administrations. Some information about treatments provided to clients in the care of social-rehabilitation facilities is collected by the public drug addiction services which provide care within the facilities themselves.

11.1. History and policy frameworks

History of social-rehabilitation facilities in Italy

The term “therapeutic community” was first applied to social-rehabilitation facilities in 1946, when Thomas Forest Main thus described the groups and activities created by the English psychiatrists of the Northfield Group.
The term “therapeutic community” was officially recognized by the World Health Organization in 1953, upon completion of a study which proposed transforming psychiatric hospitals into therapeutic communities.

In the early 1960s, Italy began to acquire importance in terms of the drug-use phenomenon. Unlike in the United States, where drug use had spread among counterculture youth and through the marginalized strata of society, drug use in Italy developed as the preserve of small groups of élite.

The inception of drug use in Italy

The sale of drugs was initially the province of lone dealers but, as the phenomenon became more widespread among youth, in suburban areas and in factories, evolving into a profitable business, organized crime became involved, substituting hashish and marijuana with opiates, which pose much greater health risks.

In 1973, the first overdose death was recorded in Italy, caused by heroin, with cocaine making its appearance in the 1980s.

The first drug-related death

The majority of therapeutic communities came into being in the late '70s and during the course of the '80s. Most of these still exist, offering different approaches to the drug addiction problem and implementing different operational strategies.

Therapeutic communities came into being in the late '70s and throughout the '80s.

During the '80s and '90s, the use of cocaine and other drugs besides opiates began to rise, partly due to the fear kindled by the spread of the HIV virus through needle sharing on the part of heroin users. The early '90s saw the advent of ecstasy, mostly among young people frequenting discotheques and rave parties.

The birth and proliferation of therapeutic communities was one of the answers society provided to counter the ever-wider spread of this phenomenon in Italy. The therapeutic models proposed and the methodology upon which communities base the services they provide have always constituted an important resource, especially during that time when an effective, well-structured institutional response to the drug problem had not yet been organized. The diverse nature of the solutions put forward by professionals working in communities is, in part, the fruit of the different ideological points of reference adopted by the different individual facilities and by the social and cultural backgrounds of their varied types of clients.

Every operational strategy required, and still requires, a philosophy regarding the roots of drug addiction and a consequent therapeutic approach.

Operational strategies in therapeutic communities

There are essentially three operational strategies:

- basic strategy
- strategy based on work and on social reintegration
- specialized strategy focusing on psychotherapy

Today, a number of communities still interpret the phenomenon as having roots in psychological issues stemming from harmful experiences during the early stages of life and adolescence, while for others, drug addiction is the result of disappointment or inadequacy in personalities that are particularly sensitive to society's realities. Some communities present themselves as surrogate families which help individuals to become self-sufficient and take responsibility for their own lives, while others present themselves as alternative micro-societies.

Social-rehabilitation facilities sometimes employ treatment methodologies that involve a shared model for living and aim to construct drug-free personalities capable, once they have concluded their therapy programme, of transferring the ideals they have acquired and internalized to the outside world as well.

Some of these facilities place great importance on work activities, with the goal of encouraging drug-dependent individuals to grow, moving out of the adolescent stage in which drugs have blocked them, by acquiring skills and assuming

The work approach

personal responsibilities upon which they can draw once they has completed their therapy programmes.

Other facilities, with the help of psychoanalysis and individual and group psychotherapy techniques, focus on helping those undergoing treatment to become aware of the deeply-rooted conflicts which led to their unhealthy behaviours. The aim of this approach is to help individuals gain the ability to recognize and manage their own unconscious tensions.

The therapeutic approach

Over the course of over thirty years of existence, facilities for the rehabilitation of drug addicts have improved and broadened the range of treatment options they offer. A large number of communities train their own staff and many more have stipulated agreements with the Ministry of Justice to take in drug-dependent prison inmates who have to serve alternative sentences.

The last 30 years have seen a great increase in the range of types of treatment available

Some structures take in drug-dependent mothers with children, those suffering from AIDS, alcoholics, people who have developed other forms of psychiatric morbidity in addition to their drug addition or those suffering from other addictions such as dependency on tobacco or compulsive gambling.

Today, drug use and abuse are no longer limited to a certain type of drug or to marginalized individuals, but involve every social class and age group, and drugs are widely available in those social venues frequented mostly be young people who are well-adjusted in their school or work environments. It is for this reason that communities have diversified their treatment programmes, adapting them to individual needs and to the new types of drug users, many of whom are poly-users of drugs and alcohol.

Few, however, have a strong personal motivation to begin treatment, and only some of those who enter communities complete their programmes. Since treatment relies most strongly on an individual's willingness to succeed, the positive outcome of treatment is linked to the ability of the therapeutic community staff to motivate the drug addict during the reception phase.

The stage when the client leaves the community, a comparatively protected environment, to be reintegrated into society, is a delicate phase which requires a programme of mentoring by professionals, and some communities expect family members of the drug-dependent clients to be involved in these different phases of the rehabilitation programme.

The delicate phase of social reintegration

Changes in types of drugs being used and methods of use require all those who are involved in this field to rethink the role of private non-profit services within the complex landscape of therapeutic alternatives.

From a regulatory standpoint, social-rehabilitation facilities, like public drug addiction services, fall under the umbrella of the Consolidated Law of Presidential Decree (DPR) 309/90. Concerning the rehabilitation and reintegration of drug addicts, the law provides, under Part X, an entire section devoted to the competences of the responsible Regional, Provincial and Local Authorities' and Local Health Units regarding the care of drug addicts.

DPR 309/90

Specifically, Article 113, "Responsibilities of the Regions and Autonomous Provinces", assigns the responsibility for prevention, treatment and rehabilitation activities for drug addictions to the Regions and Autonomous Provinces. Concerning facilities, the same Article, under Paragraph b), states that public drug addiction services and private facilities that engage in prevention, treatment and rehabilitation activities in this field must possess the structural, technological,

Competences of responsible institutional entities in the field of addictions

organizational and functional requisites listed under Article 116. Meanwhile, regarding accessibility of services, Paragraph c) states that regulations governing institutional accreditation of services and facilities ensure, in accordance with the criteria set forth in Legislative Decree No. 502 of 30 December 1992, equal access to service facilities and to the services provided by both public services and accredited private facilities.

Functions of facilities authorized to offer social-rehabilitation services

The functions of services and authorized facilities are governed by Art. 113, Paragraph d) which, for facilities devoted to rehabilitation and reintegration, lays down the following responsibilities:

1) Analysing the clinical, social, health and psychological conditions of the drug dependent addict, also in relations with his family.

4) Drafting, implementing and monitoring a therapeutic and social-rehabilitation programme, in respect of each client's individual freedom to choose his treatment facility.

Ancillary Agencies comprising facilities authorized to provide social and healthcare assistance in support of Drug Addiction Services

In addition to the public services offered by Local Health Units, care for drug addicts may also be given by non-profit Ancillary Agencies which may perform their activities for the prevention of psychological and social deprivation, assistance, treatment, rehabilitation and reintegration of drug addicts, or associations, agencies created by them for the purpose of educating young people, encouraging the social and cultural development of their personality, vocational training and job counselling.

In addition to the functions performed by the services assigned to provide social and healthcare assistance to drug-dependent individuals, other responsibilities in terms of rehabilitation are also assigned to Local Authorities and are governed by Art. 114 of DPR 309/90.

Specifically, the text of the law states that, as part of the social welfare functions vested in municipalities and the mountain communities, using the services where possible of associations and ancillary agencies, also through their consortia, or through special centres managed by themselves or through their associations, without being managed for profit, recognized or eligible for recognition, they shall pursue the following objectives with regard to the prevention and rehabilitation of drug addicts:

a) preventing marginalization and social deviance by designing and implementing, directly or indirectly, programmed schemes;

b) collecting and analysing data, in conjunction with the school authorities, on the local causes of deprivation in the family and society, which encourage the deviance of young people and failure to attend school;

c) enabling drug addicts to attend school, find work and be reintegrated into society.

Preventative, curative and rehabilitation work under DPR 309/90

Concerning care, Part XI governs those articles of the law having to do with preventative, curative and rehabilitation work. Art. 120, Paragraph 1, states that anyone who personally uses narcotic and psychotropic substances may request the public drug dependence service or an authorized private structure, after having carried out the necessary inquiries and having spoken to the person concerned, to a therapeutic and social rehabilitation programme tailored for the person which may, where the psychological and physical conditions of the drug addict makes it possible, in conjunction with the centres and using the services of

the social solidarity cooperatives and authorized associations, include initiatives designed to bring about the full incorporation into society of the person concerned through counselling and vocational training, work of public utility or social solidarity. Under the treatment programmes which include such methods, drug treatment therapies and psychological and pharmacological treatment as appropriate may be arranged. The drug dependence service shall monitor the implementation of the programme on the part of the drug addict.

The 5 August 1999 State-Regions Accord

Following significant and diverse evolution of the responsibilities of the agencies and associations collaborating with public drug addiction services in every sector of the field, encouraging, on the one hand, dialogue between public and private sectors and reciprocal enhancement of their analyses and knowledge of issues and, on the other hand, allowing for shared training experiences and the realization of joint projects, the State-Regions Accord Act of 5 August 2999 defined the minimum standards required for private healthcare services to obtain authorization for operation and accreditation to assist drug-dependent individuals.
This regulatory act lays down requirements for subjects, facilities, operations, staff and staff training within agencies and associations which carry out preventative, curative and rehabilitation activities whose goal is the protection and restoration of the health of persons who use or are addicted to narcotic and/or psychoactive drugs. Furthermore, this act defines criteria for accreditation, service sectors, treatment programmes and their planning as well as access to services, in addition to other functions.

Areas of service as established under the State-Regional Accord Act of 5 August 1999

The services which must be provided by agencies or associations which aspire to accreditation are divided into the following areas of service, based upon the programme's overall structure:
1) reception services
2) therapeutic-rehabilitation services
3) specialized treatment services
4) pedagogical rehabilitation services
5) integrated multidisciplinary services

Reception services

Reception services are defined by the fact that they may provide the following services:
- non-selective patient reception, including those undergoing pharmacological treatments, of a length of no more than ninety days
- assessment of the overall state of health of the patient, including the diagnosis of any infectious diseases linked to drug addiction
- where possible, the design of a global treatment programme and identification of the type of facility most suited to provide it
- counselling and psychological support
- guidance and support sessions for patients' families
- general medical care for health problems requiring attention during the patients' stay in the facility and in support of pharmacological treatments where necessary

Therapeutic-rehabilitation services

Therapeutic-rehabilitation services are defined by the fact that they may provide the following services:
- reception of patients possessing pre-established characteristics who do not use substances of abuse
- reception of patients undergoing pharmacological replacement treatments as necessary

- multidisciplinary diagnostic monitoring (possibly conducted by public services personnel) according to Regional quality procedures
- implementation of a detailed and personalized treatment programme of no more than eighteen months, with related monitoring of the psychological and physiological conditions of the patient, and modification of said programme as necessary
- individual and/or group counselling and psychological support, to be provided in a continuous fashion and, where suitable, structured individual or group psychotherapy sessions scheduled according to each individual patient's needs
- management of each individual patient's general health problems as appropriate according to the type of issue and its seriousness, a service for which personnel must be available a minimum of three hours per week

Specialized treatment services

Specialized treatment services are defined by the fact that they may provide the following services:

- reception of patients with pre-defined characteristics, specific medical/psychotherapeutic treatment issues (e.g. psychiatric problems, women who are pregnant or postpartum, etc.)
- multidisciplinary diagnostic assessment (performed by public service personnel) in accordance with Regional quality procedures; management of issues (medical and non) which fall under specialist categories, including involving recourse to pharmacological treatments and the monitoring these entail
- all remaining therapeutic-rehabilitation services, where these are not contraindicated

Pedagogical rehabilitation services

Pedagogical rehabilitation services are defined by the fact that they may provide the following services:

- reception of patients with pre-defined characteristics who do not use substances of abuse and who are not undergoing replacement pharmacological treatments; multidisciplinary diagnostic assessment (performed by public service personnel when necessary) in accordance with Regional quality procedures
- implementation of a detailed and personalized treatment programme of no more than thirty months in length whose goal is to focus on restoring the patient's social integration abilities and improving his or her life in terms of relationships, employing a pedagogical-educational methodology, with related monitoring of the psychological and physiological conditions of the patient, and modification of said programme as necessary
- continuous individual and/or group psychological support where suitable
- medical assistance for health problems requiring attention during the period of observation, as necessary

Multidisciplinary services

Integrated multidisciplinary services are defined by the fact that these programmes, activities and services are at least potentially available in public facilities, and that they fulfil the requirements (both structural and productive) established for them. The accreditation for these types of services is for an entire package of services offered, and excludes their partial accreditation as parts of other service areas. It is the Regions which, when establishing criteria for accreditation of public service operative units, take decisions on the details of these types of programmes, including:

a) the types and numbers of working personnel, expressed as a staff-to-patient ratio

b) the structural requirements, based on the type of services being provided
c) criteria for accessing services and manner of access, partly to avoid different treatments being duplicated
d) minimum operating hours for the service and maximum wait-time on any waiting lists
e) the obligation to accept patients without subjecting them to any type of entry selection and to make available to them all services guaranteed under the law and Regional provisions
Regions regulate the manner by which, in special cases, patients can be transferred to other accredited services, in accordance with the rules as set forth in (the following) Art. 19.
According to the criteria for registering facilities in the Regional and Provincial rolls for Ancillary Agencies, Agencies which are mentioned in a special table and which manage facilities for the rehabilitation and social reintegration of drug addicts as set forth in the State, Regions and Autonomous Provinces Accord Act, the facilities are classified as follows:

Classification of Ancillary Agencies in residential, semi-residential and outpatient facilities

- Residential facilities (offering lodgings and residential activities)
- Semi-residential facilities (offering a place to stay and daily activities of no less than eight hours per day, at least five days a week, or, in other words, at least forty hours per week, which may be distributed differently.
- Non-residential/outpatient facilities (offering a place to stay and activities for a total of less than forty hours per week)

The National Action Plan 2010 - 2013

On a national level, in 2010, the Department for Anti-drug Policies of the Presidency of the Council of Ministers drafted the National Action Plan on Drugs 2010-2013, approved in the 29 October 2010 session of the Council of Ministers. The document establishes the simultaneous development of four different parts:

1. The National Action Plan (NAPD - actual strategic recommendations)
2. Individual Regional Programmes (RP) which are to be carried out in a completely independent fashion by the individual Regions and Autonomous Provinces
3. Methodological guidelines
4. National Projects in support of the Plan

The Action Plan as a whole is the sum of these four parts which, in order to be effective, must provide an explanation of general strategies by means of lists of goals and actions, of organizations assigned the responsibility of carrying these out and of using outcome indicators and which will, at the same time, have to monitor individual Regional plans and calculate, as best as possible, the resources allotted to them. In addition, guidelines are provided for the principal action areas as well as a series of national projects in support of the NAPD which will involve numerous operative units.

The new National Action Plan is logically subdivided into 5 principal action areas:

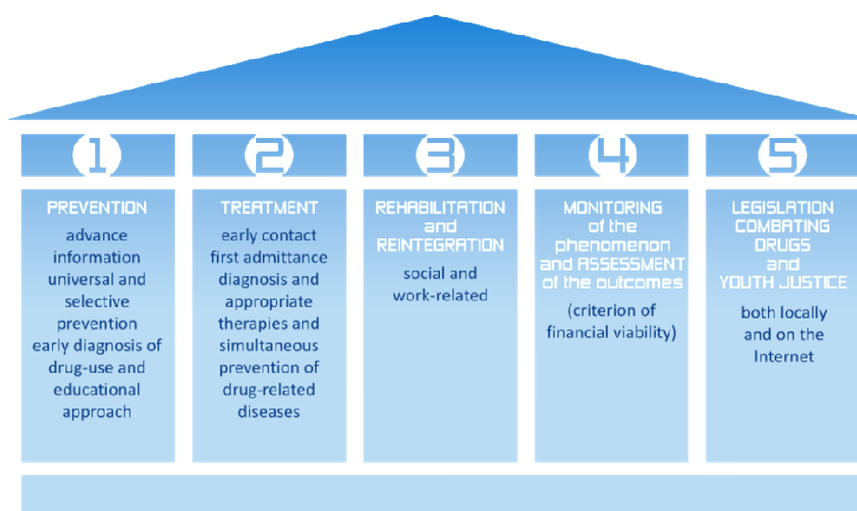
The 5 principal action areas of the National Action Plan on Drugs 2010-

1. **Prevention** - Information provided early, starting in elementary schools and with the support of families and schools; continuing universal prevention but with projects targeting, above all, individuals with behavioural problems (selective prevention). Launching projects for the early detection of drug use and alcohol abuse (It’s never too early); encouraging educational approaches to the problem.

2. **Treatment and diagnosis of drug addictions** – Encouraging early outreach projects for drug addicts not yet undergoing treatment. Increasing the number of individuals accessing therapeutic communities and the proper, rational use of replacement drugs in Public Drug Treatment Units. Continuing projects for the prevention of drug-related diseases (HIV, the hepatides, TBC).
3. **Rehabilitation and reintegration** – Focusing more strongly on increasing social and work integration programmes, encouraging forms of self-financing for those therapeutic communities which are capable of providing drug-dependent individuals with job training and placing them on real, concrete paths to reintegration in the work world.
4. **Monitoring and assessment** – Making information systems more timely and efficient in order to more rapidly become aware of variations in the phenomenon and thus be able to more quickly plan necessary responses. At the same time, introducing systems which make it possible to evaluate the real results obtained from the different types of treatments (outpatient or residential), and make the presence of such systems a necessary "funding criterion" for facilities.
5. **Legislation, the fight against drugs and juvenile justice** – Beginning a process of renewal of the primary regulations having to do with drug addiction, in order to render them more suitable for different needs in the field. Continuing to maintain pressure in the fight against drugs and organized crime, both within national borders and on the Internet.

2013

Figure 11.1: The five action areas of the National Action Plan on Drugs 2010-2013



Source: The Department for Anti-drug Policies

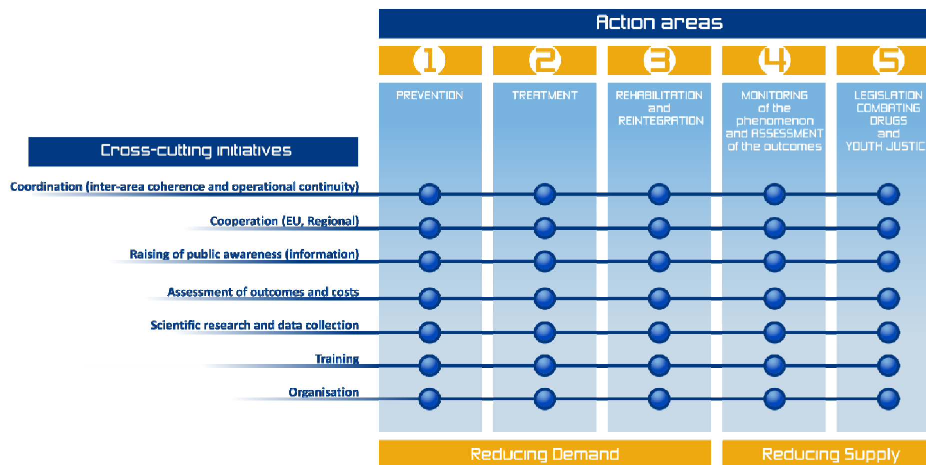
As set forth in European recommendations, a series of **transversal actions** are provided for each of the five action areas. These have to do with coordination, cooperation, raising public awareness, assessing results and costs, scientific research and data collection, training and organization. Each of the five action

Transversal actions within

areas is provided with a series of transversal actions having to do with coordination, cooperation, raising public awareness, assessing results and costs, scientific research and data collection, training and organization, according to the following scheme. These transversal actions represent the action recommendations which should be followed for each of the five action areas in order to improve the overall effectiveness of the plan.

the action areas

Figure 11.2: The transversal actions of the five action areas



Source: the Department for Anti-drug Policies

All the countries of Europe are in agreement regarding the fact that the drafting of a national action plan is born of the imperative need to be in possession of recommendations for the creation of anti-drug projects. The aim is to protect future generations from the tragedy of drug addiction and alcoholism spawned by the use of drugs and alcohol abuse, in full knowledge of the fact that in our country, as in every other State in Europe, such a plan is critical if we wish to take on the issues of the proliferation of drugs and of drug use and alcohol abuse in a coordinated and effective manner.

Our nation, like other European countries, will take on the responsibility of responding to the drug problem by means of an integrated approach involving reduction of drug supply and demand on the basis of the principles of shared responsibility and proportionality, in accord with the basic principles of dignity of those individuals who are affected by the drug problem worldwide, including drug addicts and in full respect of basic freedoms and of human rights. However, on this topic, it must be pointed out that Italian law and, more importantly, the ethical principles which underlie preventative, curative and rehabilitation work, do not recognize the “right to take drugs” as a human right because of the irrefutable harm it can cause to health, the negative consequences it can have on third parties who come into contact with individuals who use these substances and the serious losses it causes on a social level.

As mentioned above, among the five principal action areas of the National Action

Plan on Drugs (NAPD), one is specifically devoted to the rehabilitation and social and work reintegration of drug addicts. Rehabilitation and reintegration are the central features of the plan, underlining the belief that total recovery of drug-dependent individuals and their full reintegration into society is not only always possible but of fundamental importance. In order to do this, the NAPD proposes a number of concrete solutions involving the launch of special units devoted specifically to reintegration.

The NAPD goals relevant to this area, which are flanked within the document by specific actions and assessment indicators to monitor results attained, are as follows:

NAPD 2010-2013 goals for the rehabilitation and reintegration action area

1. Reduce criminal and illegal activities, besides prostitution, among drug addicts through the promotion of specific programs of reintegration into society and work.
2. Standardise at national level the principles and main methods of rehabilitation and reintegration.
3. Promote concrete actions and specific projects to increase rehabilitation activities n both the social and interpersonal sphere of drug addicts undergoing treatment with drug addiction services and in therapeutic communities
4. Improve the level of education and job skills of drug addicts in treatment
5. Promote the development, within the Addiction Departments, of operating units which specialise in reintegration activities
6. Supplement and coordinate reintegration work among the various local agencies (Public Drug Treatment Units, Therapeutic communities, local and provincial administrations, hospitals, business associations).
7. Involve companies and public administrations (Town Councils, Provinces, Local Health Authorities) directly in social and work reintegration for drug addicts, through the allocation of contracts to social cooperatives operating in this sector.
8. Encourage the reintegration of drug addicts into the work cycle of ordinary companies.
9. Direct organisations which deal with social and work reintegration to develop corporate social responsibility programs in order to promote the creation of organisations for reintegration which can produce income and thus self-finance their own activities.
10. Promote a specific national project for the rehabilitation and reintegration into society and work to support the process of national innovation in this sphere.

The RELI project

With reference to the final objective, the Department for Anti-drug Policies, in the context of the launch of the 2010-2011 DPA Projects Plan (funded with a budget of approximately 26 million Euros), allocated 34% of that budget solely to a project devoted to the social and work reintegration of drug addicts (the RELI Project).

Objectives of the RELI Project

This project, of key importance, aims to define, promote and proliferate an integrated social and work reintegration model for both public services and the private non-profit sector, based firstly on the support and creation of "productive units" capable of hosting drug-dependent individuals during their rehabilitation in order to ease their work reintegration. These productive units are intended to be strongly oriented toward social enterprise work, with workers receiving regular pay (with a managed and regulated credit line) and producing goods or services which can be placed on the market, creating income which could partially or totally cover operating costs.

The project thus intends to give rise to a process of cultural and organizational transformation in the attempt to create a "structural variation" in the systems of care which have existed until today, in order to free those organizations which are responsible for reintegration, as far as is possible, from welfare-type thought processes and create conditions of self-sufficiency for these types of activities and for the organizations which conduct them.

Methodologies employed in the creation of the RELI project

There is an intention of creating a nationwide coordination group for the various local entities which will manage to become involved in the project. This coordination group will have two components: firstly, the productive units, meaning organizations belonging to either public services or private non-profit which are equipped with units devoted to social and work reintegration; secondly, support and collaboration units, meaning those administrations and organizations capable both of creating conditions favourable for the allocation of contracts to the productive units and of identifying possible companies which have not fulfilled their hiring quotas for individuals with disabilities or which are in a situation to offer job positions.

The productive units would thus be easily and effectively supported by public companies offering non-complex maintenance contracts, as well as by private companies with local specialised labour requirements who could therefore provide direction for productive units' professional training programmes, thus creating conditions where their specific labour requirements were fulfilled and at the same time raising the probability work reintegration for the clients of those productive units.

11.2. Availability and characteristics of residential treatment

Social-rehabilitative facilities

Table 11.1: Social-rehabilitative facilities for drug addicts operating in Italy on 31/12/2011, by type of care provided

	Social-rehabilitative facilities											
	Residential			Semi-residential			Outpatient			Total		
	2010	2011	Δ %	2010	2011	Δ %	2010	2011	Δ %	2010	2011	Δ %
Abruzzo	14	14	0	4	3	25	8	7	-12.5	26	24	-7.7
Basilicata	7	5	-28.6	1	0	-100	5	5	0	13	10	-23.1
Calabria	25	23	-8	10	9	-10	3	3	0	38	35	-7.9
Campania	20	21	5	8	5	-37.5	12	11	-8.3	40	37	-7.5
Emilia Romagna	83	86	3.6	23	19	-17.4	15	16	6.7	121	121	0.0
Friuli Venezia Giulia	9	8	-11.1	5	6	20	6	6	0	20	20	0.0
Lazio	29	29	0	13	10	-23.1	9	7	-22.2	51	46	-9.8
Liguria	24	24	0	5	7	40	6	4	-33.3	35	35	0.0
Lombardy	134	134	0	20	19	-5	29	29	0	183	182	-0.5
Marche	32	31	-3.1	13	14	7.7	10	8	-20	55	53	-3.6
Molise	6	5	-16.7	0	0	0	2	2	0	8	7	-12.5
AP Bolzano	2	2	0	1	1	0	0	0	0	3	3	0.0
AP Trento	4	4	0	1	1	0	1	1	0	6	6	0.0
Piedmont	68	66	-2.9	3	4	33.3	8	6	-25	79	76	-3.8
Apulia	47	46	-2.1	17	19	11.8	19	20	5.3	83	85	2.4
Sardinia	23	22	-4.3	2	0	-100	8	8	0	33	30	-9.1
Sicily	26	26	0	7	7	0	8	8	0	41	41	0.0
Tuscany	55	53	-3.6	19	18	-5.3	8	8	0	82	79	-3.7
Umbria	27	27	0	4	4	0	1	1	0	32	32	0.0
Valle d'Aosta	1	2	100	0	1	-	0	0	0	1	3	200.0
Veneto	79	80	1.3	46	44	-4.3	18	18	0	143	142	-0.7
Total	**715**	**708**	**-1**	**202**	**191**	**-5.4**	**176**	**168**	**-4.5**	**1.093**	**1.067**	**-2.4**

Source: The Interior Ministry – Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources

1% decrease in the number of residential facilities, 5.4% decrease in semi-residential facilities and 4.5% decrease in outpatient facilities

On 31 December 2011, according to Ministry of Health and Interior Ministry Sources, there were a total of 1,067 social-rehabilitative facilities operating in Italy. The majority of these were residential facilities (66.4%), followed by semi-residential facilities (17.9%) and outpatient facilities (15.7%). In comparison with 2010, there has been a 2.4% decrease (26 facilities) in the number of social-rehabilitation facilities, a decrease which has affected a greater number of semi-residential facilities (5.4%) and outpatient facilities (4.5%).

1,067 social-rehabilitative facilities, of which 66.4% residential communities

An examination of the distribution of social-rehabilitative structures throughout the

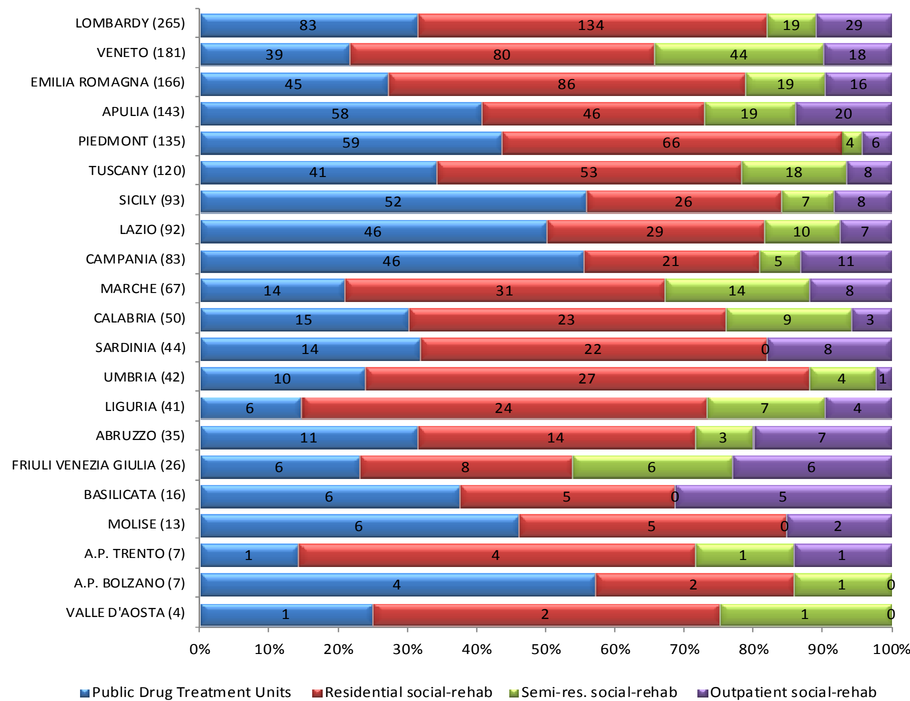
Higher

country reveals a higher concentration in the northern Regions. In 2011, as in 2010, 17% of these were located in Lombardy, 13% in Veneto and 11% in Emilia Romagna. When comparing 2011 data to 2010 data in view of possible reorganizations of services, we mainly find an increase in drug addiction services in Lombardy (+11) and in Campania (+3), while, concerning social-rehabilitative facilities, we can see a decrease in the number of residential facilities in Calabria, Basilicata, Piedmont and Tuscany (-2). Regarding other types of facilities, Emilia Romagna reports a decrease in semi-residential facilities (-4) and Lazio and Campania both report a reduction by 3 (Table 11.1).

concentration of facilities in the north

If we draw a distinction between public health facilities and those belonging to private non-profit, we find a higher percentage distribution of Public Drug Treatment Units in the Autonomous Province of Bolzano, in Sicily, in Campania and in Lazio (Figure 11.3).

Figure 11.3: Distribution of social and healthcare facilities for drug addicts, by type and by Region - the Year 2011



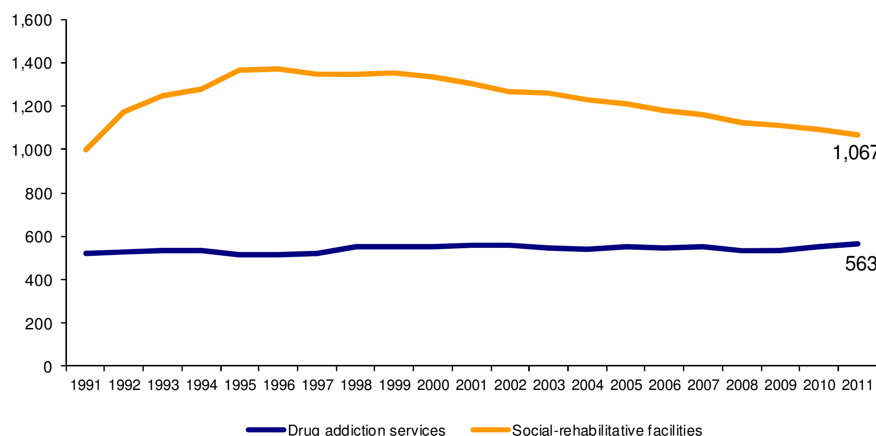
Source: Based on data from (1) The Ministry of Health; (2) The Interior Ministry – Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources

Trends in numbers of social and healthcare facilities over the past twenty years show an increase in numbers of services in operation for drug addicts, which rose from 518 in 1991 to 563 in 2011, an 8.7% increase. The trend in numbers of social-rehabilitative facilities shows much greater fluctuation; according to reports from the Ministry of the Interior, numbers of social-rehabilitative facilities rose during the early '90s, due to the effect of Law 162 of 1990, which led to an increase in the number of both public and private health services dealing with the ever-growing treatment demand for drug addictions. This increase in numbers of facilities peaked at 1,372 units in 1996, followed by a slow decline which became more significant beginning in 2002, falling to 1,067 existing facilities in 2011.

An 8.7% increase in the number of Public Drug Treatment Units between 1991 and 2011

Decrease in social-rehabilitative facilities since 1996

Figure 11.4: Trends in the number of social and healthcare facilities for drug addicts - the Years 1991-2011



Source: Based on data from the Ministry of Health

During the course of the first quarter of 2012, Regional Authorities, as set forth in the Framework for State-Regional Accord Act of 5 August 1999, conducted a survey regarding the recognition of private non-profit facilities (accredited/authorized Ancillary Agencies pursuant to Articles 115 and 166 of DPR 309/90) and public diagnostic - therapeutic - rehabilitation facilities. From information gathered from all the Regions and Autonomous Provinces (with the exception of Valle D'Aosta) on a specific online platform created by the Department for Anti-drug Policies, it was found that there were a total of 52 residential and semi-residential private diagnostic – therapeutic – rehabilitative

State-Regions Accord Act of 5 August 1999

facilities which were not or could not be included in the survey as specified under the State-Regional Accord Act, 15 less than in the previous year (Table II.2.2). The number of residential facilities fell steeply, continuing the trend already observed in the previous year (-31.8% in comparison with 2010) as did the number of semi-residential facilities (-30.4% in comparison with 2010). The types of services which fall under the category of “Reception” Services according to the Accord Act Framework increased (+6,7%); it is not possible to make a direct comparison between numbers for residential and semi-residential facilities in 2010 and 2011, since, in 2011, there were a large number of facilities for which a type was not indicated. On the other hand, the number of facilities which fell under the category of therapeutic-rehabilitative decreased by 10%, the number of pedagogical-rehabilitation services fell and so did the number of services offering specialized treatments (-13.1%). There are a total of 153 facilities which fall in the category of specialized treatment, of which 26% provide services for patients with dual diagnoses, 20% are for alcoholics, 16% are residences for patients with AIDS and 12% provide services for women with children.

31.8% decline in the number of residential facilities

6.7% increase in reception services

Specialized treatment services fell by 13.1%

Table 11.2: Private diagnostic - therapeutic - rehabilitative facilities according to Framework of the State-Regional Accord Act of 5 August 1999, by type of facility and type of care provided. The years 2010 – 2011

	Residential			Semi-residential			Not specified			Total facilities		
	2010	2011	Δ %	2010	2011	Δ %	2010	2011	Δ %	2010	2011	Δ %
Pathological addictions in general (not included or able to be included in the survey under the Accord Act Framework	44	30	-31.8	23	16	-30.4	-	6	□ □c	67	52	-22.4
Reception services Art.11	35	21	-40.0	10	6	-40.0	-	21	n.c	45	48	6.7
Therapeutic-rehabilitative Services. Art. 12	353	285	-19.3	77	49	-36.4	-	53	n.c	430	387	-10.0
Specialized treatment services. Art.13	170	136	-20.0	6	12	100.0	-	5	n.c	176	153	-13.1
13 a) Dual diagnosis	53	36	-32.1	3	3	0.0	-	1	n.c	56	40	-28.6
13 b) Mothers with children	24	18	-25.0	-	0	n.c.	-	0	n.c	24	18	-25.0
13 c) Alcoholics	29	28	-3.4	1	2	100.0	-	1	n.c	30	31	3.3
13 d) Cocaine addicts	-	1	n.c.	1	1	0.0	-	0	n.c	1	2	100.0
13 e) Pathological gamblers	-	0	n.c.	-	5	n.c.	-	0	n.c	0	5	n.c.
13 f) Juveniles	14	14	0.0	1	1	0.0	-	1	n.c	15	16	6.7
13 g) Couples	1	1	0.0	-	0	n.c.	-	0	n.c	1	1	0.0
13 h) Crisis centres	14	5	-64.3	-	0	n.c.	-	1	n.c	14	6	-57.1
13 i) AIDS Residences	24	24	0.0	-	0	n.c.	-	1	n.c	24	25	4.2
13 l) Other	11	9	-18.2	-	0	n.c.	-	0	n.c	11	9	-18.2
Pedagogical rehabilitation services, Art. 14	155	114	-26.5	32	25	-21.9	-	0	n.c	187	139	-25.7
Integrated Multidisciplinary Services Art. 15	10	10	0.0	1	0	-100.0	-	0	n.c	11	10	-9.1
Other accredited programmes	-	0	n.c.	-	0	n.c.	-	0	n.c	0	0	n.c.
Total	**76**	**596**	**-22.3**	**149**	**108**	**-**	**-**	**85**	**n.**	**916**	**789**	**-**

Decrease in in numbers of crisis centres, dual diagnosis services and services for women with children

7		27.5	c	13.9

n. c.= figure not able to be calculated

Source: Based on data from the Regions and Autonomous Provinces

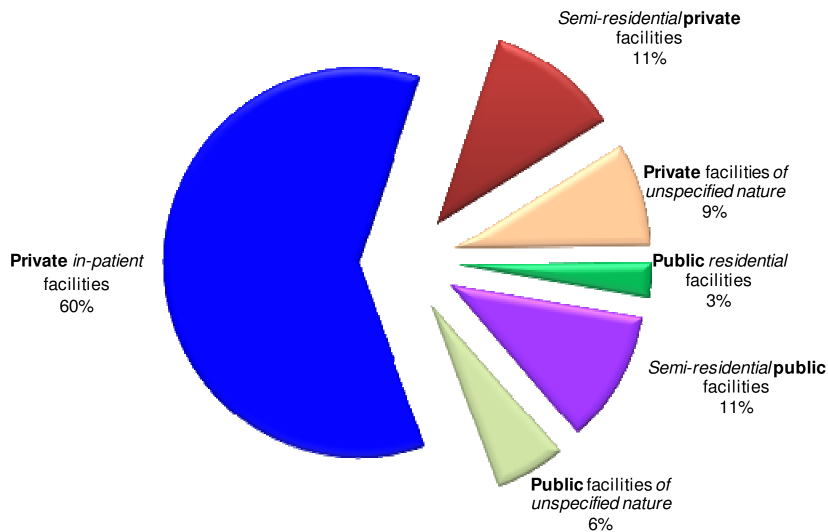
In addition to the private facilities, there were a total of 193 public (residential, semi-residential or unspecified) diagnostic-therapeutic rehabilitative facilities in the Regions participating in the survey. Principally, 43% are therapeutic-rehabilitative facilities, 32.6% are specialised treatment facilities and 18.7 % are reception facilities. Of the specialized treatment facilities, 38% provide treatment for alcoholics, 23.8% to minors and 12.7 to dual-diagnosis patients.

Table 11.3: Public diagnostic - therapeutic - rehabilitative facilities according to Framework of the State-Regional Accord Act of 5 August 1999, by type of facility and type of care provided. The year 2011

	Resident ial	**Semi-residential**	**Not specified**	**Total facilities**
Pathological addictions in general	0	5	6	11
Reception services	1	2	33	36
Therapeutic-rehabilitation services with no further specifications (including pharmacological replacement treatments)	11	63	9	83
Specialized, Art.13	16	38	9	63
13 a) Dual diagnosis	5	1	2	8
13 b) Mothers with children	0	0	0	0
13 c) Alcoholics	1	21	2	24
13 d) Cocaine addicts	1	3	0	4
13 e) Pathological gamblers	0	1	1	2
13 f) Juveniles	2	12	1	15
13 g) Couples	0	0	0	0
13 h) Crisis centres	1	0	1	2
13 i) AIDS residences	1	0	1	2
13 l) Other	5	0	1	6
Total	**28**	**108**	**57**	**193**

Source: Based on data from the Regions and Autonomous Provinces

Figure 11.5: Percentage distribution of diagnostic therapeutic and rehabilitative public and private facilities according to the Framework for the State-Regional Accord Act of 5 August 1999. The year 2011



Source: Based on information from the Regions and Autonomous Provinces:

Clients in the care of social-rehabilitative facilities

As of 31.12.2011, according to sources from the Ministry of the Interior, there were a total of 16,923 clients receiving care from social-rehabilitative facilities operating throughout the Italy, most of whom (11,371 subjects, or 67.2%) were receiving care in residential facilities, followed by outpatient services (4,183, or 24.7%) and finally semi-residential facilities (1,369, or 8.1%).

In comparison with numbers from 2010, we can see a 13.1% increase in the number of clients in facilities on 31.12, an increase which was more marked for outpatient services, which increased by 20.6%, and residential facilities (+11.7%).

16,923 clients in social-rehabilitative facilities on 31/12/2011, of whom 11,371 in residential facilities

Table 11.4: Clients in Social-rehabilitative facilities for drug addicts on 31.12.11, by type of care being received

	Social-rehabilitative facilities											
	Residential			Semi-residential			Outpatient			Total		
	2010	2011	Δ %	2010	2011	Δ %	2010	2011	Δ %	2010	2011	Δ %
Abruzzo	174	154	-11.5	34	38	11.8	99	73	-26.3	307	265	-13.7
Basilicata	76	97	27.6	0	0	-	0	28	-	76	125	64.5
Calabria	255	345	35.3	25	23	-8.0	1000	5	-99.5	1280	373	-70.9
Campania	324	446	37.7	58	21	-63.8	0	183	-	382	650	70.2
Emilia Romagna	1937	2058	6.2	60	50	-16.7	51	229	349.0	2048	2337	14.1
Friuli Venezia Giulia	51	44	-13.7	14	17	21.4	76	25	-67.1	141	86	-39.0
Lazio	330	491	48.8	230	252	9.6	30	1201	3903.3	590	1944	229.5
Liguria	219	276	26.0	19	20	5.3	26	12	-53.8	264	308	16.7
Lombardy	2374	2276	-4.1	229	162	-29.3	178	1443	710.7	2781	3881	39.6
Marche	469	483	3.0	76	92	21.1	130	149	14.6	675	724	7.3
Molise	62	60	-3.2	0	0	-	4	0	-100.0	66	60	-9.1
PA Bolzano	10	16	60.0	0	0	-	65	0	-100.0	75	16	-78.7
PA Trento	135	128	-5.2	44	39	-11.4	1290	68	-94.7	1469	235	-84.0
Piedmont	1026	1282	25.0	63	86	36.5	90	121	34.4	1179	1489	26.3
Puglia	409	528	29.1	40	44	10.0	37	257	594.6	486	829	70.6
Sardinia	260	410	57.7	0	0	-	67	98	46.3	327	508	55.4
Sicilia	192	345	79.7	80	146	82.5	194	106	-45.4	466	597	28.1
Toscana	854	850	-0.5	157	150	-4.5	25	122	388.0	1036	1122	8.3
Umbria	300	259	-13.7	40	44	10.0	3	18	500.0	343	321	-6.4
Valle d'Aosta	13	15	15.4	0	6	-	37	0	-100.0	50	21	-58.0
Veneto	713	808	13.3	139	179	28.8	67	45	-32.8	919	1032	12.3
Total	**10183**	**11371**	**11.7**	**1308**	**1369**	**4.7**	**3469**	**4183**	**20.6**	**14960**	**16923**	**13.1**

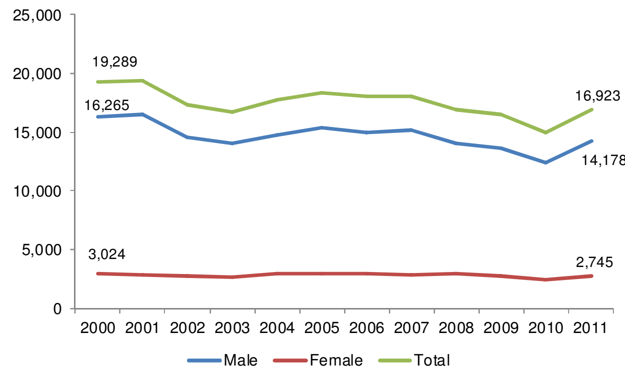
Source: Ministry of the Interior – Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources

11.7% increase in the number of clients in residential facilities, 4.7% increase for semi-residential facilities and a 20.6% increase in outpatient clients

Increase in numbers of clients during the last year

Trends in clients receiving care from social-rehabilitative facilities from 2000 to 2011 reveal a prevalence of male subjects; fluctuation among this group influences the overall trend for treatment during the time period in question.
From 2000 to 2003, we find a downturn in the trend of clients receiving care from these types of facilities (19,289 clients on 31.12.2000 vs. 16,725 clients on 31.12.2003), followed by fluctuations lasting until 2010 (14,960 clients in 31.12.2010), and then by an increase over the last year (16,923 clients on 31.12.2011).
The trend in numbers of female clients in social-rehabilitative facilities is more stable, showed recorded variations equal to a 9.2% drop.

Figure 11.6: Clients present in social-rehabilitative facilities on 31 December of each year of reference - The years 2000 – 2011

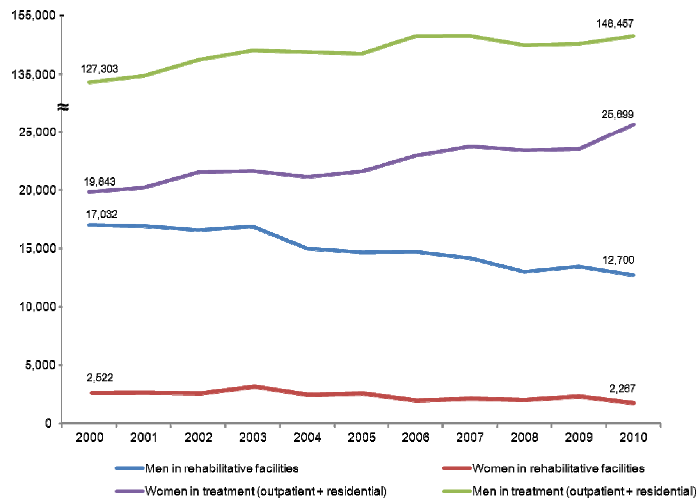


Source: Based on data from the Ministry of the Interior

Differences between information flows from the Ministry of the Interior and the Ministry of Health

Data on clients undergoing treatment in social-rehabilitative facilities is also collected by another information flow: the Ministry of Health information flow, which is comprised of clients receiving care and treatment from addiction services, some of whom are in social-rehabilitative facilities. Unlike the Ministry of the Interior information flow, which provides us with a "snapshot" of clients in the care of social-rehabilitative facilities on a certain date, the drug addiction services information flow of the Ministry of Health provides information on clients entering social-rehabilitative facilities during the course of the year, a figure which therefore shows us client "flow".

Figure 11.7: Persons receiving care from drug addiction services (either as part of outpatient programmes or within social-rehabilitative facilities) and persons entering social-rehabilitation facilities - The years 2000 – 2010



Source: Based on data from the Ministry of Health

Trends in the total numbers for people receiving care from addiction services and for those who entered social-rehabilitative structures during the period of reference reveal different characteristics for the genders. The total number of clients receiving care from services rose for both genders between 2000 and 2011 (men from 127,303 to 148,457; women from 19,843 to 25,699), in contrast with a decrease in the number of men in social-rehabilitative facilities during the same time period (falling from 17,032 to 12,700), while numbers of women entering facilities during the period of reference remained largely stable (2,522 vs. 2,267).

Fewer men entering social-rehabilitative facilities

The increase in the total number of female clients in the care of addiction services is largely attributable to a rise in the number of women receiving outpatient treatment.

11.3. Quality management in residential treatment

In 2011, in order to complete its coverage of the National Action Plan's four components in the rehabilitation action area, the Department for Anti-drug Policies put together a theoretical-practical manual regarding the social and work reintegration of individuals with addictions.

Daily experience in the treatment of drug addicts has highlighted the fact that, if the proper support is not provided during the stages of rehabilitation and reintegration, then these can represent the weak link in the therapeutic process, presenting a high risk of recidivism. It was this practical evidence which gave rise to the need to proceed to develop an idea capable of envisioning an operational model which, basing itself upon the multiple factors which comprise the condition of drug addiction, takes into account the social and rehabilitative aspects as integral, fundamental parts of the treatment process for drug-addicted individuals.

Confirmation of the above can be found in the resolution approved during the 54th

Session of the UN Commission on Narcotic Drugs in Vienna in March 2011, ""Promoting rehabilitation- and reintegration-oriented strategies, aimed to promote health and social well-being among individuals, families and communities, in response to drug use disorders and their consequences" (CND, 21-25 March 2011). This resolution underlines the importance of a multi-sector approach coordinated between government agencies and non-governmental organizations, guaranteeing that special attention is paid to rehabilitation and social reintegration activities in the context of general programmes to reduce drug use and its consequences. The importance of social reintegration as an instrument to combat the social stigmatization and marginalization of drug addicts is also highlighted as an integral part of prevention and early treatment access programmes aimed to promote health and social well-being between individuals, families and community.

This resolution, approved by all the States, is reconfirmed within the National Action Plan, which identifies the social and work reintegration of drug addicts as a central feature of new anti-drug policy in our country.

The manual provides a series of strategic recommendations, based on these premises, regarding principles of recovery-oriented approaches, meaning those oriented towards the recovery and cure of the individual, laying down the principles on which organizations and departmental systems should consistently base themselves when formulating their strategies.The publication is born of the need to have an available base of shared, scientifically-oriented methodologies which those working in the field can draw upon when developing new operational models with a pragmatic, concrete approach, ever-more oriented towards the recovery and cure of the drug-addicted individual through the development and consolidation of life skills.

In the operational practice of Public Drug Treatment Departments and Therapeutic Communities, reintegration is traditionally part of the final phase of any therapeutic programme (diagnosis, care and treatment, reintegration). In the proposed model, however, the basic idea is the incremental logic of the healing process, in which every phase is integrated with the others, with each becoming more powerful as a result, in a process that is circular, not linear. Introducing rehabilitation activities into the treatment process from the very beginning makes it possible for the individual to recover and develop those social and work stills which are needed to attain self-sufficiency and social integration as quickly as possible.

The incremental logic of the treatment process unfolds gradually in response to the resources and difficulties presented by the subject during the course of his personalized therapeutic programme.

Moreover, the approach presented focuses attention on the resources of the individual and his social context, as well as on the strengthening of his abilities, thus going beyond a model centred around deficiencies and faults which need repairing. Although this model centres its attention mainly around the drug-addicted individual, it is also important to underline the importance of his or her social context, which should not only be considered a backdrop for treatment, since each individual's well-being is also determined by the social environment he inhabits. It is therefore essential to promote social policies which aim to encourage the development and maintenance of healthy and positive contexts of living, full of stimuli for personal growth and improvement.

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Chapter 11: Residential treatment for drug users in Europe

History and policy frameworks

History of residential treatment

Residential treatment for drug users is a historically recent phenomenon in Cyprus, dating back less than a quarter of a century. The law L57(I)/92 concerning alternatives to imprisonment or community work for example, which specifically provides for the referral of substance-dependent offenders to residential treatment centres, dates back to 1992; and it is probably also a sign of the relative novelty of residential treatment, that this law has still not been practically implemented for various practical but also substantial reasons.

Initial provision for both alcohol and drug users arose through both public need and the professional interest of certain psychiatrists and psychologists in the 1980s, and mostly involved admission to the Athalassa psychiatric hospital in Nicosia - a context which was characterized by the difficulties inherent in treating substance-dependent patients in a non-dedicated environment. It may be said, however, that the first formal residential treatment made available specifically for drug users in Cyprus was based at the treatment unit THEMEA, established in 1991 at a wing of the Nicosia General Hospital. THEMEA initially treated alcohol users and drug users, both on an outpatient and an inpatient basis; but in recent years it has operated exclusively as an inpatient and outpatient treatment centre for alcohol and benzodiazepine (medicines) users. It is worth mentioning that in the non-governmental sector, the outpatient drug treatment programme TOLMI, run by the NGO KENTHEA also commenced its operations in 1992, but it has never provided residential treatment per se (cf. www.veresies.com).

Towards the end of the decade, in 1998, AGIA SKEPI, the first therapeutic community for drug users offering specialized residential treatment was founded, commencing its operations a year later in 1999 (cf.www.agiaskepi.org). The initiative for this TC came from Metropolitan Athanasios of Limassol, who at the time was Abbot of Machairas Monastery, where a number of young drug users sought help. From its inception, the TC was run by scientifically-trained staff in a purpose-built structure located in an area separate from the monastery itself, and has since successfully branched out, operating a number of associated treatment, counselling and rehabilitation programmes in Nicosia and Limassol. More data from this residential treatment context will be provided below.

An interesting case in point regarding the history of residential treatment in Cyprus has been the operation of PYXIDA. PYXIDA commenced its operation in 2003 as a long-term residential treatment programme for adult drug users run by the governmental MHS. It was found, however, that despite the known numbers of problem drug users in Cyprus, PYXIDA had a low turn-out in that treatment format. Three years later, in 2006 it attempted to increase its accessibility and client numbers by expanding to include programmes for drug users with less severe dependence issues, who did not require residential treatment. While undergoing more organisational and structural changes in 2007, it nevertheless experienced further decreases in turn-out, possibly due to the concurrent establishment of the governmental detoxification and

substitution programme, GEFYRA, with which it nevertheless attempted to establish a working cooperation (Poulopoulos & Papanastassatos, 2009). As of late 2008, PYXIDA ceased operations as a residential treatment programme entirely, and by 2012 it has also ceased to function under that name; it is now known as the Nicosia Centre for Multiple Interventions of the MHS, and operates as a counselling station with an outpatient programme. It is probably significant therefore, that PYXIDA cites three main reasons for these changes (Kalakoutas, 2012):

- Reduced demand for closed treatment programmes
- The operation of GEFYRA drawing most of the problematic drug users
- Increased demand for outpatient programmes

The cessation of PYXIDA as a residential treatment programme essentially rendered AGIA SKEPI the only remaining option for long-term residential treatment in Cyprus. In the governmental sector the only residential treatment programme for illicit drug users available since 2009 has been ANOSI, based in Limassol, which is however essentially a detoxification programme; more data from this residential treatment context will also be provided below. Similarly, the privately-owned Veresies Clinic (cf.www.veresies.com) which provides paid substitution and detoxification treatment to adult drug and alcohol users, offers residential detoxification treatment, but no long-term residential treatment per se. The distinction made in ch.5 between substitution treatment for detoxification or for maintenance purposes may be relevant to the operation and self-description of both ANOSI and the Veresies Clinic as residential treatment programmes.

This brief history of residential treatment in Cyprus may suggest that treatment provision has addressed a mixture of variable treatment needs emerging from the changing patterns of public drug use and its consequences, but also from a diversity of flexible and creative attempts on behalf of professional and voluntary bodies (both in the governmental sector and from NGOs) to respond to those needs. It may be surmised that the current picture is far from complete, and likely to be subject to future changes and developments.

Strategy and policy frameworks for residential treatment

The main legal framework for residential treatment in Cyprus is the law L128(I)/2000 concerning the Prevention of the Use and Dissemination of Drugs and Other Addictive Substances (Establishment of the Anti-Drugs Council and Fund). All persons or organisations aiming to offer residential or any other form of treatment to substance-addicted persons must be approved by the CAC as stipulated by this law and its amendments between 2000 and 2008.

Apart from fulfilling the criteria of the CAC as a scientific ‘umbrella’ authority, residential treatment programmes must also abide by legislation relevant to nursing homes and/or shelters, depending on whether the treatment they are offering has a predominantly medical or psychosocial character. Residential treatment such as that offered by AGIA SKEPI, which includes a long-term psychosocial component, must satisfy the requirements of law L65(I)/2011 concerning Shelters for the Aged and Disabled 1991 to 1994, as demanded by the MLSI; and residential treatment programmes with a predominantly brief, medical character such as those offered by ANOSI and the Veresies Clinic must satisfy the requirements of law L55(I)/2011 concerning Control and Supervision of the Foundation and Operation of Private Nursing Homes 2001 to 2011.

Beyond the legal framework, residential treatment programmes also need to be informed by the CAC policy guidelines, such as those published in the CAC Treatment Guide (see selected issue ch.11 in NR 2010). They must also share the overall aims set forth for the treatment and social reintegration pillar of the NDS 2009-2012 (cf. NDS section B(2)). These aims, and their associated actions as laid out in the text of the NDS include the following areas[74]:

- Availability and accessibility
- Assessment, diagnosis and treatment planning
- Evidence-based treatment
- Human rights and human dignity
- Targeting special sub-groups and conditions
- Treatment in the penal system
- Community involvement
- Clinical service management
- Treatment system

Financing models and main funders of residential treatment

As mentioned above, in 2011 and at the time of writing, there are 3 residential treatment programmes in Cyprus, two of which are however primarily detoxification programmes. Financing models and main funders for these programmes originate either from the government and/or from private sources. Interestingly, the three programmes represent a spectrum of funding:

AGIA SKEPI (NGO; non-profit) reports that its funds derive both from state and private sources. Its main source of funding is secured by an associated NGO, the "Association of Friends of AGIA SKEPI", which is mandated to locate sources. Funds also come from: the CAC, MOH, MLSI, the Human Resource Development Authority (for vocational training), income from products of the community (e.g. organic bread baked by community members), and a number of private individual or NGO benefactors (Papadopoulos, 2012).

ANOSI (MHS) is entirely government-funded, being part of the state budget of the MOH. The daily cost of inpatient care per person is stated as €622.30 during 2011 (Kalakoutas, 2012)

VERESIES CLINIC (private) (www.veresies.com) is a privately-owned and run institution based in Larnaca, offering a range of therapeutic programmes addressing various issues ranging from smoking and alcoholism to gambling and heroin addiction. For the latter, the clinic includes the possibility of a 7-day residential detoxification programme using buprenorphine followed by naltrexone implants for relapse prevention, combined with a long-term outpatient psychosocial programme.

[74] It is beyond the scope of this SI to discuss these areas further; more detail can be found in the text of the NDS 2009-2012.

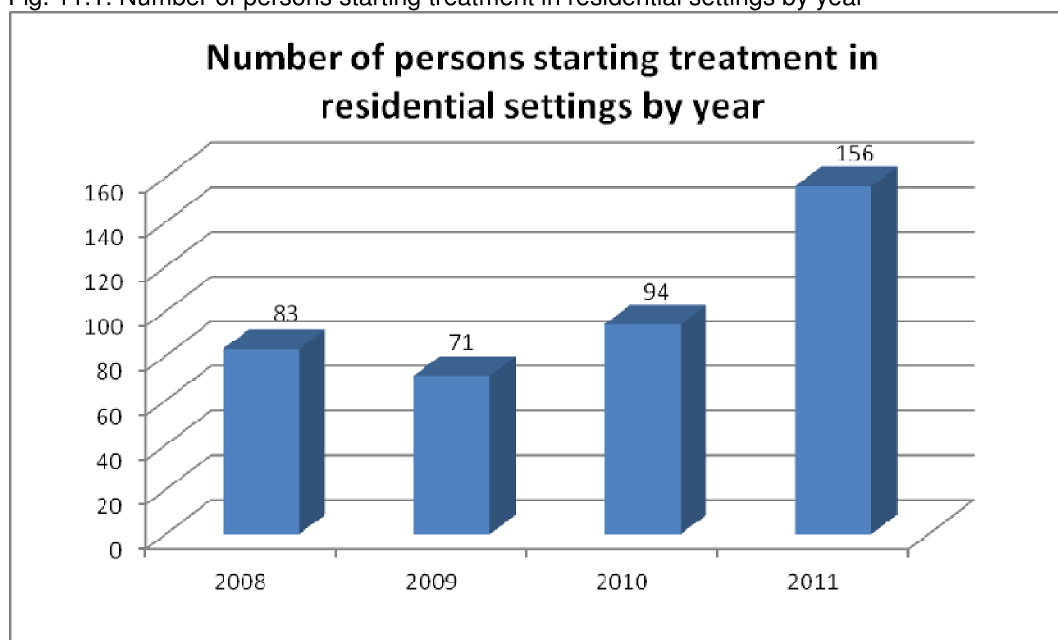
Availability and characteristics

National (overall) availability and accessibility

As explained above, there is currently only one long-term residential treatment programme in Cyprus, namely the therapeutic community AGIA SKEPI; the ANOSIS detoxification programme and Veresies Clinic detoxification programme do involve a residential treatment component, and because they self-identify as being such programmes, they are included in this chapter wherever data from them is available. These three programmes necessarily cover the residential treatment needs of the entire non-occupied area of Cyprus. Further details of the AGIA SKEPI programme, as well as of the programme offered by ANOSI, will be offered in section 11.2.2. This section will be used to provide such descriptive data on residential treatment in Cyprus as have been made available to the NFP.

Based on an NFP analysis of treatment demand data received as feedback from residential treatment programmes overall, the most interesting characteristics emerging from this analysis will be presented below. A graph of numbers of persons entering residential treatment in Cyprus between 2008 and 2011 can be seen in fig. 11.1:

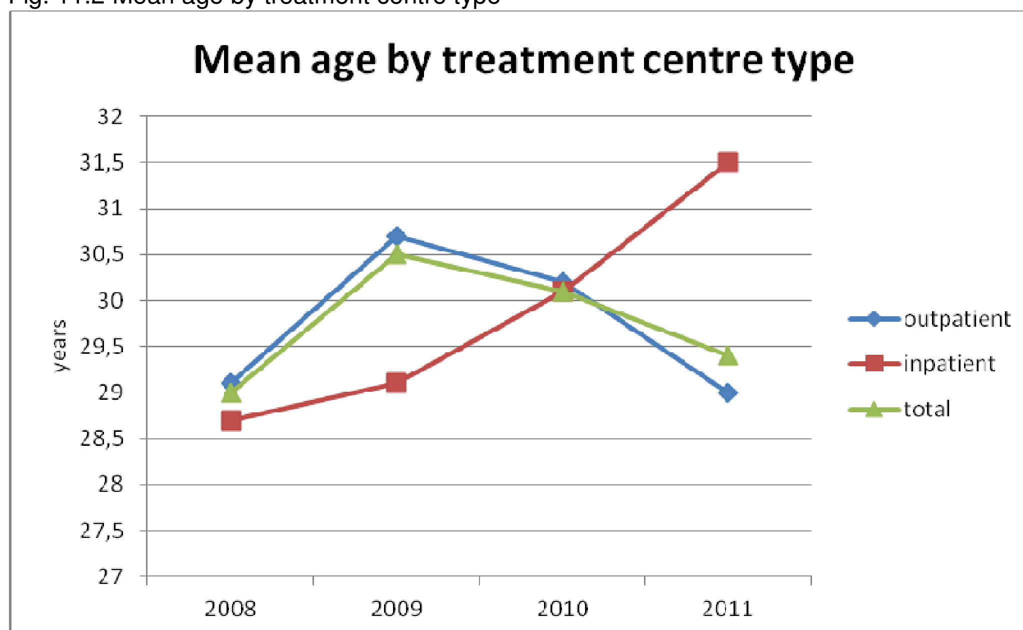
Fig. 11.1: Number of persons starting treatment in residential settings by year



Source: NFP, 2012

Although numbers appear to be rising, it is worth pointing out that in the majority of cases, these clients had been treated before (71.2%). Therefore, one interesting demographic characteristic of these persons is perhaps their age in relation to outpatient programme clients (fig. 11.2):

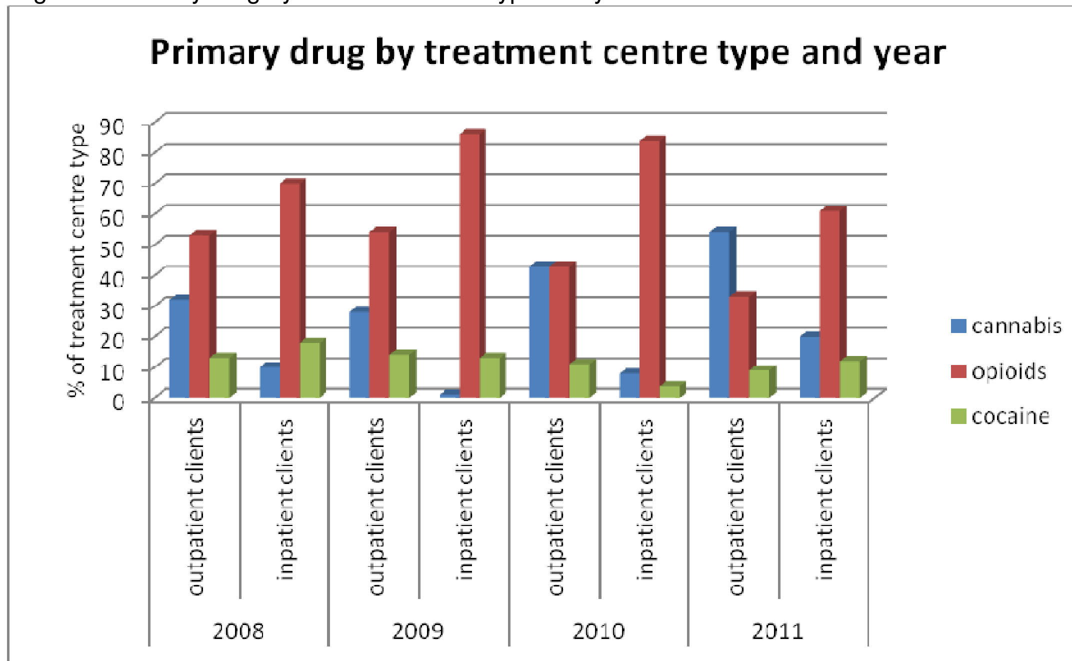
Fig. 11.2 Mean age by treatment centre type



Source: NFP, 2012

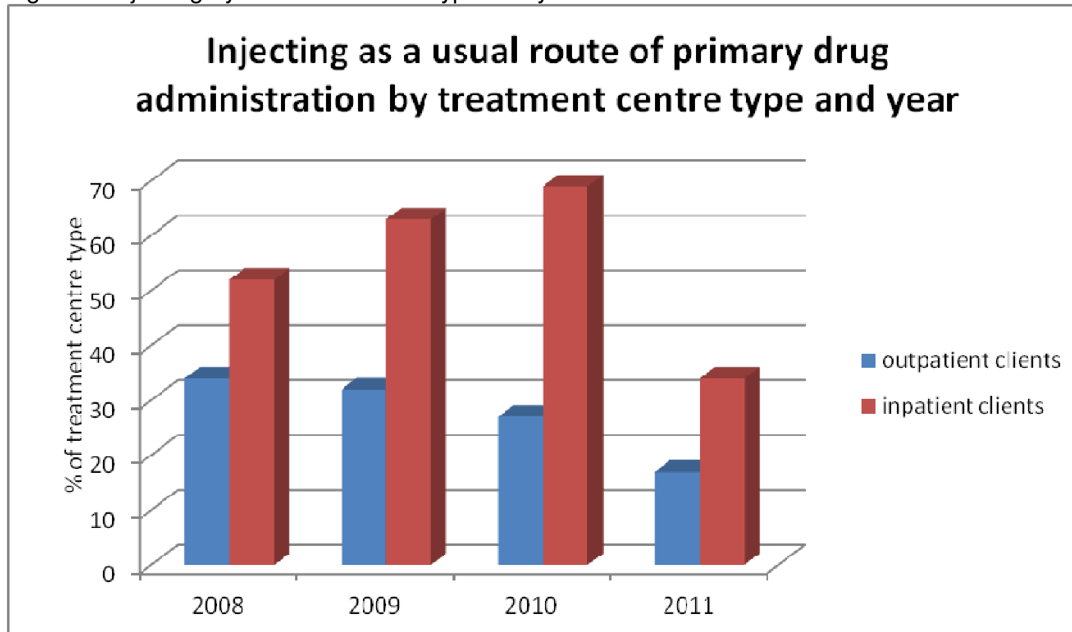
The range of years between 2008 and 2011 is probably too brief to draw any firm conclusions, but there does seem to be a tendency for residential treatment clients to be getting older, which resonates with recent observations made about users of heroin in general (see ch. 2 and previous NRs). As the graphs below suggest, most residential treatment patients are indeed users of injected opioids, as expected (figs. 11.3 and 11.4):

Fig. 11.3 Primary drug by treatment centre type and year



Source: NFP, 2012

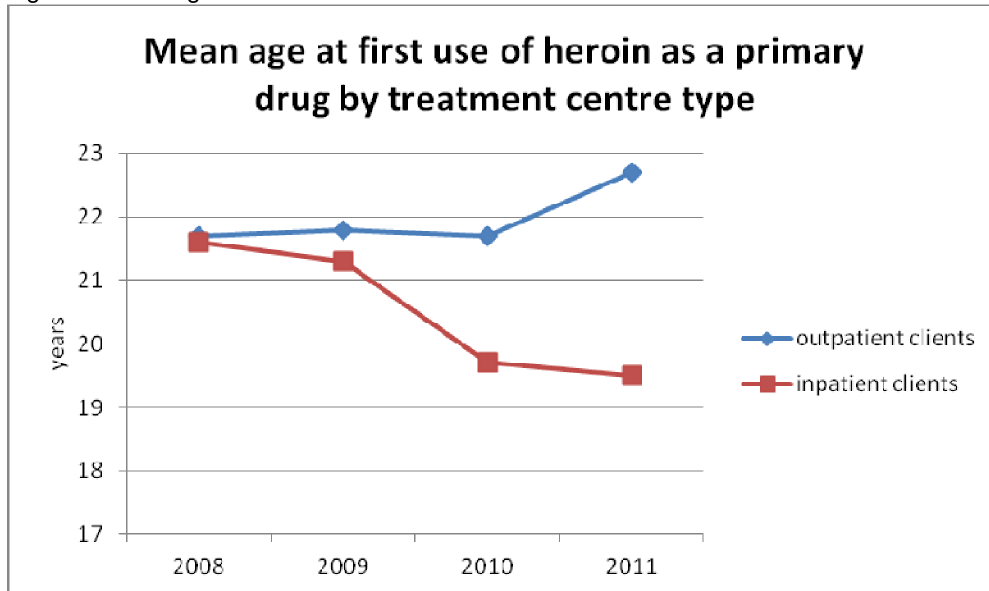
Fig. 11.4 Injecting by treatment centre type and year



Source: NFP, 2012

Interestingly, inpatient clients also appear to have started heroin use earlier than those in outpatient programmes, suggesting perhaps that their addiction tends to be more severe. Again however, this finding is not unexpected given the more intensive character of residential treatment (fig. 11.5):

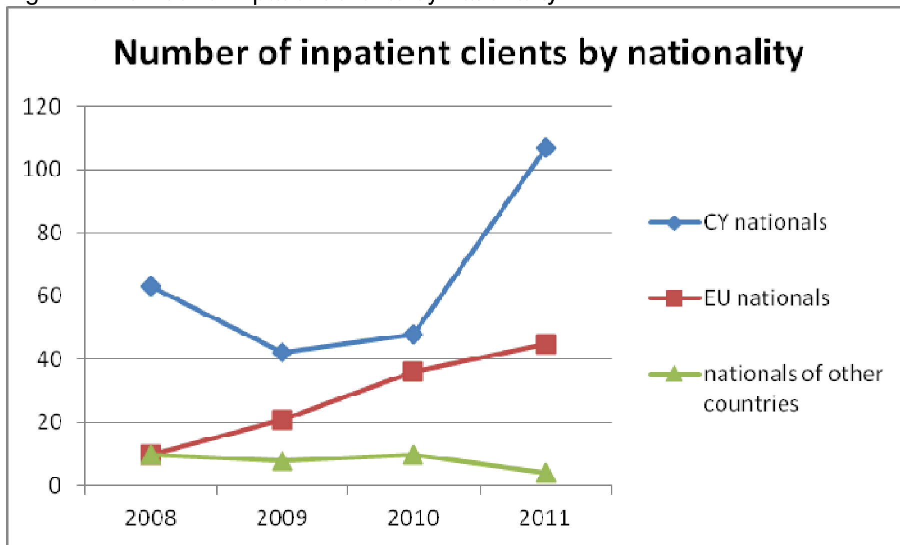
Fig 11.5 Mean age of first heroin use



Source: NFP, 2012

The majority of these residential treatment clients appear to be Greek-Cypriot nationals, with an increasing tendency for other EU nationals to also make use of services (fig. 11.6). Again, this is probably representative of drug users in Cyprus generally, rather than exclusive to those in residential treatment:

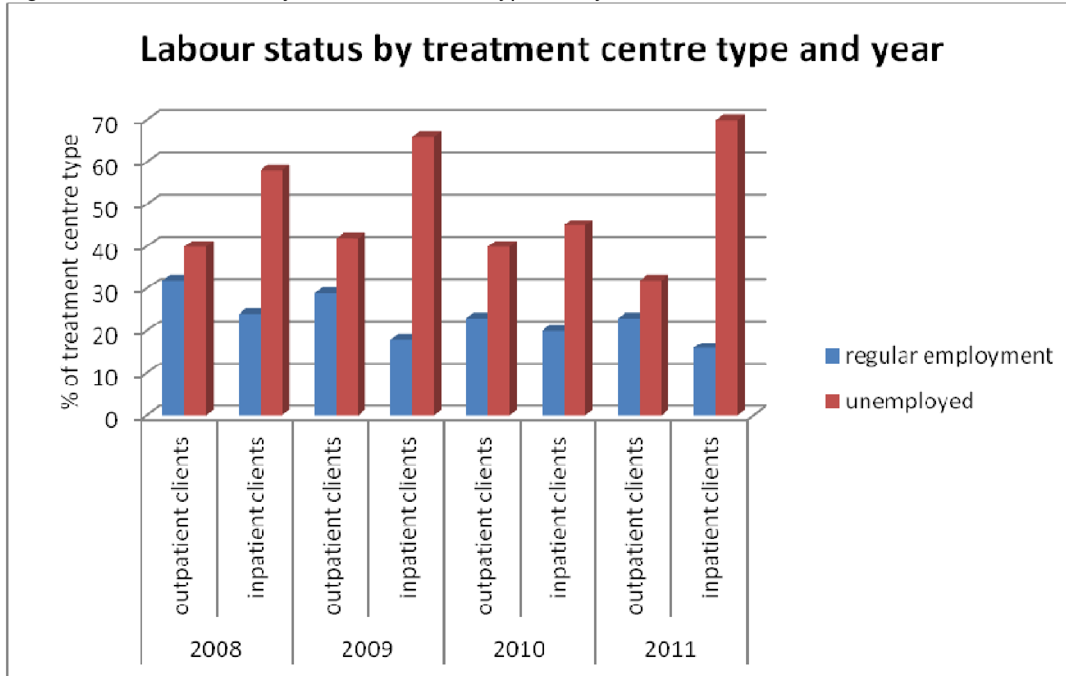
Fig. 11.6 Number of inpatient clients by nationality



Source: NFP, 2012

It is also perhaps to be expected, that residential treatment clients tend to be unemployed more frequently than those in outpatient programmes, and are less frequently in regular employment (fig. 11.7):

Fig. 11.7 Labour status by treatment centre type and year



Source: NFP, 2012

Types and characteristics of residential treatment units

The information given below will describe the residential treatment offered at the three units mentioned above. No information specific to 2011 has been collected for the privately-run Veresies Clinic, although the NFP will attempt to get specific feedback as of next year. Some of the following information will also be reported on the REITOX extranet as requested.

AGIA SKEPI

AGIA SKEPI (Papadopoulos, 2012) reports that it is based on the model of therapeutic communities (TCs), using a cognitive-behavioural treatment approach. During the middle stages of the programme (approx. 6 months) psychodynamic work takes place, while much is also applied from motivational interviewing and systemic theory throughout treatment.

The aspects of treatment which a community member may benefit from include case management, HCV/HIV screening, HCV therapy, careers counselling, entertainment, anger and crisis management, legal counselling, financial management, housing (during residential treatment and social reintegration), relapse prevention training, family therapy and a treatment programme exclusively for women. When there is comorbidity, 2 psychiatrists are available for consultation and parallel treatment.

All therapeutic staff at AGIA SKEPI must possess a postgraduate degree.

The residential treatment programme lasts approximately one year, including a phase of social reintegration. However, there is also a year's follow-up after completion of the social reintegration phase.

Prior to admission to the programme, there is collaboration with the ANOSI Detox programme. In case of a drop out during the TC programme, the person is referred to PYXIDA or another suitable programme. The level of collaboration and networking (Baldachino et al, 2011) is self-rated by the TC as level 2, nominative referrals and meetings between agencies.

ANOSI

ANOSI is located in a specially renovated wing of the Old Hospital building in Limassol. It is a closed inpatient unit in operation since 2004, which offers brief residential treatment for drug users during the detoxification stage. The programme aims to cover "the medical, psychological and social needs of dependent persons" (cf. www,moh.gov.cy) in the first stage of treatment.

The unit is run by the government MHS under the direction of the MOH. In 2011, 126 intakes involving 59 patients were noted. The mean duration of a patients' stay is 20 days, and the therapeutic model used is stated as a combination of pharmacotherapy, counselling and occupational therapy (Kalakoutas, 2012). The aspects of treatment which a patient may benefit from include medically supervised detoxification, case management, relapse prevention, information and referrals for HIV/AIDS/HCV/STI, entertainment and creative activities.

ANOSI reports that good practice guidelines are applied, and its staff is university-educated. Moreover, the results of its activities are evaluated (though further details of the evaluation are not supplied with the 2011 feedback). Also, ANOSI reports having extensive cooperation with counselling centres, closed treatment centres and TCs, therefore the level of collaboration and networking (Baldachino et al, 2011) is probably level 3, formal joint working (not self-rated). Since 2004, the programme also reports having observed a stabilization of treatment demand for opioids, and an increase in treatment demand for stimulants.

VERESIES CLINIC

The following information can be found on the website of the clinic, www.veresies.com. No quantitative data regarding the programme operation in 2011 have been collected.

Veresies Clinic offers a treatment of addiction-detoxification from heroin (and other opiates). As the clinic website explains, the programme is offered both on an inpatient and outpatient basis. It involves an intensive programme of personal psychological rehabilitation as well as the treatment of co-morbidity. Treatment involves either of two options:

1. A heroin antagonist - DHC (EXTERNAL program) Once the calculation of the dose is determined, the dose of substance DHC is set, which is administered orally in low doses. Medication is also administered for sleep, as well as antidepressants and several vitamins. The diet of the patient is rich in liquids, especially fresh juices.

2. A heroin agonist / antagonist – Buprenorphine brief residential programme. This lasts 7 days and involves treatment/detoxification with buprenorphine (SUBOXONE). In the Physical Detoxification Treatment Program implemented by VERESIES CLINIC, buprenorphine is administered in the form of a sublingual tablet, a type of pill that should not be swallowed or chewed, but left to dissolve in the mouth (it takes 15-30 minutes). The action begins after 30 minutes and lasts, depending on the dose, up to three days. The daily dosage is usually between 2 mg and 16 mg, phasing out for no more than 7 days.

A "Step by Step" structured individual rehabilitation program based on rational-emotional-behavioural therapy is applied, which according to the website can be applied at any stage of heroin usage. The "Step by Step" program is applied via very regular individual meetings lasting a half hour each (according to the needs of the patient) by a trained psychologist. After the successful assimilation of this step, the program is applied gradually to cover the following main aspects:

1. Recognition and acceptance of problem
2. The relation of the patient to substance dependence and dependent conduct [sic].
3. The psychological condition of the patient – administration of psychometric test.
4. Psychoeducation
5. The existence of motivation; searching for and enhancing motivation.
6. Changing attitudes and beliefs about the phenomenon of using heroin and other drugs.
7. Active participation / planning / changing behaviour associated with the use.
8. Demarcation of relations / place/ time.
9. Setting goals
10. The problem of use and the family of the patient / co-dependence / allies.
11. Preventing relapse

Involvement in treatment programmes at home as well as in group psychological rehabilitation programmes is also suggested to drug users and their families. Moreover, regular participation in self-help groups for 5-10 years after the therapeutic intervention is suggested as keeping the drug user from relapse.

Quality Management

Availability of guidelines and service standards for residential treatment

As mentioned in section 11.1.2, residential treatment programmes need to be informed by the CAC policy guidelines, such as those published in the CAC Treatment Guide, and they must also share the overall aims set forth for the treatment and social reintegration pillar of the NDS 2009-2012.

This is at least partially ensured by the fact that CAC funding for treatment programmes is made available on the basis of approval of a relevant application made annually. The treatment programme approval application includes sections on the level of networking with other services, the individual treatment costs, the programme capacity, intake criteria, staff qualifications etc. This applies to state-run programmes like ANOSI, as well as private institutions like AGIA SKEPI and VERESIES CLINIC.

State-run programmes like ANOSI also submit an annual report to the MHS, which is communicated to the NFP. Evaluations by independent scientific experts, such as those by the Centre for Intrdisciplinary Addiction Research of Hamburg University reviewing the government MHS in 2007 (see NR 2008), and others conducted for privately-run institutions' own purposes also take place sporadically.

Discussion and outlook

As mentioned above, the history of residential treatment in Cyprus, together with residential treatment client characteristics such as the observed tendency since 2008 for these clients to be getting older, but also the increased presence of both local nationals and other EU nationals on these programmes, suggests the residential treatment format will remain a viable form of drug treatment in the foreseeable future.

Nevertheless, residential treatment also needs to remain flexible and open to new developments, such as changes in patterns of drug use and emerging client needs. While service standards, staffing levels and minimum requirements for staffing qualifications are assured partly through the work of umbrella organizations such as the CAC and the existing national legal context, alternative non-professional residential treatment programmes such as those emerging from Narconon or RETO (http://www.asociacionreto.org/en/inter/) have at times posed a challenge to existing scientific practice, as well as to its legal context. Irrespectively of concerns about their scientific or legal propriety however, the existence of such programmes, as well as those discussed in this chapter which do adhere to internationally recognized standards of scientific practice, suggests that residential treatment for drug use is a genuine need emerging from specific drug user groups, which therefore deserves to remain an important option on the therapeutic treatment spectrum.

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11. Residential treatment for drug users in Europe

11.1. History and policy frameworks

Patient treatment involving a stay of at least 24 hours in a treatment facility is provided by hospital inpatient centres equipped with addiction profile beds and at rehabilitation centres. Therapeutic communes are not available in Latvia. To date the only existing therapeutic commune for people with addiction problems was amalgamated with the addiction hospital *Ģintermuiža* in 2007 as the result of the economic crisis. Currently, the only programs that are of more than 30 days' duration and are focused on the patient's re-socialization and re-integration into society are medical and social rehabilitation programs. The main difference between these two programs is their funding source.

Overall, State hospitals and rehabilitation centres provide medical assistance for drug addicts as follows:

- Emergency addiction assistance, mainly as detoxification;
- Motivation Program: the phase between detoxification and the subsequent course of therapy selected. The program duration for drug-dependent adults and children under 18 years is 12 days. The techniques used are: the 12-step addiction treatment method, the cognitive behavioural psychotherapy method; elements of psychodrama
- *Minnesota* 12-step program: a packaged, short-term psycho-social treatment method for addiction diseases, of 28 days' duration. The techniques used are: individual and group counselling, lectures, discussions, elements of psychodrama; art and music therapy; group therapy with patients and family members.
- Medical rehabilitation: a medical, psychological, ergo-therapeutic, instructional, educational, social, legal, life and work skills acquisition system, which focuses on patients' re-adjustment, re-socialization and re-integration into the community, conditional upon the patient abstaining from the use of addictive substances. Program duration is 1 year. The program is funded by the Ministry of Health
- Social rehabilitation: similar to medical rehabilitation in having a set of measures e.g. educational, psychological, educational, social, legal and occupational therapy aimed at the patient's re-socialization and reintegration into society, by creating incentives for not using addictive psychoactive substances. Program duration: Adults - 1 year; children - 1.5 years. The program is funded by the Ministry of Welfare.

In addition, assistance in rehabilitation is also provided by several non-governmental organizations, which operate on the therapeutic community principle. The basis of this service

can generally be described as psycho-social assistance and resocialisation into society, i.e., a community member receives psychological support from other members of the community, learning to live without the use of intoxicating substances, learning new skills, and making new friends without addiction problems. Basically, these centres perform social assistance functions. For the most part, these centres have a religious orientation with the main treatment method being occupational therapy. The centres are led by former addicts but professional counselling is not provided. Accordingly, they cannot be regarded as professional rehabilitation programs, or professional therapeutic communities. At the same time, the demand for this type of religious community has sharply increased in recent years as existing inpatient rehabilitation programs fail to implement therapeutic community principles.

Medical rehabilitation programs are regulated by Cabinet Regulation No. 70 of 24 January 2012 *Arrangements for the Treatment of Patients Addicted to Alcohol, Drugs, Toxic Substances and Gambling* which stipulates that the decision to transfer a patient to a rehabilitation institution that provides medical rehabilitation services shall be made by the treating addiction specialist, at the same time informing the patient about the future possibilities of obtaining State-funded social rehabilitation services. A patient's medical rehabilitation is organized in several stages, based on a multidisciplinary approach and the integration of medical, psychological and social therapy, which focuses on the patient's re-adjustment, re-socialization and re-integration into society.

11.2. Availability and characteristics

In assessing the long-term treatment options for patients with drug dependency, psychosocial interventions provided by inpatient hospital and rehabilitation centres were taken into account, as well as assistance with re-integration offered by non-governmental organizations and Christian communities.

Drug Addiction Bed Fund in Hospitals

The Centre for Disease Prevention and Control compiles statistics annually on the hospital inpatient support services and availability of resources. State hospital patients with dependency problems are offered emergency drug treatment as well as a motivation program, the *Minnesota program*, and medical rehabilitation. The availability and usage of inpatient facilities are evidenced by the addiction profile Bed Fund, in which inpatient services are

provided to patients with alcohol-and drug-related diagnoses (F10-19). In general, a decline has been observed in the number of beds available: from 350 beds in 2009 to 261 beds in 2011. There has also been a reduction in the average number of bed-days, and the coefficient of bed movement has increased, suggesting a reduction in the time spent by a patient in hospital (see Table 11.1.).

Table 11.1. Addiction profile bed fund and turnover in inpatient facilities, 2009-2011

	2009	2010	2011
Beds	350	277	261
Number of beds per 1 inhabitant	1.6	1.2	1.3
Average number of bed-days per one patient	5.4	4.4	4.5
Bed turnover	41.1	52.0	56.0

Source: Centre for Disease Prevention and Contol of Latvia, 2012

Emergency Addiction Assistance, Motivational program, *Minnesota* program

The number of detoxifications and other inpatient interventions performed are registered in the National Health Service (NHS) inpatient services payment settlement system (SPANS). In order to describe available inpatient intervention in general, information has been compiled on inpatient hospital admissions for patients with diagnoses related to consumption of alcohol (F10) and drugs (F11-19, F17 exception). Cases were selected where detoxification, a motivation program and the *Minnesota* program had been undertaken in hospital. During a single hospitalization, a patient was able to undergo one, two or three therapeutic interventions without interruption.

Data recorded in SPANS show that in 2007-2011, 42 709 inpatient hospital admissions were recorded for patients with diagnoses related to consumption of alcohol (F10) and drug use (F11-19, F17 exception). 92.8% of hospital deaths were attributable to alcohol (F10), and 7.2% to the use of drugs (see Table 11.2.).

Table 11.2. Number of hospitalisations in inpatient facilities between 2007-2011; diagnoses F10-19, excepting F17

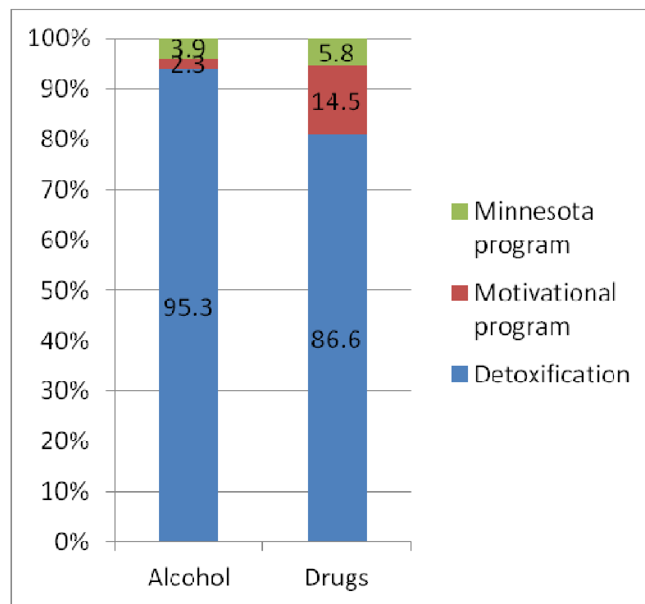
		2007	2008	2009	2010	2011	Total
Alcohol	Number	10335	10197	6813	6083	6205	39633
	%	93.4%	92.9%	91.8%	92.9%	92.6%	92.8%
Drugs	Number	727	775	609	466	499	3076
	%	6.6%	7.1%	8.2%	7.1%	7.4%	7.2%
	Total	11062	10972	7422	6549	6704	42709

Source: National Health Service, 2012

The majority of patients (98.1%) received one inpatient intervention during hospitalization. More rarely, two (1.8%) or three (0.1%) treatment courses/programs (detoxification, motivation, *Minnesota*) were completed. As many more patients with alcohol-related diagnoses are assisted in the addiction profile beds, there is much less assistance provided to patients with drug-related diagnoses.

It was observed that patients who had taken drugs were much more frequently involved in a motivation program while in hospital. By comparison, in 14.5% of cases a patient with F11-16, F18-19 diagnoses was enrolled in a motivation program during hospitalization, compared to 2.3% of patients with F10 diagnoses enrolling in a motivational program during hospitalization (see Figure 11.1.).

Figure 11.1. Interventions provided during hospitalisation, in absolute numbers and as a proportion of all hospitalisations.[75]



Source: National Health Service, 2012

In 2007-2011 a total of 3079 hospitalisation cases were registered with drug-related diagnoses (F11-16, F18-19). In 52.2% of cases, hospitalization was associated with use of opiates (F11), 29.6% of cases with use of multiple substances (F19) and 9.2% with use of stimulants (F15).

Over the relevant period, detoxification and hospital interventions were provided to 2154 persons, of whom 24.5% were women, and 75.5% were men. The average age of patients during hospitalization was 26.5 (SD 9, 1); women - 26.3 (SD 10, 6), men - 26.6 (SD 8, 6). The youngest patient was aged 10 years and the oldest was aged 78 years. A total of 18.1% of patients were minors at the time of their last hospitalization; 25% were aged 18-24 years, 42.1% were aged 25-34, 10.2% were aged 35-44 years and 4.6% were over 45 years of age.

In order to assess the effectiveness of the Motivation and *Minnesota* programs provided in hospitals during 2007-2011, cases were selected from SPANS where in-patient intervention (Motivational and *Minnesota*) had been the last recorded entry in the patient's treatment history. Specifically, in 73.4% of cases where the patient had undergone a motivational program during

[75] Several interventions may be performed during a single hospitalisation. The calculation includes individual interventions.

hospitalization, there was no subsequent entry for that patient being readmitted to a hospital after completion of the program. If the patient had undergone the *Minnesota* program during treatment, in 79.2% of cases this had been the last recorded episode of inpatient treatment for that patient. If during a single hospitalisation the patient had undergone both the motivation and the *Minnesota* programs without interruption (47 cases), in 39 cases, this was the last episode of hospital treatment as an inpatient.

Table 11.3. Number of hospitalisations during which an inpatient intervention was the last episode in a patient's treatment history, 2007-2011.

	Motivational		Minnesota		Motivational and Minnesota	
	Number	%	Number	%	Number	%
Number of hospitalisations in a set treatment program	398	26.6	130	20.8	47	17
Number of hospitalisations in which a completed treatment program was the patient's last recorded treatment episode as an inpatient	292	73.4	103	79.2	39	83

Source: National Health Service, 2012

Overall, the compiled data indicate that a relatively large number of patients do not return to hospital again. Here, however, it should be noted that it is not known how many of these patients continue treatment in an outpatient rehabilitation program and/or no longer use drugs.

Medical rehabilitation

The number of drug addiction or medical rehabilitation places in hospitals can vary, depending on how much State funding is allocated from the health care budget. In 2011 a total of 7.5 places were funded for adult persons in two psychiatric and addiction centres. By contrast, National Health Service SPANS 2011 data recorded 32 unique patients (24 men and 8 women) who had received treatment for "drug addiction rehabilitation". As the number of unique patients in "addiction rehabilitation" is greater than the number of places allocated by the State, it is thought that some patients meet the cost of their treatment at their own expense or, possibly, patients generally do not remain in the program for very long.

Given that medical rehabilitation has been the longest-established treatment program, cases were selected from National Health Service SPANS in which the patient stayed in hospital longer than 35 days, which could indicate that the patient has received a lengthy

treatment course for emergency drug addiction assistance, motivational, *Minnesota* or mandatory treatment as a child. A total was recorded of 66 unique patients who had stayed in hospitals for more than 35 days in 2011. At the same time, 24 patients were recorded who had stayed in hospital for more than 90 days and only two patients who had stayed in hospital for all of 2011 (365 days).

Social rehabilitation

A social rehabilitation service is provided in two treatment institutions: one at a state psychiatric and drug addiction profile hospital (program available for adults only) and one at a rehabilitation centre (program available for children to age 18 years.). The social rehabilitation program is a voluntary rehabilitation program. In 2012 the State funded 10 places in social rehabilitation programs for adults with alcohol and drug addictions.

Table 11.4. Social rehabilitation places and number of patients in hospitals and rehabilitation centre in 2012

	Number of patients	State funded places
Hospital *Ģintermuiža*		
Adults	10	10
Rehabilitation centre *Saulrīti*		
Juveniles	36	64

64 beds are funded by the State each year for the rehabilitation of juveniles. Prior to 2012 social rehabilitation services were provided by two institutions, but in 2012 they were provided by only one institution. The centre has a capacity of about 35 places, or a little less than half of the possible total. The remaining places were filled at the rehabilitation centre *Dzīves Enerģijas*, which was closed in 2011. Thus, there are currently 29 State-funded places a year, which are not being filled. As the number of potential social rehabilitation places has decreased, the spring of 2012 saw 5-6 people queue for this service. It should be noted that in previous years no queue was observed for State-funded places for the rehabilitation of minors, and neither was the number of available places fully taken up.

Apart from the above programs, the Ludza regional hospital has established a social rehabilitation program for people with alcohol and drug addiction as part of an ESF project. 12 people are enrolled in the rehabilitation program, which is of 100 days' duration. During the year a total of 30 days of rehabilitation services is provided to 36 people.

Non-governmental organizations

A total of 4 non-governmental organizations operate in Latvia providing assistance to individuals combating alcohol and drug addictions, and then re-socializing them into society. A total of seven centres have been identified which provide rehabilitation services for about 90 people.

Accessiblity

Patients with dependencies related to alcohol and various drugs are accepted for inpatient addiction profile beds and rehabilitation programs. Rehabilitation programs can accommodate persons who have received emergency assistance for drug addiction and who have preferably passed the motivation and *Minnesota* programs.

The arrangements for receipt of State-funded social rehabilitation services are stipulated in Cabinet Regulations. The social rehabilitation service is free, but an intending applicant must submit the following to the social services department of their local municipality:

- written submission concerning the need for services;
- addiction specialist opinion and recommended treatment program;
- an extract from outpatient medical records regarding the person's general state of health.

After receiving the documents, the municipality forwards them to the State Social Integration Agency, which decides on payment for the rehabilitation of the person concerned.

In cases where rehabilitation is to be provided to a minor, the procedure is the same, but in cases where the young person refuses to attend treatment programs, they may be subject to a mandatory treatment program, followed by mandatory social rehabilitation.

The main route by which a person can enter a rehabilitation program is via a referral from an addiction specialist, i.e. a visit to an addiction specialist is necessary. A person may see an addiction specialist immediately after emergency medical treatment, or after completing a motivational program, or the *Minnesota* program; or by referral from the family physician, in accordance with the patient's individual preferences. In cases where a juvenile refuses to go to an addiction specialist, but is to undergo mandatory treatment, the addiction specialist may acquire information on the patient by indirect means e.g. from a municipal social service department, from treatment institutions or from social adjustment institutions etc.

Social rehabilitation may be refused for a patient where any of the following contraindications exists:

- Intoxication by alcohol, drugs, psychotropic or other addictive substance or withdrawal syndrome.
- Psychotic disorders.
- Adjustment disorders with suicidal thoughts and behaviour.
- Mental and behavioural disorders due to brain disease, damage, or dysfunction.
- Personality disorders with decompensation.
- Moderate to severe mental retardation.
- Somatic illness requiring intensive special examination and treatment (can be admitted in a state of remission).
- Marked disorders of movement and coordination.
- Public hazard.

The acceptance of clients at assistance centres established by non-governmental organizations is usually decided by the centre/community management or leader. Primarily, persons are accepted with alcohol or drug dependencies. Admission requirements may differ in each community, e.g., a centre may take men only, or allow an entire family to stay, to assess whether the person is suitable for admittance to an existing community; some communities will accept clients experiencing withdrawal symptoms.

Types and characteristics of residential treatment unit

State hospital patients are given emergency medical assistance, access to a motivation program and the *Minnesota* 12-step program. In three hospitals, inpatient clients are invited to undergo medical and social rehabilitation. The service is provided to underage persons and adults with a diagnosed dependency on psychoactive substances. In one centre, social rehabilitation is based on the community therapy principle, while in the other two centres it is based on the medico-psycho-social rehabilitation of addiction.

Rehabilitation based on medical technologies is a medical-psycho-social rehabilitation of drug addiction, which is carried out under therapeutic community principles. It aims to achieve a person's rejection of the use of psychoactive substances; to improve health, promote the re-socialization into society and the development of a socially responsible personality. The methods used include: cognitive behavioural therapy, group therapy, individual psychotherapy or psychological counselling, formation of an environmental regime, family systems therapy. In addition, the client is offered counselling by an addiction specialist and any necessary medical

assistance. In all programs, the rehabilitation team includes a social worker, as well as services offered to improve education or job skills.

Basically, rehabilitation takes place in four phases: adjustment, active work, resolution of social problems and social reintegration. During treatment the patient is forbidden to use any psychoactive substance, initiate sexual relations, or to promote aggression. Rehabilitation time is 3, 6 or 12 months.

Table 11.5. Description of State funded programs

Riga Psychiatry and Addiction Centre	***Number of places:*** *1.5 (medical rehabilitation)* ***Treatment period:*** *12 months* ***Location:*** *A psychiatric and drug addiction hospital providing outpatient and inpatient assistance for drug addiction.* ***Program description:*** *psychosocial assistance for persons addicted to psychoactive substances. Basically cognitive-behavioural therapy, group therapy, psychotherapy. Program consists of four phases. The team: an addiction specialist, psychologist, medical nurse, social worker.* ***Integrated services:*** *counselling with a social worker; at client request it is possible after rehabilitation to apply for admission to a halfway house and for group therapy.*
Hospital *Ģintermuiža*	**Number of places:** 6 (medical rehabilitation) and 10 (social rehabilitation) **Treatment period:** 3, 6 and 12 months **Location:** A psychiatric and drug addiction hospital providing outpatient and inpatient assistance for drug addiction. **Program description:** voluntary medical-psychosocial rehabilitation in six phases. Medication-based therapy can be used. Basically group therapy, individual psychotherapy, occupational and environmental therapy. The team: social worker, carers, addiction specialist, psychotherapist, psychologist, work supervisors. **Integrated services:** acquisition of work skills, counselling with a social worker; possible to attend group therapy after rehabilitation.
Ludza regional hospital (program developed within the framework of an ESF project)	**Number of places:** 12 (social rehabilitation) **Treatment period:** 100 days **Location:** Ludza regional hospital **Program description:** voluntary psychosocial assistance. The team: duty physician, carers, addiction specialist, psychologist. **Integrated services:** acquisition of work skills, counselling with social worker, possibility of attending group therapy after rehabilitation.
Rehabilitation centre *Saulrīti*	**Number of places:** 35 (social rehabilitation) **treatment period:** 3, 6, 9 and 18 months **Location:** Rehabilitation centre, affiliated with addiction profile hospital. Located outside urban areas. **Program description:** psychosocial intervention, community therapy. The program comprises four phases and includes such elements as following a set routine and occupational therapy. The team: addiction specialist, psychotherapist, social instructor, psychologist, trainer. **Integrated services:** acquisition of general environmental education, counselling with social worker.

Case study

As part of a study, students of the *Saulrīti* rehabilitation centre were asked to complete questionnaires about the social rehabilitation program. Questionnaires were completed by 14 students at the centre, representing a proportion of all students. Respondents included 9 girls and 5 boys. Most of the juveniles were aged 15-16 years (n = 11); the others were aged 14, 17 and 18 years respectively.

For 12 respondents this was their first rehabilitation program, while two young people were in this program for the second time. In 10 cases the juvenile was attending the rehabilitation centre for using of alcohol, and 4 juveniles were attending because of drug use. However, in almost every case the juveniles had also used marijuana. 6 juveniles noted that prior to joining the program they had undergone a Motivation program, and one had completed the *Minnesota* program.

A total of 10 young people noted that they had joined the program because of pressure. Most often the pressure came from parents (n = 6). Among the responses there were also references to the judicial system and the family physician. With regard to the reasons for starting the program, the most frequent response was that the respondent would like a more normal life (n = 6) and positive changes (n = 5).

The juveniles were asked to rate the program on a scale of 1 to 10, where 1 denotes "the program does not work" and 10 denotes "a very helpful program." The overall evaluation score for the program was 7.43. The juveniles noted that most often they had been helped to refrain from using drugs or alcohol by a staff member (n = 9), a group organised by the institution (n = 8), followed by an addiction specialist (n = 5). The strengths of the program were noted as the team, educators and psychologists. Cited among the weaknesses of the program were the negative attitude of other juveniles towards the program, excessively strict control and alienation from the world (internet, phone). In general, almost all the juveniles noted that they were satisfied with the work of staff and that they could discuss a variety of problem issues.

Non-governmental organizations

The known non-governmental organizations that provide assistance to dependent persons operate on the community principle, and almost all the communes have been established at the initiative of churches or other religious communities. All non-governmental organizations place importance on the role of living by Christian values. For the most part, the communes are located in remote areas in rural homesteads. The daily routine of the commune

is modelled on a set daily regime, in which occupational therapy is an important element, e.g., the establishment of subsistence farming, or building improvement.

Table 11.6. Description of rehabilitation programs offered by non-governmental organisations

Kalna svētības kopiena (Mount Blessing commune)	***Number of places:*** *10* ***Treatment period:*** *2-3 years* ***Location:*** *a single centre remote from inhabited areas* ***Program description:*** *Religious commune. Important elements of therapy: prayers, following set routine and occupational therapy. Operational structure of commune based on the addiction commune "Senacolo" model. Accepts only men addicted to drugs or alcohol.* ***Integrated services:*** *counselling by social services staff, acquisition of work skills.*
Dieva ģimene **(*Family of God*)**	**Number of places:** 30 **Treatment period:** 12 months **Location**: three centres, remote from inhabited areas **Program description:** Religious commune. Important elements of therapy: prayers, following set routine and occupational therapy. Accepts men addicted to drugs or alcohol. **Additional services:** acquisition of work skills.
Neatkarība balt **(*Independence Balt*)**	**Number of places:** 35 **Treatment period:** 12 months **Location:** two centres on private property remote from inhabited areas **Program description:** Commune. Important elements of therapy: following a routine and occupational therapy. Accepts men and women addicted to drugs or alcohol. **Integrated services:** acquisition of work skills; cooperates with State Probation Service, counselling by psychologist and social worker available periodically.
Association *Saules sala*	**Number of places:** 15 **Treatment period:** 12 months **Location:** Rural homestead, remote from inhabited areas **Program description:** community therapy. Important elements of therapy: following a routine, occupational therapy, art therapy, psychotherapy groups, and Christian teachings. The team: addiction specialist, psychotherapist, social worker, attendant. Basically only accepts men addicted to drugs or alcohol. **Integrated services:** counselling with social worker, acquisition of work skills, halfway house.

Coloboration with other institutions

In practice, a rehabilitation centre cooperates with other institutions such as hospitals, family physician practices, municipal social services department; the State Probation Service, and is based on the client's individual needs and can range from simple counselling (Level 1) to integrated cooperation (level 4). However, no study has been undertaken on the levels of cooperation in providing rehabilitation services.

The most prominent cooperation with other services occurs in cases where a juvenile is being treated. This applies both to the commencement of a rehabilitation program, and to its suspension and conclusion. For example, if the juvenile refuses treatment, a decision is made regarding compulsory treatment. To achieve this, integrated cooperation takes place between the Orphans' court, the municipal social services department, municipal police and the addiction specialist. Furthermore, if a juvenile has arbitrarily left the centre and has not returned within 24 hours, this fact is reported to the municipal social services department. After completion of the program, and until attaining adulthood, the Orphans' Court and the municipal social services department continue to work with the juvenile. The integrated cooperation model is implemented on the basis of Cabinet Regulation No.726 which sets out arrangements for undertaking the mandatory treatment of a child.

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LITHUANIA

11. Residential treatment for drug users in Europe

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Additional information for this chapter is also available in the Annex 1 "Residential treatment for drug users in Europe"

11.1 Introduction

The definition of residential treatment included programs or treatment models, which provided therapy and other forms of support for drug users, including medical and social interventions, in settings where individuals stayed for a night. The main characteristic of such programs was that they met several needs of an individual, including but not limited to drug use, health, quality of life, improvement of social functioning,

This definition did not take into account inpatient detoxification (withdrawal management) only units, also programs, designated only for social support (e.g. night shelters) and drug treatment programs in prisons.

Data was extracted from facilities, which provided 3 types of residential treatment in correspondence with definition (the full list of the facilities is in the Appendix 1).

1. Residential programs, which included withdrawal management. They were based in 5 Dependence Treatment Centres (DTC) in biggest cities – Vilnius, Kaunas, Klaipeda, Siauliai and Panevezys. These residential programs aside from medical included services of social workers and psychologists.

2. Long-term residential psychosocial treatment programs. They were based on different approaches (individual and group psychological support, 12 step program, training of social and vocational skills, etc.). This group included 2 long-term psychosocial treatment programs based Vilnius and Kaunas DTC and 15 therapeutic (rehabilitation) communities (TC), most of which were private non-profit or non-governmental organizations (NGO).

3. Short-term residential psychosocial treatment programs. They were based in 3 Vilnius, Kaunas and Klaipeda DTC and often called Minnesota type programs. They provided services based on 12 step approach.

List of Acronyms used in this chapter:

CBT	Cognitive Behavioural Therapy
DTC	Drug Treatment Centre
ESFA	European Social Fund Agency
HBV	Viral hepatitis B
HCV	Viral hepatitis C
HIV	Human Immunodeficiency Virus
NGO	Non-governmental organizations
OST	Opioid Substitution Therapy
TC	Therapeutic community

11.2 History and policy frameworks

Till 1990 Lithuania was part of the Soviet Union. The topic of illegal drug use was not allowed for public discussions in the Soviet Union. The information about prevalence of drugs and the number of drug users was not for public. Behind the "iron curtain" the use of illegal drugs was rare. Most often medicines, such as morphine or codeine were used illegally. Drug

users usually were arrested and placed into prisons. After 1980, the extraction of opioids from locally grown poppy shells and poppy straws for injecting use became increasingly popular. The inpatient closed treatment unit for involuntary (mandatory) treatment was founded in Kaunas Psychiatric Hospital for withdrawal management and treatment between 1980 and 1990. The mandatory duration of treatment was 2 months.

After regaining of independence in 1990 Lithuanian addiction specialists were invited to visit various treatment centres in European Union and United States. After coming back from the visits, they have established Western-type treatment programs. Some treatment programs aimed at the achieving of abstinence. Others incorporated a spectrum of treatment goals, including opioid substitution treatment (OST) and harm reduction, which were highly controversial at that time. 1992 Vilnius DTC, which belonged to Vilnius municipality, opened the first voluntary specialised unit for drug withdrawal management, and later Klaipeda DTC opened specialised wards. 2000 m. when Kaunas, Siauliai and Panevezys DTCs were established, they opened specialised units for drug withdrawal management and psychosocial services.

1992 Vilnius DTC opened 28 day residential Minnesota program http://www.vplc.lt/stacionarinis_gydymas. Later Kaunas and Klaipeda DTCs opened these programs as well. While at first almost only alcohol dependent individuals were treated there, from 2005 the number of drug dependent patients in these programs started to increase.

In 1993 Lithuanian AIDS Centre under the Ministry of Health established a TC as a model for long term residential psychosocial treatment. The duration of treatment was 14 months and there were 13 beds. 1994 Vilnius DTC opened a unit for long term inpatient psychosocial unit with treatment duration 8 months and 10 treatment beds. For nearly 7 years these two long term residential programs were the only in the country.

The all above mentioned residential programs, including the drug withdrawal management (5), Minnesota type short-term psychosocial treatment programs (3) and long term psychosocial treatment programs were units (2) in health care institutions. From their foundation the staff of Minnesota type and long-term residential psychosocial treatment units had good links with drug user self-help groups (Narcotics Anonymous, NA). Most often 12 steps approach of NA was incorporated into all residential units for the purpose of the follow up treatment.

Since 2000 many former clients/patients, who graduated long-term psychosocial treatment programs, as well as confessional NGOs initiated therapeutic communities (TC) (also known as – rehabilitation institutions). Most often families of clients paid for services in TCs. Also governmental financial support was provided. TCs partially were funded from the government budget through the Drug Control Department under the Government of the Republic of Lithuania and partially from European Social Fund Agency (ESFA). Due to this financial investments, in 2012 there were 15 TC in the country, which provided long term residential psychosocial treatment, 10 of them received support from ESFA until 2012.

Residential programs, which included drug withdrawal management in 5 DTC provided also specialist psychosocial support (psychologists and social workers) alongside with medical care as well as introduction to 12 step program of NA. The duration of such treatment could be as long as 28 days.

Long-term residential psychosocial treatment programs (17 altogether) usually provided treatment from minimal duration of 8-10 months (in Vilnius and Kaunas DTCs) up to 12-18 months in TCs. The long duration (12-18 months) was still recommended by TCs. Nevertheless, many TCs during the recent years admitted that treatment duration could be dependent on the needs of the client. E.g. some individuals finished 6 month TC treatment course and that was considered as a satisfactory achievement. The duration of treatment in TC could be shorter, if client had been earlier in similar TC programs.

The duration of treatment in DTCs Minnesota type psychosocial treatment remained stable over the last 20 years and was around 30 days.

Non professional residential programmes existing in the country can be described in they are part of the national response;

5 DTC as health care institutions were regularly licensed on 5 year term by the National accreditation body under the Ministry of Health for provision of medical and psychosocial services: withdrawal management, short– and long–term residential treatment according the substance dependence treatment and rehabilitation standards, approved by the Ministry of Health .

Most of TCs had specialists (psychologists, social workers, etc.). There were no minimal standards for the specialist type and staffing level. The number of specialists could vary and in some cases specialists could be not available. Some TCs used confessional elements in their treatment philosophy and practice. Therefore, TCs differed from each other considerably in their level of professionality.

The recent (2012) Governmental Decree stated that from 2013 organizations, which would be willing to continue to provide social support, will be licensed for the services. Since 2015 it is expected that all organizations, which will provide psychosocial support (psychosocial treatment) with temporal housing for individuals dependent on psychoactive substances, will have an appropriate licence from national authorities.

As TCs were not licensed so far, there was not enough criteria to assess programs as non-professional psychosocial treatment programs or professional ones.

The data indicated, that in the last years:

- younger individuals applied for outpatient and inpatient treatment;
- individuals with shorter drug use history applied for treatment;
- there were more cases of multi-substance use;
- more individuals applied in relapse after previous attempts of treatment in TCs;
- residential programs became more flexible and took into the account individual needs of the client/patient (duration of staying, possibility to attend a school, vocational training at the Labour Exchange, to resolve his/her legal or health problems)

11.3 Availability and characteristics

1. Residential treatment programs, which included withdrawal management wee available in 5 DTC and had 57 beds.
2. The overall number of beds in long-term residential psychosocial treatment programs was 310.
3. Short-term psychosocial residential treatment programs (Minnesota type) were available at 3 DTCs. The number of beds allocated to drug users was up to 15 (most of patients were dependent on alcohol).

The majority of patients/clients were dependent on heroin. In 2011 the number of patients treated by a difference substance was the following:

1) Residential treatment programs with withdrawal treatment treated 467 opioid, 12 sedative, 31 amphetamine type stimulants, 2 cocaine 19 inhalant, 17 cannabis, 177 multiple substance users.

2) Long-term residential psychosocial treatment programs treated 362 opioid, 9 sedative, 36 amphetamine type stimulants, 16 cocaine, 1 inhalant, 2 cannabis, 161 multiple substance users.

3) Short-term residential psychosocial treatment program in Vilnius DTC treated 31 opioid users, 1 sedative, 2 amphetamine type stimulants, 1 cannabis, 17 multiple substance users (data from other DTC was not available).

TCs, where psychiatrist consultation was not available, had difficulty to report data on correct diagnosis.

Based on the collected data, it was possible to draw the following social-demographic profile of the typical patient/client of residential treatment: male, dependent on opioids, with secondary education, unemployed, with injecting heroin use history between 5 and 10 years. Females account for 30% of all patients/clients

Health care institutions (5 DTC) for all 3 types of the residential treatment required personal ID and referral from out-patient specialist (psychiatrist or family physician) with diagnosis. Contraindications for the residential treatment included serious infectious disease or physical conditions. Admission criteria for residential programs in DTC were the following: a patient met indications for treatment, agreed with program internal regulations, signed informed consent form.

Long term psychosocial residential treatment programs in TC indicated the following criteria: personal ID and absence of serious physical conditions. Referral from medical institutions, as most TC indicated, was not always necessary. Some TCs required a document from the psychiatrist or family physician to document that a person was dependent from psychoactive substances.

Residential treatment programs for withdrawal treatment used medical assistance, including buprenorphine, methadone, sedatives and other medications. Alongside, consultations from a social worker, educational events and introduction to 12 step programs were usual. Groups for social skills improvement were available. Individual and group consultations of psychologists were also available for patient education and training of relaxation techniques. Patients were tested on their HIV and HCV status.

Long-term residential psychosocial treatment programs applied the following approaches: 12 step program, training of social skills, motivational interviewing, vocational training, art therapy, cognitive behavioural therapy (CBT), family therapy, DAY TOP program.

Short term (Minnesota) programs applied 12 step program, consultations of psychiatrists, group therapy facilitated by psychologists as well as individual consultations. In case of co-morbid mental disorders, treatment was continued with antipsychotics or antidepressants.

Kaunas DTC applied psychosocial residential program for adolescents and youth of 10 month duration, combined with school education and social skills development, art therapy, etc.

OST (buprenorphine and methadone) was integrated into residential treatment of DTC. Opioid medications were used not only for detoxification purposes, but also for patients, who were a long time in OST and needed to stop concomitant use of sedatives, amphetamines or alcohol in the isolated conditions. Patients, who were finishing their OST, could also be placed in residential treatment for the termination of the OST. Some TC in their long-term residential psychosocial treatment programs, which had psychiatrists on their staff, applied short-term tapering with buprenorphine or buprenorphine/naloxone. In some cases slow tapering of methadone and buprenorphine (for several weeks or even months) was integrated with long-term psychosocial program under the generally abstinence-oriented treatment.

Patients on buprenorphine or methadone maintenance were very rare in Minnesota programs. Staff of these programs so far was resistant to have OST patients in their programs.

Collaboration and networking with other units and services depended on the number of professional social workers employed in residential treatment programs and their competence.

Residential programs, which included the withdrawal management and also residential Minnesota programs collaborated with other institutions most often on the 1st level. They provided contacts of self-help groups (NA) or other sources of support. Patients were motivated to attend these groups. Their primary focus was implementation of 12 step program. Motivation to continue treatment in TCs was provided often as well. Their contacts were given for patients to organize treatment for themselves.

In these programs, on case by case basis, usually under the request of patient, collaboration of the 2nd level was organized. In these cases social workers helped to register at Labour Exchange, mediated in referring patients to other medical institutions or found a place in the night shelter. Under the request of the client, these services were provided also in TCs, especially in sending to vocational training courses provided by the Labour Exchange.

The 3rd level of collaboration, meaning official joint activities with other institutions without sharing clients' documents, was usually implemented according needs of clients. Usually collaboration was implemented with the Labour Exchange, municipal units for social support, bailiff's offices in solving client's debts situation, and medical institutions. Collaboration on the 3rd level was more common in long-term residential treatment programs. The level and the quality of collaboration depended on how many professional social workers were employed in these programs, how well they could identify individual needs of the client and to work jointly.

The 4th level of collaboration, which included official exchange of documents of the client, was available in the long-term residential programs in implementing joint care of patients referred to treatment by the territorial Probation Inspections under the Ministry of Justice in implementing court-mandated treatment or with municipal Child protection services in implementing treatment for the drug dependent parents.

DTCs, as medical institutions shared medical information about their patients in accordance of the Ministry of Health regulations when patients were referred to psychiatric treatment, diagnosis and treatment of HIV, HCV, TB or treatment of complications injecting to family physicians, infectious and psychiatric hospitals.

11.4 Quality management

Substance dependence treatment and rehabilitation standards, which were approved by the Ministry of Health (2002), were implemented in DTC. They defined minimum requirements for the contents, duration, staff, which included psychiatrists, nurses, social workers and psychologists.

Hygiene requirements for the premises, medical procedures, etc. did not differ from the requirements, which were set by the Ministry of Health for all health care institutions. Each DTC as all other health care institutions under the regulations of the Ministry of Health had to implement internal medical audit group to ensure the quality of services. Internal audit group was responsible for service quality maintaining system, developed procedures and protocols of services, approved service target indicators, developed procedures of examining of complaints by patients, initiated inquiries into the quality of services and their effectiveness.

Drug Control Department under the Government of the Republic of Lithuania has published a Guide with recommendations to increase professionalized services of social workers, psychologists and medical specialists for TCs in 2008[76]. In 2012 there were no other national Guides, which regulated provision of the residential psychosocial treatment. The ministry of Social Affairs and Labour planed to develop regulation to licence residential treatment programs in 2013.

DTCs were obliged to staff residential treatment programs according the treatment and rehabilitation standards approved by the Ministry of Health (2002). They required that treatment should be delivered by psychiatrists, nurses, psychologists and social workers. The competence of psychiatrists and nurses was determined by the specialist competence descriptions (Medicinal Norms), approved by the Ministry of Health. Licensed health

[76] Auglytė Ž., Dragūnevičius K., Litvinienė J., Kriščiukaitytė R., Narmontienė J., Skučienė D., Subata E., Šumskaitė L., Žalimienė L. Asmenų, priklausomų nuo narkotinių ir psichotropinių medžiagų vartojimo, reintegracija į visuomenę ir į darbo rinką: socialinės atskirties problemų sprendimas. Darbo su priklausomais nuo narkotinių medžiagų asmenimis metodika// Narkotikų kontrolės departamentas prie Lietuvos Respublikos Vyriausybės. Vilnius, 2008

practitioners had to renew their licence for practice every 5 years. Since 2012 social workers had became obliged to undergo their regular professional licensing as well.

There were no national minimal standards for specialist qualifications or staffing levels for TCs.

In DTCs medical records were filled in accordance of the requirements of the Ministry of Health. Statistical information was provided according the approved procedures by the Ministry of Health. Internal audit groups of medical institutions had a mandate to evaluate the quality and effectiveness of different treatment services continuously and ensure the quality of services.

TCs, which were funded by ESFA filled documentation according Agency's requirements. On the national level for TCs there were so far no requirements for clients' files and documentation. Services which were provided for clients were documented according their internal regulations or in the free form.

DTC residential programs were funded from the state or municipal budgets according the planned indicators of the number of patients/day in the next year. Funding was not linked with the number and the quality of services provided. TCs, which were funded from ESFA filled their applications for funding according the requirements of the Agency.

11.5 Discussion and outlook

The number of treatment beds for residential treatment in long-term psychosocial programs has increased more than 10 times since 2000 (from 23 to 310). The number of organizations, which provided such treatment increased 8 times (from 2 to 17). Considerable funding from ESFA and state budget has been invested in the development of the long-term residential treatment and their services became significantly more professional during this period. The need for further development of the capacity of this type of treatment is not well known. On the one hand the monitoring of the existent long-term residential treatment and its effectiveness was not well examined. On the other hand, the out-patient treatment potential (pharmacotherapy, early intervention, psychosocial support, including motivational interviewing, CBT, and 12 step programs, were not fully implemented by the mental health care centres in their communities (municipalities) and in DTC in biggest cities. The access to outpatient treatment is still limited by the availability of funding.

After funding for TC from ESFA will finish in 2012, the model for the further funding of TC is not clear. 15 of 17 long-term residential treatment programs were so far not licensed. There were no national legal acts on the minimal requirements for the contents and quality of services, staff composition and staffing levels, requirements for the monitoring, evaluation of effectiveness and collaboration with other institutions. The monitoring of the residential treatment services was so far not adequately established. There was not enough information on how effectively ESFA funds were spent for the development of residential treatment. The cost-effectiveness analysis of funds invested was not carried out so far.

In DTCs 2 long-term residential treatment, 3 short term residential treatment Minnesota type programs and 5 residential programs which included withdrawal management were units within health care facilities. They met usual requirements for health care institutions. They were obliged to implement internal quality control systems and were monitored through established procedures. Unfortunately, funding for residential services and other services, as an exception from all other health care sector, was not associated with the number and type of services delivered. Funding was not bounded to the results and quality of treatment. Therefore, this model of funding was not stimulating further increase of the quality and cost-efficiency of services. The existing funding of DTCs according a fixed planned budget from state or municipalities budgets usually was not sufficient. Therefore, patients had to cover part of the

treatment expenses by the small fee themselves. Also additional funds were allocated from the State Patient Fund to fill the funding gap.

Residential treatment was potentially very important to some drug user groups, especially for those, whom the out-patient and community based treatment was not successful. The long-term residential treatment programs could be particular relevant for clients, which are socially marginalized and need longer time to recover from drugs damage to health, to learn social skills and stay in a protective environment. Other client group, which could likely benefit very much from long-term residential programs, are clients who have unfavourable/unstable family situation, e.g. with drug and alcohol use, mental disorders, physical and sexual abuse, etc. In general short-term and long-term residential treatments are likely to be beneficial more to amphetamine type stimulants, cocaine and cannabis users, were outpatient treatment is likely to be less effective.

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LUXEMBOURG

1. History and policy frameworks

1.1. History of residential treatment

The "Central Hospice" was the first institution providing residential care to persons living on the edge of society from 1855 onwards in the Grand Duchy of Luxembourg. In 1901 it turned into the "Maison de Santé" and admitted persons with psychiatric disorders. Since 1974 the "Maison de Santé" was renamed into "Neuro-psychiatric Hospital of Ettelbrück (HNP)".

In 1978, the first, and so far, the only national residential treatment centre for alcohol dependant persons, an annexe of the HNP, called the Centre of Useldange (CTU), was opened. At the same time, an increasing demand for drug treatment (not only detoxification) did emerge. In 1980, the Residential Treatment Centre of Manternach for drug addicts (CTM) opened its doors with a capacity of 18 beds. At that time, the CTM was a department of the HNP.

Simultaneously, in the beginning of 1980, a youth club of Hesperange (City near Luxembourg) took care of marginal groups and drug addicts. Thanks to a financial convention with the Ministry of Family, the youth club established a non profit association called "Kollektiv Spackelter" and implemented a residential treatment centre. This treatment centre was closed in 1984. In April 1984 a new NGO was created and conventioned by the Ministry of Health, called "centre d'action anti-drogue" Jean Baptiste de la Salle. The therapy centre was called "Schléckenhaus" with a capacity of 18 beds. Both treatment centres (CTM and "Schléckenhaus") offered individual and group psychotherapy as well as occupational therapy. In 1985, the CTM got a new directorate and a new multidisciplinary team and the concept was revised. A mix of psychotherapy with occupational therapy was offered, and the therapeutic program was adapted to the daily routine of life (e.g. therapy after work).

In 1986, the capacity of both residential treatment centres was not fully used and the need for two residential treatment centres was questioned. The "Schléckenhaus" treatment centre closed its doors and its patients were referred to the CTM.
In 1986 the first outpatient treatment centre called "Jugend-an Drogenhëllef" (JDH) opened in Luxembourg-City. The JDH also implemented the national methadone programme a few years later (in 1989).

In 1989 the CTM opened an outreach centre near the drug scene in Luxembourg City. A decade later (in 1998) the first methadone patients have been accepted in the CTM and its offer was expanded to systemic family therapy.

In 1998 the HNP became a public establishment of private law[77] and increasingly specialised in care provision for persons with psychiatric disorders, older persons with geronto-psychiatric disorders and persons with mental handicaps. The "Neuro-psychiatric Hospital of Ettelbrück (HNP)" was renamed to "Centre Hospitalier Neuro-Psychiatrique" (CHNP). Currently, 3 main

[77] Loi du 17 avril 1998 portant création d'un établissement public dénommé « centre hospitalier neuropsychiatrique »

services with different offers exist: the “Rehaklinik – Un der Uelzecht” (psychiatric rehabilitation of psychosis, dependence, alcoholism and psychogeriatry), the “Centre Pontalize” (elderly people health care) and “de Park” (socio-pedagogic accompaniment of mentally handicapped persons).

In 2003 the CTM launched an aftercare supervised accommodation offer. Until 2012, 30 housing units were created. In 2003, an outreach and guidance centre in Luxembourg City called “Alternativ Berôdungsstell” and managed by the CTM also opened. In 2006, an annexe was built on the CTM site with single rooms, mainly for clients with children.

Meanwhile, in 1989, a reform of institutional psychiatric offers was launched. The “Haefner report”[78] of 1993 recommended a decentralisation of psychiatric care based on, evidence-based interventions. The report also put forward the crucial role of social reinsertion offers helping patients to return to real life environment or to supervised extra-hospital structures (treatment, accommodation, job and leisure time). The “Rössler report” (2005)[79] was in line with the previous strategy, which can be summarized as follows: decentralisation, ‘dehospitalisation’, ‘destigmatisation’ and prevention. In this respect, since 2005, opened facilities for mentally ill persons as well as the paediatric and adolescent psychiatry have been implemented in the main hospitals of the 3 hospital regions. Besides, the placement of mentally ill persons has been ensured from then on by acute services of general hospitals. The tradition of 150 years to primordially place mentally ill persons in the CHNP ended at this time. The new mission of the CHNP was thenceforth the psychiatric rehabilitation. A decentralisation of related offers was furthermore developed and is currently still in progress.

The governmental declaration of 1999 defined drug dependant persons as ill persons in need of help in the first place. In 2000, the Ministry of Health was therefore assigned to coordinate the overall activities in the field of demand reduction and a governmental drug coordinator was appointed. Coordination and financial supervision of all state accredited drug services felt under the responsibility of the Ministry of Health.

1.2. Strategy and policy frameworks for residential treatment

The national drug action plan (2010-2014) includes a project of creation of a specialised post-hospital residential and medicalised stabilisation unit for drug dependent persons. The target group consists of drug dependent persons who have undergone previously a detoxification treatment in a regional psychiatric ward. This project originates from the recommendations of an expert working group from the Ministry of Health and has been implemented in the beginning of 2012. It is a short-term accommodation offer with a multidisciplinary care. The objective is a physical and psychological stabilisation of the drug dependent person after an acute phase. The concept foresees 12 to 14 beds for a duration of stay lesser than 1 month. The stabilisation unit offers day care, supervised activities and outgoings and an accommodation. This stabilisation unit is meant to discharging general hospitals, reducing waiting lists and providing for a better utilisation of resources.

[78] Gemeindepsychiatrie; Grundlagen und Leitlinien; Planungsstudie Luxemburg 1993; Rössler, Salize, Haefner, VIP-Verlag; ISBN 3-85184-004-6

[79] Psychiatrie Luxemburg; Planungsstudie 2005, Rössler, Koch ; Auftragsbericht, Ministère de la Santé, Luxembourg

In the framework of the application for "Recognized for Excellence" (EFQM), the CTM has defined a five year plan concerning its mission, its vision and values (in 2009). A Balanced Score Card was developed in order to collect indicators that are relevant for the policy and strategy. Regular meetings with the CHNP addiction sector (*filière toxicomanie*) as well as SWOT analyses allow the CTM to discuss and agree projects.
Strategic aims of the CTM are as follows (source: CTM EFQM qualification file 30/9/2010):

- enlarge the spectrum of services for the rehabilitation of drug-addicted persons,
- develop the aftercare services jointly with other actors,
- develop the collaboration with similar centres in the greater region (neighbouring countries),
- improve the therapeutic network by regular contacts and exchange and specifically with a national reference person system,
- evaluate all the services on a regular basis,
- train and involve employees continuously,
- improve the quality management system in order to assess effectiveness,
- renovate and adapt existing facilities for a modern and sustainable rehabilitation.

The budget of the CTM is managed by the central financing department of the CHNP. CTM-CHNP are depending on the National Health Fund (CNS). As the CTM is a department of the CHNP, which is legally speaking a hospital, its financing depends on the budget of the CHNP. The CNS negotiates each year individually with each hospital an operational budget according to a global or an anticipatory budgeting system. The State, by means of investment subventions, participates up to 80% in the modernisation, the accommodation and the construction of certain hospital infrastructures and heavy equipment. These investments are to be approved by the Minister of Health following a previous decision by the Permanent Commission of the hospital sector.

The authors of the study on the estimation of direct economic costs of policies and interventions in the field of illicit drug use (Origer A., 2002)[80] have accounted, among other tasks, all costs related to the functioning of the CTM for the year 1999. The total expenditures, including staff costs, travelling and subsistence expenses, and the total operating costs, reached 646,327 Euros in 1999.

The law of 28 August 1998[81] indicates that the Minister of Health is in charge of the coordination and planning of the hospital establishments. Each hospital establishment needs an authorisation for its creation, as well as an authorisation for its operation from the Minister of Health. Among other tasks, the "hospital plan" determines the sanitary regions, and assesses needs in terms of infrastructures, services and hospital beds. The "hospital plan" is based upon a *'sanitary card'* that is revised each 5 to 7 years. The sanitary card is an "annual snapshot" of national hospital services in the light of sanitary needs.

The CTM also depends upon the national PRN (Nursing Research Project), an instrument allowing to calculate staff needs in the health care domain. The PRN score builds upon the documentation of nursing activities.

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[80] Origer, A. (2002). Le coût économique direct de la politique et des interventions publiques en matière d'usage illicite de drogues au Grand-Duché de Luxembourg. Séries de recherche n°4. Point focal OEDT Luxembourg – CRP-Santé. Luxembourg.
[81] Loi du 28 août 1998 sur les établissements hospitaliers.

2. Availability and characteristics

2.1. National (overall) availability and accessibility

To date, the therapeutic centre “Syrdallschlass Manternach” (CTM - CHNP), a decentralised department of the CHNP Rehaklinik “Un der Ulzecht” in Ettelbrück, is the only national residential centre for drug-dependant persons at national level. As cited above, it was founded in 1980. The centre operates on the model of a therapeutic community for drug dependant persons. CTM admits up to 25 persons, including client on substitution treatment, prior to their admission (since 1998). Parents accompanied by their children are also admitted. The therapeutic offer includes social and professional reinsertion measures.

The CTM:

- offers the clients an appropriate and diversified medico-socio-psychological and ergo therapeutic treatment,
- helps clients to assume accountability for their behaviour as well as to improve capacity building in conflict resolution,
- aims to develop clients emotional, social and intellectual capacities, as well as their individual autonomy,
- encourages the resocialisation, professional and familial reinsertion,
- provides alternatives to the behaviour of drug dependent clients.

Each interested client can be informed about the therapy by contacting the outreach service of the CTM “Alternativ Berôdungstell” or by contacting directly the CTM. Then, an intake interview can be convened either alone, with the partner or with family members. Contact interviews are also organised in hospitals or in prison.

In 2011, the total team was composed of 19.5 FTE corresponding to 25 different collaborators (orientation and aftercare included).

In 2011, 57.9% (62.5% in 2010) of admissions of CTM have been new admissions. A total of 92.1% of clients were unmarried (single) and 38.15% were parent of at least one child. 11.8% of admissions have been transferred from the CHNP to the CTM and 40.8% have been transferred from regional hospitals. 7.9% have been transferred from the CPL (national prison) and 38.2% on demand from the client himself. 1.3% of the admissions came from another therapeutic centre. 73.7% (70.3% in 2010) of clients in therapy at the CTM underwent a methadone substitution treatment with the objective to reduce progressively their daily dose. A total of 23 persons have been present at the CTM on 31 December 2011. 44.8% of clients were over 30 years old, 32.9% were aged 26-30 years, 21% were aged 20-25 years and 1.3% were aged less than 20 years. 76.4% of clients were nationals, 13.2% Portuguese, 2.6% German, 2.6% Italian and 5.2% other nationalities.

Aftercare housing offers are also managed by the CTM. These are supervised housing offers for persons who have undergone treatment at the CTM. The level of the supervising offer can be modulated. These homes predominately situate in the east of the country and are focussing on social interventions.

The CHNP “Rehaklinik”, implemented in February 2012, is a multidisciplinary care for drug dependent patients for a period of 3 to 4 weeks in order to stabilise the psychological and

physical state in a medicalised stabilisation unit. Specific objectives are the stabilisation of the substitution treatment, the diagnosis and/or treatment of associated harms, the improvement of health after detoxification and an orientation towards a post-hospitalisation project in close contact to a national referent. The stabilisation unit offers a residential support, individualised activities and supervised outgoings. The target group consists of drug-dependent persons who have previously undergone a detoxification treatment in a general hospital. The stabilisation unit has a capacity of 15 beds.

Admission criteria are as follows:

- aged more than 18 years,
- negative urine drug test for non-prescribed drugs,
- stable physical and psychological state without signs of pharmacological intoxication, without signs of withdrawal from illicit substances and non prescribed drugs,
- medical certificate attesting that the patients state is sufficiently stable before admission.

2.2. Types and characteristics of residential treatment units

2.2.1. Common approaches;

The offer of the CTM is based upon individual psychotherapeutic sessions and group sessions. After two months, each patient gets a therapeutic planning which defines the duration of the therapy (varying between 6 and 15 months). The therapy plan is individually designed, defines therapeutic aims and regulates therapy agreements (for example personal themes to be dealt with, duration of therapy etc.). Regularly, these aims are re-discussed with the client and, if necessary, newly defined.

The admission criteria are as follows: the patient has to agree on the therapeutic concept and, previously to its admission, has to have undergone a detoxification treatment. He/she has to present a medical certificate attesting his/her general health status. He/she has to undergo a urine analyses and accept that the personal belongings are searched through. The patient has also to subscribe individual third-party insurance.

At the beginning of the therapy, the client is assigned a reference person from the group as referent person from the staff team, and as therapist. The community life is regulated by internal house rules.

The main house rules are:

- no violence
- no threat of violence
- no consumption of illegal drugs
- no consumption of alcohol.

The CTM works according to the principles of a therapeutic community which are based upon mutual help within the group (and by providing professional support). This method enables clients to develop and formulate their own needs, to get more autonomous, to progressively adopt more responsibility and to learn to recognize and respect limits.

Phase 1 is called motivation phase (duration about 8 weeks). The patient has to familiarise with the therapeutic concept, to get accustomed to the house and the group, to conform to rules and

to take distance from the drugs environment. Contact to the outside is limited. This phase is meant to create relations to the other group members and the staff team.
The therapeutic offer includes: individual interviews, thematic group sessions, gender specific group sessions, family therapy, ergo therapy, sports therapy, corporal and relaxation therapy, leisure time activities and learning support.
The client has to make an application for the next phase. After agreement of the group and the staff team, an individual therapy plan is established for the next phase.

Phase 2 is called development phase (duration about 4 to 7 months). The patient is invited to intensely participate to the therapeutic sessions (individual, group, as also family and couple sessions). The client has to learn to take responsibility for his own actions but also for his work, the rules and the other members of the community. If possible, she/he will now be responsible for a certain work plan/sector (kitchen, gardening, joinery, keeping of animals, household...). At the end of this phase the main focus is laid on external referral and the reintegration to social life.

Phase 3 is called detachment phase (duration about 2 to 3 months). It is the switch from a protected community life to a more autonomous life. Objectives are a reintegration to the employment market, organisation of leisure time outside the community and search for accommodation.

2.2.2. Typical mix/integration of services;

The CTM only admits patients who have previously undergone a detoxification treatment in a hospital. The CTM offers continuation of previous OST, individual psychotherapeutic and group sessions, gender-specific sessions, family therapy, ergo therapy (joinery, locksmithery, animal husbandry, gardening, kitchen work, housekeeping, landscape planning), recreational therapy (fitness, music, PC, darts, cultural visits, pedagogical activities), sports therapy (jogging, football, volley-ball, basket-ball, handball and swimming), relaxation and corporal therapy (shiatsu, massage, meditation, aromatic therapy, foot reflexology, autogenic training) vocational training (reading, arithmetic, orthography), life skills training, housing and employment.

2.2.3. Integration of OST in residential care;

The CTM is organised as a therapeutic community and admits patients who follow a methadone substitution treatment. In 2011, 73.7% of patients in therapy were on OST. Clients get their daily dose of methadone in liquid form either once or twice a day by a nurse. Once a month the multidisciplinary team decides on the opportunity to reduce the daily dose of the client and discusses the retained option with the client. The reduction of methadone to zero level is not the primary aim in the therapy concept. Drug screening tests are organised weekly, unheralded or on suspicion.

2.2.4. Typical levels of collaboration and networking;

A formal joint working agreement exists, which means that close cooperation with other units providing treatment, rehabilitation or complementary services is set up and is promoted.

The aftercare homes of the CTM offer 30 places. To be admitted, the client has to have stayed at least 3 months at the CTM. The concept also foresees procedures to get regular employment by and for clients. The client has also to pay a monthly rent (lower than common market prices). 1.5 FTE educators take care of clients.

In the framework of the European Foundation of Quality Management "EFQM", the CTM closely collaborates with the drug treatment centre "Schaumberger Hof". In 2010 a benchmarking convention was signed with the "Schaumberger Hof" (Saarland- Germany) and "Hanosiusmühle" (Rhineland-Palatinate- Germany).

3. Quality management

3.1. Availability of guidelines and service standards for residential treatment

The CHNP is a member of the alliance of Luxembourgish hospitals ("Entente des Hôpitaux Luxembourgeois – EHL"), which is the association representing the institutions of health from the acute sector (hospitals and clinics) respectively of the long stay care sector. The implementation of the EFQM model in hospitals, the management model developed by the "European Foundation for Quality Management", was decided by the EHL and the Union of Sickness Funds (Union des Caisses de Maladie - UCM) in 2002. This EFQM model was implemented in hospitals during 2004 and 2006. A progressive implementation of common performance indicators, quality indicators and result indicators is pursued since 2005. Also the grand-ducal decree of 13 March 2009 implementing the national hospital plan[82] sets up in each hospital an evaluation and quality assurance committee as well as a national quality assurance committee. The committee has to elaborate an annual report of good functioning and of the quality of services provided. Each hospital establishment has also to designate a quality coordinator. The committee has to follow the guidelines and recommendations of the national quality assurance coordination committee. The law defines the CHNP as a specialised establishment which has to proceed every 3 years to a widespread evaluation of the medical practices and accorded care as well as to proceed to a comparison with similar structures abroad and best practices.

The CHNP is an active member of the EFQM association and of the Luxembourgish Quality Movement (MLQ which was created on 5 March 2001) and promotes the logic of excellence and of the development of competency centres. The aim is to guarantee excellent services for the patients/clients, quality relations with partners and satisfaction of collaborators. A steering group for quality was implemented inside the CHNP.

In 2006, the CTM has received the Luxembourgish Award of Quality with the mention "on the route of Excellence". The CTM-CHNP was recognized for excellence in 2010 in the framework of the EFQM. Three assessors of the European Foundation of Quality Management have been evaluating the organization of the management, the human resources, the infrastructure, the processes and the results. On the basis of a quality report, the international team of assessors underlined the high level of organisation of the CTM and its culture highly oriented towards the client.

Since 2004, every two years, an EFQM self-assessment is conducted in the CTM trough the CHNP. A quality coordinator from the CHNP is actively implicated in the quality management of the CTM. Each year, the CTM organises a client satisfaction survey. Besides this, employee satisfaction surveys are conduced regularly. In the framework of the EFQM, the following indicators are evaluated since 2007: readmissions, clients on waiting lists, number of clients

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[82] Règlement grand-ducal du 13 mars 2009 établissant le plan hospitalier national et déterminant les missions et la composition minimales des structures d'évaluation et d'assurance qualité des prestations hospitalières et les modalités de coordination nationale de ces structures.

with ADHS, clients staying more than 6 months, liver function tests, methadone substitution, number of clients from the “Alternativ Berôdungsstell” and number of consultations, employee absence, right to care posts (PRN), hours of training of CTM employees, press articles, visits by external organisations, number of practitioners from nursing school, participation in community activities, suppliers, collaboration with partners, turnover CTM, turnover in apartments (aftercare), operating costs, mean duration of stay of patients and occupancy.

4. Discussion and outlook

4.1. Outlook

The Therapeutic Centre Syrdallschlass (CTM) currently shows high occupation rates. During recent years the offer of group therapy switched to an increasingly individualized psychotherapy offer. Individual needs of clients are increasingly focused on in the drug help system. Experts also notice a tendency towards more social, intellectual and educational deficits from the clients in therapy.

In 2008, a special working group of the Ministry of Health elaborated recommendations in the field of national needs in offers of treatments for drug dependent persons. The group recommended not to increase the number of beds for the CTM but to continue to diversify offers and modulate the different levels of care.

As the CTM is the only residential treatment centre in the Grand-Duchy of Luxembourg, an average of 120 patients per year undergo a therapy abroad. Related costs are covered by the social security scheme.

Related websites:

www.chnp.lu
www.schaumbergerhof.de
www.fachklinik-hanosiusmuehle.de
www.ehl.lu
www.cns.lu
www.ms.public.lu
www.legilux.public.lu
www.jdh.lu
www.relis.lu

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HUNGARY

11. RESIDENTIAL TREATMENT FOR DRUG USERS [83]

Overview

In Hungary the residential treatment[84] of drug users takes place in hospital addiction and psychiatry wards financed from the health fund and at drug therapy institutes financed from mixed (health and social) funds. The two types are not clearly distinguished from each other, from the aspect of control and financing they are not separately defined either. Traditionally and typically the programmes offered by hospital wards focus on the treatment of patients with psychiatric and alcohol problems, the treatment of drug users is less typical in these institutes. Partly due to difficulties of definition and partly because of the low level of treatment monitoring, no appropriate data is available to describe this form of residential treatment.
Because of the above this chapter is restricted to describing drug therapy institutes and the treatment provided by them. The TDI data presented contain both clients treated in hospital wards and those treated in drug therapy institutes.
Drug therapy institutes are organisational units that typically do not operate within the framework of the traditional system of hospital-healthcare institutes; they give a long-term therapeutic response to the multiple treatment demand of psychoactive drug users and patients suffering from behavioural addictions while living in a therapeutic community; and they are typically maintained by the church, NGOs or municipalities.

11.1. HISTORY AND POLICY FRAMEWORKS

11.1.1. History of residential treatment

In Hungary the first drug therapy institutes were established in 1986, before the change of the political regime, in a socio-political environment that was not open to civil initiatives and that refused to acknowledge the drugs problem. In this period the treatment system had no institutional healthcare or social answer to illicit drug use. The first two specialised outpatient treatment centres in Hungary were established at the same time as the first therapy institutes. Typically, these residential institutes were founded by the church. At the beginning the therapy programmes were set up based on the relationship with foreign sponsors, applying typically faith-based, closed and hierarchic models (e.g. Teen Challenge). The first few years were characterised by a lack of professional experience, appropriate forms of training and literature in Hungarian, and also by extremely limited finances. The first institutes financed their properties and operation exclusively from foreign grants; they could not rely on state resources

[83] The authors of this chapter are: Anna Péterfi, Ákos Topolánszky
[84] In this context “residential treatment” is defined as a range of treatment delivery models or programmes of therapeutic and other activities for drug users, including medical-psychosocial interventions within the context of residential accommodation. One defining characteristic of such programmes is that they address multiple treatment needs, including but not limited to the following domains: drug use, health, quality of life and wider social functioning.

at all. The state started to undertake responsibility only at the end of 1988, directly before the change of the political regime, first by issuing low-budget calls for tenders, and from 1989 in the form of small-scale social formula (per capita) financing. The latter represented the first stable national resource for the institutes.

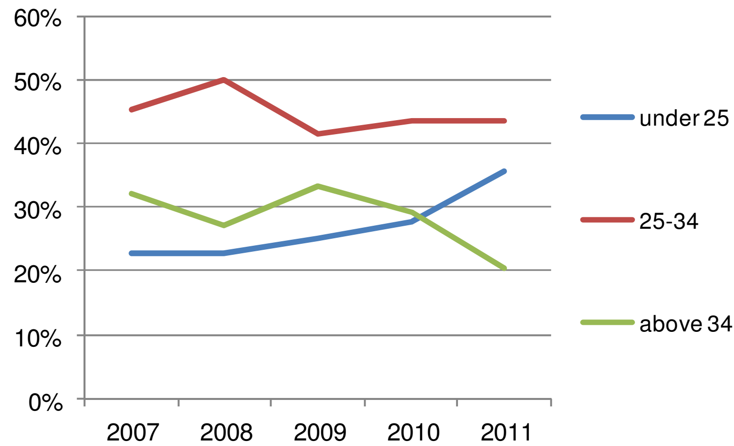
During the 90's the institutes slowly consolidated their status. In this period the controlling and regulating activity of the state increased. The Association of Hungarian Drug Therapy Institutes, an umbrella organisation for representing the interests of civil initiatives in the field, was founded in 1995, at that time with the participation of 7 therapeutic homes. Currently the association unites all Hungarian drug therapy institutes (a Romanian organisation is also among its members).

Between 2001 and 2004 the capacity of therapy institutes more than doubled (from 147 beds to 353 beds) within the framework of a central budget support programme, while the already operating institutes were modernised and they were able to enrich their therapeutic programmes. Currently there are 14 therapeutic communities, on the basis of the latest available data they operate with a total number of 353 beds (data from 2009, covering the capacity of the 13 operating institutes at that time).

By now the institutes have significantly extended their therapeutic services, and within their own organisation they have set up low-threshold, halfway and follow-up care services, opened towards new client groups, and have a significant network of institutional relations. Many of the currently operating therapy institutes are so-called third-generation therapy systems. The capacity, recognition and budget of therapy institute treatment have not changed or only slightly in recent years.

Concerning treatment demands, in the second half of the 80's drug users were admitted to residential treatment first of all due to the use of synthetic opiates (medicines containing morphine), natural opiates (poppy tea) and barbiturate derivatives. After the political change heroin addiction became increasingly more characteristic among the clients treated. From the second half of the 90's an increasing number of amphetamine users demanded treatment in the drug therapy institutes. In the past few years an increasing number of cannabis users and users of new psychoactive substances have been admitted to the residential institutes, and patients with behavioural addictions also appeared in greater proportions. The qualitative survey carried out by the National Focal Point in 2012 among outpatient and inpatient treatment units and harm reduction services (Csák 2012) pointed out that among the users of new psychoactive substances (primarily synthetic cathinones) treatment demand develops even after a few months of use. Residential treatment units, including drug therapy institutes, are also contacted by an increasing proportion of such clients, who are typically younger than their usual group of clients and are generally characterised by a lack of motivation, which is a burden for the institutes (Csák 2012). Some of the drug therapy institutes participating in the survey reported that they do not have the right responses for younger clients, as in the past typically older clients were involved in their programmes, following several years of drug use, who had to be prepared for reintegration into the labour market, while for young people a school has to be found to complete their studies. (For further details concerning the survey see chapters 4.3. and 5.) On examining the data on clients starting treatment, the same trend can be observed: there is an increasing proportion of clients under the age of 25, while an increasingly lower proportion of users above the age of 34 is being admitted to residential treatment.

Figure 1. *Breakdown of clients entering residential treatment*[85] *by age, between 2007-2011 (%)*



Source: TDI data collection (OAC 2012b); analysed by: NFP

When therapeutic programmes were launched 25 years ago, their duration varied between 14 and 24 months. The results of the survey carried out by Topolánszky et al. (2009a, 2009b) show that today the programmes have become significantly shorter, 15 months on average, although in half of the cases an individual therapy length is determined.

11.1.2. Strategy and policy frameworks for residential treatment

Strategy

Long-term, typically abstinence-oriented treatment has become a stable part of national addiction treatment. The first National Strategy relating to the period between 2000-2009, besides other types of treatment, was also aimed at improving inpatient treatment in respect of capacity, availability and the efficiency of treatment. Basically the Strategy determined two forms of inpatient treatment: hospital based inpatient treatment, aimed at detoxification primarily, and treatment provided by long-term therapy institutes, therapeutic communities. In the document the following three basic therapeutic aims were set concerning the theoretical framework of the treatment:

- achieving a life free from psychoactive substances,
- assisting in performing the various life activities with the greatest possible satisfaction,
- prevention of relapse and reduction of harms arising from drug use.

The new drug strategy adopted in 2009 did not become the governing policy document of the field (see chapter 1.3.), so it is not discussed in this report.

[85] The cases were selected (here and in the other parts of the chapter as well) according to the definition given at the beginning of the chapter (they do not include all inpatient cases), and they include both the clients treated in therapy institutes and in hospital wards.

Financing

With regard to the dual (health and social) nature of long-term treatment provided by them, the operation of drug therapy institutes is determined, regulated and supervised both by social and healthcare administrative bodies. Their operation is typically funded from state resources and, to a smaller extent, by the municipality (75.7% and 13.4%). All other sources of income represent an insignificant proportion (11% of the total budget) (Topolánszky et al. 2009a, Topolánszky et al. 2009b). The budget of the institutes can be planned well; as compared to other social services it is relatively stable even in the present economic situation.
Basically the institutes can access two types of financing. On the one part, in accordance with Act III of 1993 on social administration and social services, they might receive financing on the basis of their turnover, in respect of which they render an account to the Social and Public Guardianship Authority of the county Public Administration Offices in a daily electronic reporting system. From a professional aspect their operation is controlled by the regional methodology institutes[86]. Presently this support is not granted on a universal basis, which means that the institute does not always receive it based on its entire capacity (the total number of beds), because the available budget is limited, so the financing of capacities is distributed through the so-called regional compensation system. Among the standard support determined annually in appendix 3 of the Budget Act, within the category of the 'permanent residential care of people living with disabilities, of psychiatric patients and of patients suffering from addictions', in 2011 a fixed amount of EUR[87] 2,559/person/year was available for the rehabilitation institutes for persons suffering from addictions. This is equivalent to EUR 7 per person per day. In the past years social formula financing remained nominally the same, but in real terms it decreased significantly. For the financing of halfway house beds the institutes can use the so-called 'residential rehabilitation homes for psychiatric patients, patients suffering from addictions, people with impaired vision, physically disabled persons, mentally disabled persons and for people with multiple disabilities' per capita support (EUR 2,199/person/year).

The other main type of financing is the healthcare financing provided by the National Health Insurance Fund (based on Act CLIV of 1997 on healthcare), also reported electronically and based on accounting of so-called client days, where the institutes appear as independent, daily financed (quasi) hospital service providers providing chronic treatment. In this respect the permission is issued by the Public Health Department of the county Public Administration Offices, on the basis of the act on healthcare and its related decrees. This type of support constitutes the largest part of the permanent and stable income of drug therapy institutes. Presently the amount of the financing is calculated by multiplying the chronic inpatient base (EUR 20.2) by the 1.2 multiplier[88] determined for the institutes, which equals EUR 24.2 /person/day. For days when the client receives other health services as well, this type of financing cannot be requested.

Consequently, from the social and healthcare sources together, the maximum base funding that could be requested in 2011 for the treatment of a client in a drug therapy institute amounted to EUR 11,549/person/year (EUR 31.6/person/day).

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[86] On the basis of Decree 1/2000. (I. 7.) SZCSM of the Ministry of Social and Family Affairs on the professional tasks and conditions of operation of social institutes providing personal care, and on the basis of the professional programme of the institute, the Organisational and Operational Rules of the institute and the agreements concluded with the clients.
[87] The amounts in this chapter were calculated on the basis of the official exchange mid-rate of the EUR for 2011 (EUR 1 = HUF 277.7).
[88] Based on the categorisation of levels of treatment (in this case 3rd level of progression).

These forms of finance are supplemented by two other forms of support that can be provided in the framework of social employment with the aim to prepare clients for the labour market. Earlier this type of financing was provided as a formula financing, but since 2010 it has to be applied for, for three year periods, on the basis of a so-called task indicator (number of working hours financed). The task indicator is determined annually. The two forms of the support are the work rehabilitation fee (EUR 2.8) and the employment support for development and coaching activities (EUR 1.3). Personnel payments and the operation costs of work rehabilitation can be financed from this support. The clients' eligibility for support is determined by the National Medical Expert Institute.

The institutes receive further training support for their employees with a so-called social registration number. The amount of this was EUR 33.1/person/year until 2008, and between 2009 and 2011 it was EUR 5.9/person/year. However, this financing covers only a fraction of the costs of compulsory further training courses.[89]

The last financing element is tender financing (provided by the state, municipalities, for-profit sector), the amount of which dropped significantly in the past years because of the economic crisis. At the same time there are an increasing number of European Union support programmes first of all for supporting development, and to a lesser extent, for supporting operation.

11.2. AVAILABILITY AND CHARACTERISTICS

11.2.1. Availability and accessibility

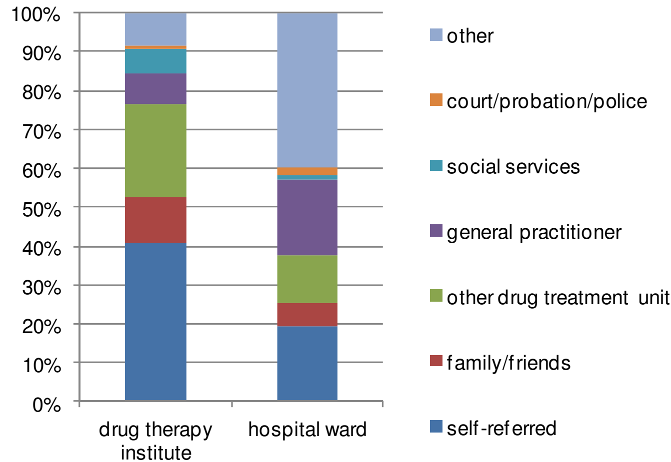
A referral is needed in order to be admitted to a drug therapy institute. Only drug users with valid health insurance can apply to these treatment units. In institutes for adult clients the minimum age is 16 years. As school is compulsory until the age of 18, the institutes are obliged to provide education for their clients under 18, most often this is solved in a private pupil status.

Drug therapy institutes must determine a so-called institute fee, but they are not obliged to collect it. Typically this fee is very low (generally around EUR 72/month), and generally only a few clients can pay it (10-20% of the treated patients on average).

In more than half of the cases (53%) clients get in touch with drug therapy institutes informally (by contacting the institutes on their own, in person or via their family or friends). In respect of institutionalised patient paths, specialised drug treatment units play a significant role (24%). This is partly due to that therapy institutes operate low-threshold services and outpatient treatment units (providing preparation for therapy or motivation strengthening services) within their own organisational framework, or they cooperate with such services in order to reach patients.
Basic treatment services (general practitioners) and the social treatment system play a less significant role in referring patients to the institutes.
In the case of inpatient hospital wards, source of referral shows a different pattern.

[89] The number of credits to be obtained in a period of five years is 60 in the case of employees with secondary qualifications and 80 in the case of employees with higher education qualifications. The fee of a course providing 13-15 credit points is EUR 90-108 on average.

Figure 2. *Breakdown of clients entering residential treatment[90] by source of referral in 2011 (%) (N=238)*



Source: TDI data collection (OAC 2012b); analysed by: NFP

The capacity of drug therapy institutes can be regarded as sufficient compared to the manifested treatment demand. On the basis of the survey carried out by Topolánszky et al. in 2009 (Topolánszky et al. 2009a, b), 3% of the clients treated during the year at the national drug therapy institutes (25 persons) were currently on a waiting list (2.1 persons per institute on average). The degree of capacity utilisation varied between 90 and 100%.

The drug therapy institutes altogether are able to accommodate 353 persons at the same time (on the basis of data from 2009). Within this capacity 269 beds were financed by the national Health Insurance Fund, and 340 beds were supported by social formula financing (the same bed can be financed from several sources).

11.2.2. Types and characteristics of residential treatment units

11.2.2.1. Therapeutic approaches

Regarding their organisational form, all of the 13 institutes[91] participating in the survey[92] carried out in summer 2009 about the operation of drug therapy institutes (Topolánszky et al. 2009a,

[90] The cases were selected on the basis of the definition given at the beginning of the chapter (not all inpatient cases are included).
[91] The Fordulópont Terápiás Intézet ["Turning Point" Therapeutic Institute] of „Forrás Lelki Segítők Egyesülete ["Spring" Association of Mental Helpers] that was founded in the year of the study could not yet participate in the survey.
[92] The survey covered 13 member organisations of the Association of Hungarian Drug Therapy Institutes (MADRISZ) performing an active therapeutic activity (drug rehabilitation) at the time of the data recording. The survey was commissioned by the National Institute for Drug Prevention.
During data recording the heads of the 13 institutes were interviewed, which means a 100% response rate. At the time of the data recording, in the 13 drug therapy institutes 253 clients were treated by 180 employees, among whom 146 employees and 240 clients were interviewed. Data recording with the heads

b), 4 institutes were operated by the state or by municipalities and 9 by non-governmental (NGO) institutes. Among the latter there were 3 private foundations, 2 associations, 2 public foundations, and 2 institutes maintained by a church.

In 2009 5 of the institutes were mixed – available both for men and women –, 7 were available only for men and 1 only for women. 2 institutes were for juvenile drug users.

The institutes are typically open towards groups with special needs. All of them admit clients from minority groups, the decisive majority of them admit people on probation, clients with a dual diagnosis, HCV positive people, homeless people and people suffering from behavioural addictions. 5 out of the 6 institutes available for women admit drug user mothers. At the same time, the institutes reported that they did not provide special services for these groups with special needs.

The majority of the institutes (10 institutes) could accommodate less than 25 people, the smallest institute was suitable for accommodating 10 people and the largest one could accommodate more than 100 people.

Group therapy, employment therapy and the therapeutic community model received the greatest emphasis among the therapeutic techniques applied by the institutes. On average, the 12-step model, pharmacotherapy and evangelisation were less emphatically present in the institutes.

Table 1. *Emphasis on the different therapeutic techniques in the therapeutic programmes offered in drug therapy institutes, on a 5-grade scale (1=not emphatic at all; 5=very emphatic) (2009)*

Therapeutic, counselling approach	Average	SD
Group therapy	4.92	0.277
Therapeutic community model	4.77	0.599
Employment therapy	4.62	0.65
Relapse prevention	4.38	1.502
Behavioural and cognitive therapy	4.38	1.121
Individual support, counselling	4.23	1.235
Motivation therapy	4.00	1.528
Sport and adventure therapy	3.92	1.32
Art therapy	3.38	1.325
Individual psychotherapy	3.15	1.676
Family therapy	3.15	1.625
Bibliotherapy, evangelisation	2.85	1.676

of the institutes was carried out by interviewers familiar with the field, typically applying face-to-face technique. The employee questionnaires were recorded by individual self-administered technique, while the client questionnaires were recorded by group self-administered technique. (For further details about the survey see chapter 8 of the 2010 National Report.)

12-step model	2.23	1.598
Pharmacotherapy	1.85	1.282
Aversive therapeutic methods	1.54	0.877

Source: Topolánszky et al. 2009a, Topolánszky et al. 2009b

11.2.2.2 Typical mix of services

See chapter 11.2.2.1.

11.2.2.3. Integration of OST in residential treatment

Only one of the Hungarian drug therapy institutes provides substitution treatment, and psycho-pharmacotherapy is applied in a three further institutes to supplement other elements of the programme. Three institutes named the Minnesota model as their governing or prominent therapeutic approach (Topolánszky et al. 2009a, b).

11.2.2.4 Typical levels of collaboration and networking

The drug therapy institutes are parts of the social and healthcare system. In practice there is a high level of collaboration based on referrals. The majority of the institutes identify themselves at the formal or at the integrated collaboration level. The majority of the institutes run low-threshold services or have an organised relationship with a low-threshold service provider (see the information relating to the source of referrals in point 11.2.1.). Typically they have organised relationships with hospital detoxification units too, of which there are only a few in the country. Clients who cannot be admitted are generally referred to other drug therapy institutes or to other treatment suiting their needs. The institutes usually maintain follow-up care services, halfway homes, care programmes, and they support self-help groups.

11.3. QUALITY MANAGEMENT

11.3.1. Availability of guidelines and service standards for residential treatment

Drug therapy institutes do not have specific regulations neither from the aspect of healthcare nor social administration. Presently drug therapy institutes must fulfil the minimal professional conditions of psychiatric rehabilitation. The specific minimum conditions relating to drug therapy institutes and juvenile drug therapy institute treatment are currently being elaborated.

Concerning guidelines for the residential treatment of drug users, the three healthcare protocols about the treatment of drug users (protocols describing the treatment of opiate, amphetamine and cannabis users) and the methodological letter describing methadone treatment are governing. Nevertheless, these govern the operation of the institutes only partly and indirectly. (For a detailed description of the rules of procedure see chapter 11 of the 2010 National Report.)

On the social side, the operational framework is defined by the condition system set down in 'the permanent residential care of people living with disabilities, psychiatric patients and patients suffering from addictions' (appendix 3 to the currently valid Budget Act).

There is no direct standardised outcome evaluation relating to the individual institutes or to the institutional system, neither on the healthcare nor on the social side, but some of the institutes perform internal evaluation and follow-up studies (Topolánszky et al. 2009a, Topolánszky et al. 2009b).

There is no direct connection between therapeutic performance or efficiency and financing[93]. Institutes that fulfil the formal operational conditions and regulations required in the legal acts receive financing.

11.4. DISCUSSION

From the aspect of the manifested treatment demands, the capacity of drug therapy institutes can be regarded as satisfactory, but referral to these higher-threshold residential treatment forms needs to be improved. Although the therapy institutes are open towards drug users with special needs (e.g. juveniles, women, pregnant women, dual diagnosis patients), they do not offer services tailored to these special needs.

11.4.1. Outlook

The therapeutic institutes do not have their own regulations relating only to their service segment, neither from the aspect of healthcare nor of social administration. The specific minimum conditions for drug therapy institutes and juvenile drug therapy institute treatment are currently being elaborated, which will also aid the clear organisational identification of drug therapy institutes. In connection with the standards and minimum conditions currently being prepared, it is an important issue how the level of financing changes in line with the changing of the regulation-compliance expectations. If stronger expectations (relating to employment, qualification, training, equipment, application, maintenance, etc.) are linked to decreasing financing, it may endanger the sustainability of operation.

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[93] The individual institutes define the efficiency criteria of their own therapeutic approaches differently.

MALTA

CHAPTER 11

RESIDENTIAL TREATMENT FOR DRUG USERS IN EUROPE

11.1 History and Policy Framework

11.11 History of Therapeutic Communities in Malta

Therapeutic Services for drug users in Malta were initiated during the mid 1980's.

In 1985, Caritas-Malta introduced a day programme for people with substance abuse problems. This was done after a number of staff members within Caritas returned from specialized training abroad. The project at the time was called 'Caritas Malta Rehabilitation for Drug Users'. This programme eventually developed into the first long-term residential treatment Centre in Malta. This took place in 1989 when the Day Programme eventually developed into the San Blas Therapeutic Community which is still run by Caritas to this day. The need was felt for residential services which could act as a crisis intervention centre for drug users who find themselves in situations of homelessness or are living in a chaotic environment; Caritas New Hope started a residential facility in 2004. The facility was originally meant to cater for male clients but eventually in 2009 another harm reduction shelter was opened to cater for the needs of female clients who found themselves in similar crisis situations. This programme eventually developed into a residential TC which caters solely for female clients, as previously, San Blas TC used to cater for both male and female clients.

In 1990, a former military hospital known as St. Mary's Hospital was converted and inaugurated as an orientation centre for people who were considering attending the San Blas Programme. During this time, state services for people with drug abuse problems was limited to medical related treatment which included in-patient treatment at Mount Carmel Psychiatric Hospital and the Detoxification Centre within St. Luke's General Hospital. For a short period of time between 1990 and 1994 the programme at St. Mary's; which later became known as 'Kommunita' Santa Marija', functioned as a fully fledged therapeutic Community which was independent of the Caritas programmes.

Following the publication of the Meli Report (1993), a new state agency, Sedqa was set up with the mission to offer therapeutic and preventive services related to drugs and alcohol abuse. Sedqa was inaugurated in June of 1994 and Komunita' Santa Marija was taken over by the new national agency. New staff were eventually appointed most of whom were sent for a training period at 'Communita' Incontro' which is one of the main TC's in Italy. About 10 years ago, Komunita' Santa Marija started to accept residents who also were concurrently serving a prison sentence. It is the only TC in Malta that integrates prisoners with non-prisoners at the same facility and that accepts female prisoners for admission into the programme. The Santa Marija TC is still operational to this day.

In 1989, a need was also felt to address the situation with drug use problems in the island of Gozo. A group of people met over a period of about six months to discuss the drug abuse

problem in Gozo. These discussions eventually led to the inception of the Oasi Foundation in 1991. In June 1992 the Oasi Centre was officially opened. In 1993, a study team was appointed to develop a strategy and action plan for the Oasi Foundation. By the end of July 1993, the study team presented a proposal for an integrated Oasi Substance Abuse Prevention Programme. It was recommended that Oasi should develop three distinct programmes that would respectively address preventive services, intervention and treatment and rehabilitation of drug and alcohol abuse. It was in November of 1998 that Oasi eventually opened its residential unit for the treatment of addiction. The residential Unit is situated in the centre of the island of Gozo and is still run by Oasi to date.

11.12 Strategy and Policy framework for residential treatment

In Malta there are currently three agencies which provide residential treatment to drug users. These three organisations are:

- Sedqa, which is the national drug agency and is funded completely by the government. Sedqa is responsible for running the Santa Marija residential TC.
- Caritas Malta, which is a non-governmental, Catholic Church run organisation which is partly funded by the government and operates the San Blas TC.
- Oasi Foundation, which is a non-government organisation also partly funded by the government, which provides residential treatment in the island of Gozo (though services are not restricted only to residents of Gozo).

Objectives of the programmes:
In this section the objectives of the agencies regarding residential treatment which are listed in agency documents are highlighted.

Caritas Malta: The agency offers residential services in the form of crisis intervention units (Male\female shelters) as well as a T.C (San Blas)

Male\female shelters mission statement:

To offer crisis interventions, and provide emergency shelter and sustenance to persons with drug dependant problems who are homeless or living in a chaotic environment not conducive to lessening drug intake.

San Blas T.C mission statement:

To offer beneficiaries who abused drugs the opportunity of receiving further rehabilitation on a 24-hour intensive residential basis within a safe and secure community setting.

In addition to the above statements, in its documents Caritas New hope states the criteria which need to be adhered to in order for a T.C to be considered as such.

The document states the following:

"There are certain conditions that must exist for a treatment program to qualify as a TC. The T.C. is a therapeutic environment characterized by the interactions of several factors. The major factors are the following:

1. There is a therapeutic working relationship between staff and residents;

2. The physical setting and how daily life is structured,

3. The rules or community norms,

4. The methods employed to shape and manage deviant behaviours.

5. The methods used to deal with psychological issues and the enhancement of self-awareness.

6. The tools used to develop self-competence and self-reliance".

OASI: The OASI Foundation has two main objectives which are related to drug treatment:

"To assist individuals who acquire the disease of addiction in their process of recovery and social reintegration, and
To give assistance to their families"

Funding:
Drug Treatment services in Malta are all funded by the government either in full or in part. Sedqa, which is a government agency that falls under the Foundation for Social Welfare Services (FSWS) receives its funds as part of the overall budget allocated to FSWS. The performance of the Santa Marija programme is monitored through the structures of the FSWS, in particular by the Board of Directors and the foundation's Chief Executive Officer.

On the other part, NGO's working within this field, namely Caritas and OASI are partly funded by the government through a formal agreement between the Agencies concerned and the respective ministry concerned with drug services. The Ministry currently responsible for drug rehabilitation\treatment services is the Ministry of Justice, Dialogue and the Family. This agreement is renewed every year and the amount of funds received is dependent on conditions which the agencies need to adhere to. Apart from offering services to drug users, these agencies through the agreement are bound to submit a self-evaluation report every six months to the Non Governmental Organisations Project Selection Committee (NGOPSC).

This report needs to be substantiated with supporting documents and documented evidence of the implementation or otherwise of the service outputs of the project which are listed on the formal agreement. The agencies also undertake to give a clear account of the expenditure and income of the project, which includes any contributions or fees or donations made by the service user. Because both Caritas and OASI are only partly funded by the government the agencies need to finance their programs from other sources of funding. These sources include donations and fund raising activities. The programs offered by Caritas and OASI are free of charge for the service users; however donations or contributions are accepted from those

clients who can afford to make such contributions. Those who cannot afford to contribute financially are still admitted to the services and provided with all the help and support which the agencies have to offer through their respective programmes.

11.2 Availability and characteristics

11.21 National Availability:

In Malta, there are a total of five residential drug treatment units, four in Malta and one in Gozo which are provided by the three agencies which were mentioned in section 1.2:

- Komunita' Santa Marija (Sedqa)
- Komunita' San Blas (Caritas New-Hope)
- Harm Reduction Shelter for male drug users (Caritas New-Hope)
- Harm Reduction Shelter for female drug users (Caritas New-Hope)
- OASI Residential Unit (OASI)

Note: There are a further two residential Units in Malta which cater specifically for drug users serving a prison term, and another Dual Diagnosis Unit which caters for drug users with mental health problems, which will not be covered by this chapter.

11.22 Types and Characteristics of residential treatment units:

11.22a Though there is a good working relationship between all three agencies which provide residential treatment in Malta, each agency has its own policies and criteria regarding the provision of residential treatment.

Sedqa: Sedqa's approach to residential treatment reflects that of traditional Therapeutic Communities, in which residents are assigned every day manual duties as the centre of the activities and with a strong cognitive-behavioural approach where all residents are held accountable for their individual actions with every action carrying its consequences. This is maintained through constant staff supervision and also among the residents themselves. Residents are also provided with individual attention through the allocation of a key-worker and specialized services of psychotherapy.

Caritas New-Hope (all residential units): Caritas's approach to residential treatment is also greatly based on the cognitive-behavioural approach. Residents are involved in the day to day running of the T.C. Throughout the duration of the programme, residents are provided with individual attention through the system of allocating a key-worker, professional counselling sessions and therapeutic group sessions.

Oasi: The therapeutic approach applied by Oasi is based on the 12 Step (AA/NA) and Minnesota Models. During their stay at the residential Unit, drug users are provided with group sessions and individual attention through individual sessions. The facility also makes use of informational talks, videos and reading material as part of the support and learning process for the residents.

11.22b The Santa Marija residential unit does not provide methadone treatment to residents entering the programme but provides detoxification to those who require such services through the in-patient unit which is also run by Sedqa. However, they sometimes have some residents with other kinds of substitution treatment, such as Suboxone or Subatex, although these are

kept to the minimum. Also, pregnant residents must retain any dose of methadone or substitution treatment as prescribed by the resident's doctor.

In San Blas T.C, residents admitted into the programme are required to be free from substitution treatment. This means that clients attending group sessions at the Community Services Unit need to be weaned off methadone or any other substitution treatment. Alternatively, those clients who are admitted to the Harm Reduction Shelter can take a methadone dose which does not exceed that of 40mg daily. In the event that a client is motivated to enter San Blas T.C., that client would need to be weaned off the methadone dose gradually while residing in the harm reduction shelter and prior to admission to San Blas T.C.

In the case of the female shelter, clients would ideally be on a dose of methadone not exceeding 20mgs daily or 2mg of suboxone before being admitted, however, in exceptional cases and/or crisis, this issue may be managed accordingly following a discussion on a case by case basis. Also, pregnant drug users in need of the services can enter the shelter and retain the dose prescribed by the doctor at the Substance Misuse Out-Patient Unit.

In the case of OASI residential services, clients in need of substitution treatment can be admitted whilst receiving Suboxone treatment.

11.22c In all of the residential services provided by the different agencies, clients are encouraged to receive medical care according to their needs. In the case of screening for infectious diseases such as HIV/AIDS, HCV, HBV, clients are referred to the relevant health services and/or to the Substance Abuse Out-Patient Unit. Whilst in residential units, clients also receive services such as motivational interviewing, relapse prevention, educational services and are also encouraged to be involved in leisure activities and sports organized within the TC's and sometimes even within the community. Clients in need of housing support are also helped during their stay at the residential unit so as to avoid any unpleasant situations once the client is back in society. Residents are also encouraged to seek employment before completing the residential phase of their respective programmes and support and training is also provided in collaboration with the Employment and Training Corporation (ETC) through various schemes and training courses that are locally available. Of important note is that family members of residents are also supported and are encouraged to engage actively in the process of treatment. This is done through the respective family units of the agencies.

11.22d Interagency collaboration:
As mentioned earlier in this report, all organisations within the country are committed to collaborate with other stakeholders working within the same field. A case in point to substantiate this is the fact that clients attending the Substance Misuse Outpatient Unit SMOPU or the Inpatient Unit (locally known as Dar L-Impenn) are both services which are managed by Sedqa, which is the national Drug Agency. However, clients currently using services from these Units are often referred to the service by agencies other than Sedqa. A policy that is in place is that in order to receive treatment from SMOPU a client needs to be referred by one of the available agencies. This measure was taken so that clients could be encouraged to engage with support and rehabilitative services in addition to receiving medical care for their drug use problems.

Another example of collaboration is also related to substitution treatment. An arrangement exists in which clients residing within the Harm Reduction Shelters run by Caritas can continue to receive medical support, as well as substitution treatment from SMOPU whilst in residential care. On the other hand, clients who need detoxification from drugs\substitution treatment prior

to being admitted to residential care are referred to the Inpatient Unit, 'Dar L-Impenn'. This service is used by all agencies who offer residential treatment.

Case conferences are also conducted between stakeholders and involve professionals from health services, social services and treatment providers. Another meeting which is regularly held is the Multi Disciplinary Team (MDT) meeting that takes place to discuss drug users who are pregnant

11.3 Quality Management

11.31 Availability of guidelines and service standards for residential treatment
Although agencies working in the field, particularly those receiving funding from the government, need to produce Output and performance reports as described in section 1.2, currently there are no national guidelines by which agencies are bound to perform. In this regard, the Department of Social Welfare Standards (DSWS) has this year (2012) produced a draft on the 'National Minimum Standards for Residential Treatment for People with Problems related to Drugs, Alcohol and Gambling'. This draft followed an addiction services evaluation "Service Users' Perception of the service delivered at Residential Homes that cater for People with difficulties related to drugs and/or alcohol", which was also conducted by DSWS. Reference to this particularly study is made in Chapter 5 of this report.

Since as described above national standards are not yet in place, policies related to staffing levels and minimum requirements for staff qualification remain at the discretion of the service providers which adopt their own criteria.

Staffing levels:
Sedqa:
Currently, Sedqa employs10 staff members within 'Komuita' Santa Marija' (KSM). These staff members consist of:

- A Unit Leader
- A Coordinator
- 8 care workers

It was brought to our attention that in the coming weeks, Sedqa is to open a new service called the "Assesment and Stabilization Unit". As a consequence, 4 care workers from KSM will be transferred to this new unit and the T.C is planning to reduce its full residential capacity to 15-18 clients.

Other professionals are involved in KSM, namely social workers from the Drug Community Team within Sedqa, Psychologists, psychotherapists and family workers. These professionals are involved in individual as well as group sessions at KSM.

Initially there were no staff minimum requirements, and most of the original staff compliment consisted of carers who were either former drug users themselves who had gone through rehabilitation or 'good and well meaning' persons mostly involved in voluntary work. Currently Sedqa requests a basic MCAST (Malta College of Arts, Science and Technology) qualification in Care-Work or a minimum of 6 Matsec 'O' level passes (including English, Mathematics and Maltese). Care workers are also encouraged to attend a course for care-workers which is offered at the University of Malta. The agency pays the fee for this course.

Caritas Malta:
The organization employs personnel within their residential services in the following order:

- Heads of Units 4 full time
- Facilitators 16 full time and 3 part time
- Night Shift workers/relievers 16 part time
- Receptionist 1 full time
- Secretarial 2 part time
- Employment Officer 1 part time

The organization's human resources section is responsible for recruiting and training of staff and is also responsible to upkeep Internal Policies and Procedures which need to be adhered to by all staff members. Specific guidelines according to rank within the organization are drafted. These policies and procedures specify in detail the job description of each position's duties and also provide guidelines for good working practice and in-house practice policies. The Human resources Section also assures that Performance Appraisals are held for staff members regularly every year.
Caritas also employs other professionals to provide alternate services both to clients as well as for the purpose of staff supervision. A number of volunteers also offer services in a variety of sectors. These positions are listed below.

- A psychologist
- 3 counsellor
- Creative Arts Teacher (Youth worker0
- 3 Educational Teacher (English Language, General and Art Teacher)
- A Trainee Psychotherapist

OASI:
The following staff members work within Oasi's residential unit:

- One Treatment Rehabilitation Manager (Social Worker)
- Three full time Treatment and Rehabilitation Officers (Psychology graduates)
- One House Manager
- One Medical Advisor (medical doctor)
- Eight Duty Officers (four of whom are qualified nurses)

11.4 Discussion and Outlook

11.41 Outlook
This section provides a picture of the trends in the demand for residential treatment. For the purpose of this section, data for each residential unit will be presented individually. Also, it is important to note that the number of clients was calculated, taking into account individual clients, as some clients may have entered residential services more than once in a given year, and hence it would not give a clear picture of how many clients will have opted for residential treatment (No double counting). Most of the agencies providing the necessary information for this chapter have been able to provide such data since 2005. Consequently, trends shown here reflect the last seven years, from 2005 to 2011.

Sedqa Santa Marija Residential Unit:

In Figure 10.1 below trends in treatment demand for Sedqa's Santa Marija Residential Unit are shown. It can be observed that there was a significant increase of 71.7% in clients making use of this residential unit between 2005 (N=60) to 2008 (N=-103), while in the following years, between 2008 and 2011 there was a steady decrease of 50.5% between 2008 when clients amounted to 103, and 2011 as the number of clients stood at 51 clients. Among the reasons cited by the agency to explain the decrease in demand for residential services, it was lately noticed that the profile of the 'typical' client has changed in such a way that they are becoming less chaotic and tend to have more stable relationships, have jobs and overall have less social problems, hence they may not need residential treatment. As a consequence the residential unit became more attractive to people serving a prison sentence. It was also mentioned that the agency is making a conscious choice of trying to support the client in the community when this is possible so as to prevent the effects of institutionalization, especially among those with dual diagnosis. Another factor may be that the programme was revised and made shorter.

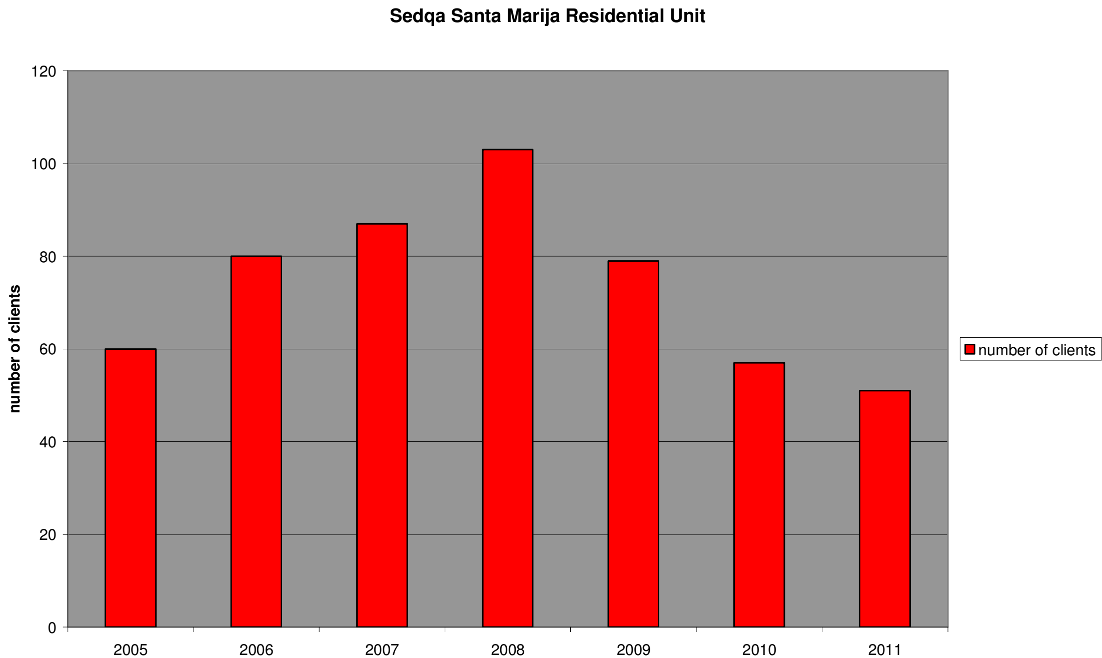

Figure 11.1

The table below shows the percentage of female clients who were residents in Santa Marija T.C. The proportion of female clients between 2005 and 2010 stood between 9% and 14%, with 2011 marking a significant increase from previous years, with 20% of the total clients being female residents. The average age of service user in 2005 was 26 years. In 2008 the average age was still similar to 2005 (26years) while in 2011 the average age increased slightly to 28 years.

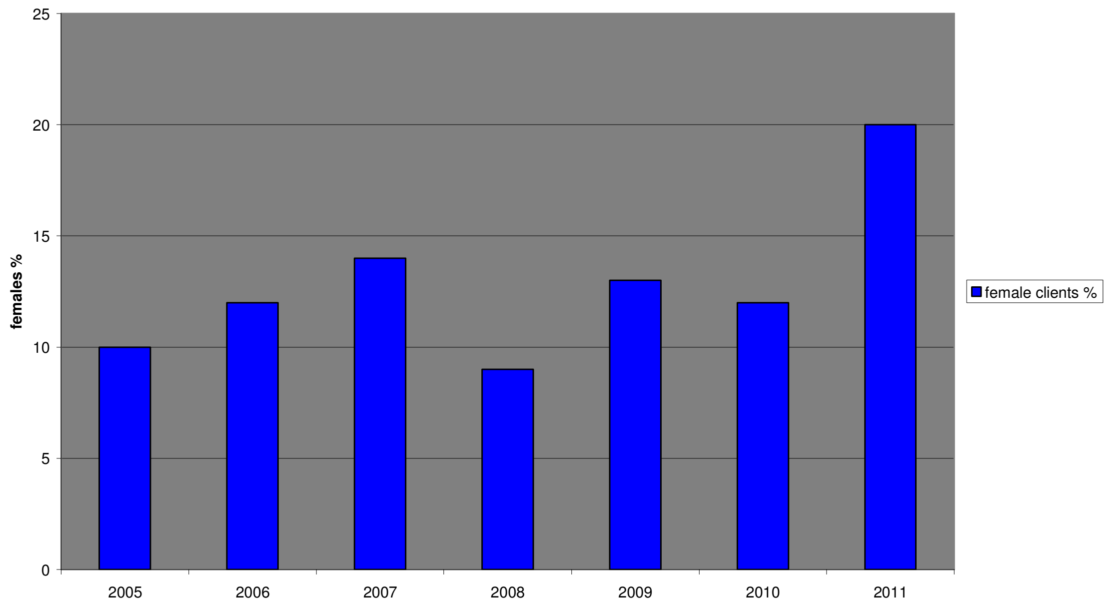

Figure 11.2

Caritas services:

San Blas Residential
In 2011, a total of 63 clients were in treatment in San Blas Residential, 4.5% less than 2010 (N=66), 11.2% less than 2009 (N=71), 18.1% less than 2008 (N=77), 14.8% less than 2007 (N=74), 12.5% less than 2006 (N=72) and 3.0% less than 2005 (N=65). Figure ( ) shows that since 2005 a steady increase in demand for San Blas T.C resulted up until 2008, which however was followed by an equally steady decrease from 2008 to 2011. It is however, important to note that before 2010, San Blas T.C offered services to both male and female clients. This all changed in 2010 when female clients started to receive services in the female shelter, which also serves as a T.C for women, instead of San Blas. If one were to take note of the figures shown in figure 10.3 the number of clients would increase by 17 in 2010 (N=83) and 20 in 2011 (N=83). This in fact resulted in an increase in demand for the T.C. The average age of service users in 2005 stood at 25 years, whilst it increased to 27 in 2008 and again increased to 29 in 2011.

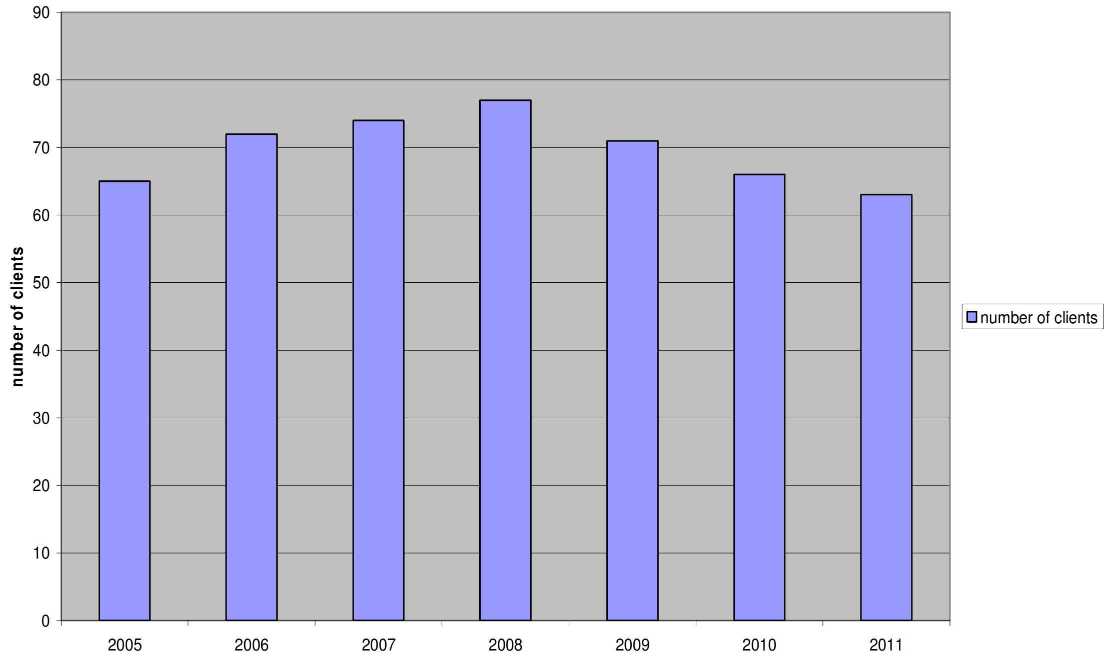

Figure 11.3

Caritas Male Harm Reduction Shelter

In 2011, a total of 82 clients were in treatment at the Harm Reduction Male Shelter, 4.6% less than 2010 (N=86), 7.8% more than 2009 (N=76), 1.2% more than 2008 (N=81), 22.3% more than 2007 (N=67), 2.5% more than 2006 (N=80) and 46.4% more than 2005 (N=56). The trends in demand for this unit seem to give a relatively stable picture on the number of clients who benefitted from the service with only 2005 and 2007 showing trends of any real decrease.

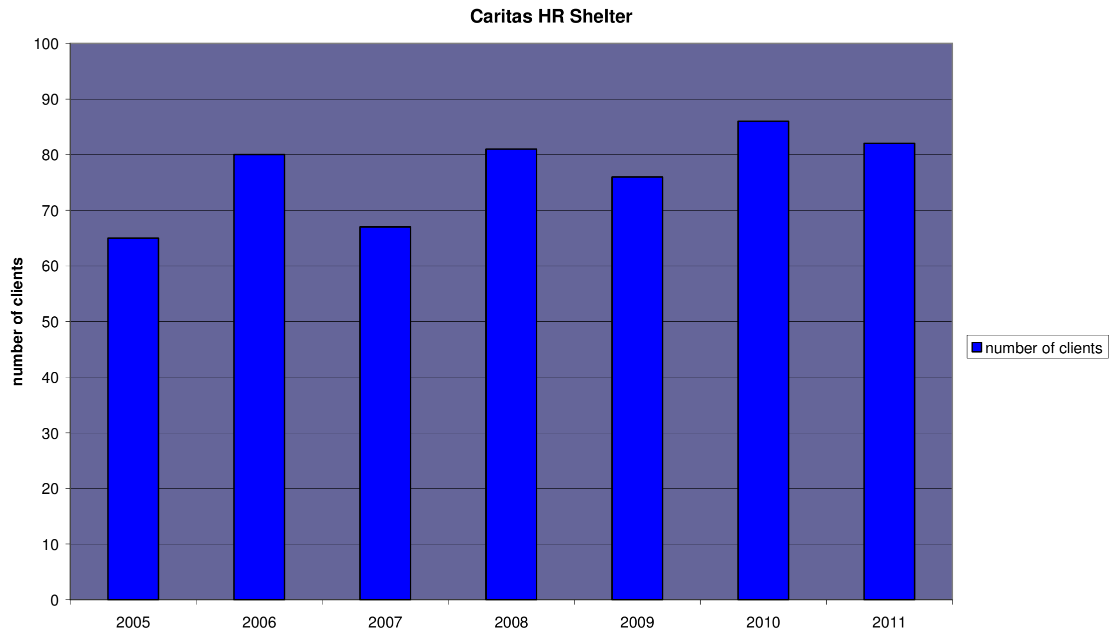

Figure 11.4

Caritas Female Shelter:
As discussed previously, since 2010, Caritas started to provide treatment for female clients in an entirely separate unit from San Blas T.C which now only provides services for male clients. In 2011, a total of 20 clients were in treatment at the Harm Reduction Female Shelter providing an average of 5 clients per month, 17.6% more than 2010 (N=17).

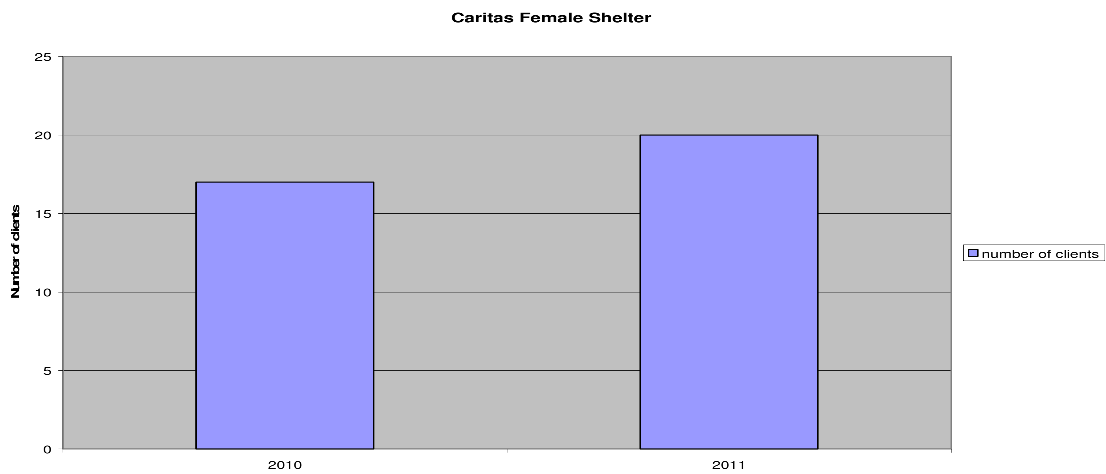

Figure 11.5

OASI Foundation:

In terms of number of clients, between 2005 and 2008 there was a fluctuation of demand for residential treatment from between 18 and 30 individuals. During 2009 the number increased to 34 clients, with a minor decrease in 2010. However in 2011, demand for residential treatment at OASI increased to 52 clients, approximately a threefold increase, since the 18 clients reported in 2005. The average age of service users in 2005 stood at 43.43 years, whilst in 2011 the average age decreased to around 30.62 years. Female clients entering residential treatment at OASI in 2005 amounted to 16.6%, whilst in the following years the proportion of female clients gradually increased and in 2011 stood at 36.5%.

It is important to note that residential treatment at OASI includes clients who have problems with alcohol use, so the number of clients attending the service may be slightly inflated due to some clients receiving services for alcohol. It is also important to note that in recent years, OASI also increased its capacity of beds in their residential units, which meant that they could also increase their intake of clients. Another development in OASI was that the residential phase duration was reduced from 3 months to a minimum stay of 6 weeks.

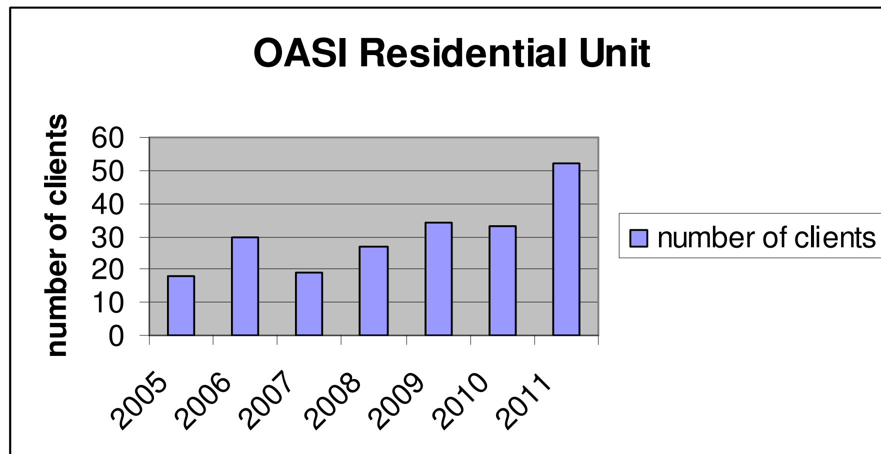

Figure 11.6

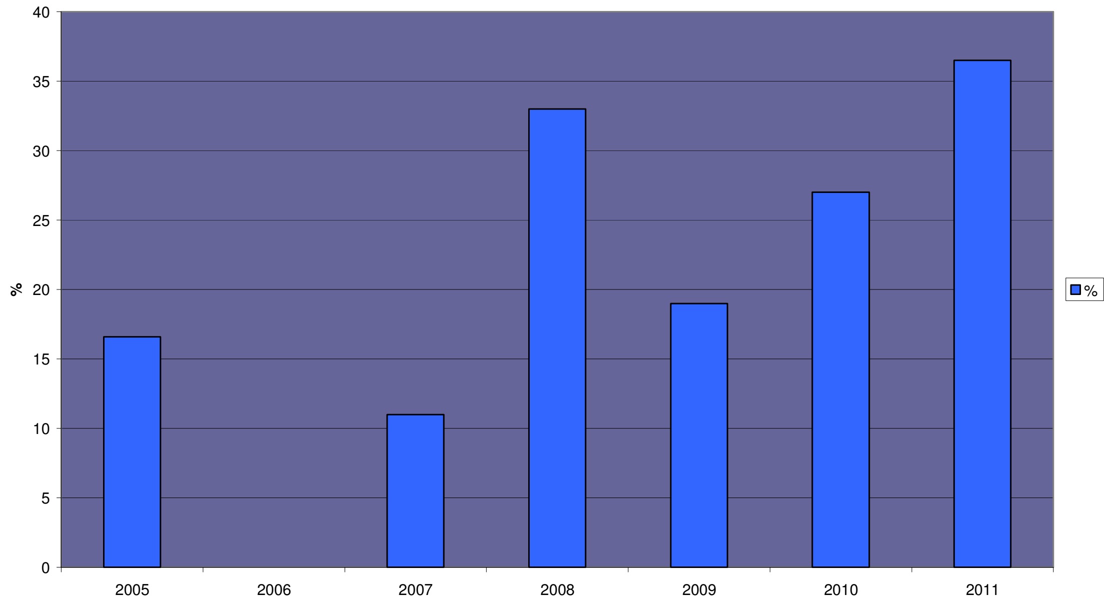

Figure 11.7

Specific Added value of residential treatment:

As reported in other national reports, demand for treatment in the country is predominantly attributed to problem heroin use. Although residential treatment is not the only option available to drug users, the benefits of this type of treatment's greatest strength lie in the fact that it creates an opportunity to provide, a safe and structured environment in which residents can be offered security, and individual attention according to that person's particular needs. Since residents are required to receive treatment for a number of months, it is also beneficial in that the person involved, together with staff will have more time to re/organize personal situations according to the need (housing, employment, relationship issues, social/poverty issues, criminal/judicial, health).

BACK TO TOP

AUSTRIA

Residential Treatment for Drug Users in Austria

This chapter discusses hospitals and other treatment centres that provide inpatient/residential addiction treatment to people suffering from drug addiction, and which are entitled to deliver this type of services as they have either been announced as an accredited treatment centre under Section 15 of the Narcotic Substances Act (SMG) or concluded agreements on cost coverage with the competent public authorities and institutions (judicial authorities, health and social care offices of the provincial governments, or social insurance funds). It is not possible to distinguish between inpatient treatment in the sense of treatment in hospital on the one hand and residential treatment in the sense of 'inpatient' treatment in centres other than hospitals, as competencies tend to overlap in Austria. The terms 'inpatient' treatment and 'residential treatment' are thus used interchangeably. However, this chapter does not include treatment units that only offer inpatient withdrawal treatment or that are specialised in other addiction diseases (particularly alcoholism), nor units that admit drug-addicted patients only for treating concomitant psychiatric diseases, in emergency situations or in exceptional cases (primarily (child and youth) psychiatric hospitals or departments). This also applies to the two special hospitals affiliated to the Stein and Josefstadt prisons. Treatment centres in which the patients have to bear the costs of treatment themselves are not discussed here either. However, this only concerns a small number of centres, for which data are available in neither a documentation system nor in reports on nation-wide or provincial addiction support and treatment services.
The information on which this chapter is based comes primarily from the Addiction Support Compass[94] and the 2011 activity reports drawn up in this context, provincial reports, publications by experts, annual reports, as well as websites of inpatient treatment centres and the Addiction and Drug Coordination Units of the individual provinces. In addition, the inpatient treatment centres were contacted directly to obtain further the required information[95].

1.1 History and policy frameworks

1.1.1 History of residential treatment

The history of Austria's addiction support and treatment system providing services to drug addicts has been described by Burian (2004), Eisenbach-Stangl and Burian (1998) as well as Eisenbach-Stangl et al. (2008). These publications distinguish between three stages:

» creation of the support and treatment system in the 1970s
» expansion in the early 1980s

94 See http://suchthilfekompass.goeg.at/ (website in German).

95 We are especially indebted to the experts in inpatient treatment centres who have provided input for this chapter.

» professionalisation, diversification and medicalisation as of 1985.

The start of the provision of drug-related support and treatment services in Austria goes back to the amendment to the Narcotic Drugs Act in 1971, which decriminalised the purchase and use of illicit substances for personal consumption, and introduced examinations by health authorities, as well as interventions in the context of social medical services. Prior to this, the only treatment available to people addicted to illicit drugs was provided by psychiatric hospitals, more or less unofficially, while specialised inpatient treatment did not exist. The 1970s saw the establishment of the first long-term treatment centres, as well as a special treatment unit for offenders needing withdrawal.

Under the amendment that entered into force in 1980, accredited treatment centres were established where drug addicts received support and treatment, and funding was provided by the Federal Ministry of Health. During the 1980s, the specialised inpatient treatment centres were expanded. Simultaneously, outpatient centres were established which, in contrast to the services in the past, pursued an approach of accepting drug-assistance. However, withdrawal and abstinence continued to be the primary goals of treatment. This slightly changed after substitution treatment was officially introduced in 1987. In these years, the institutions of the health-care system became important players and were also involved in the implementation of the principle of treatment instead of punishment. Since 1986, the Ministry of Justice has also provided funds for treatment in centres not affiliated to the judicial system. By the end of the 1980s, the treatment capacities of these centres were twice as high as those linked to judicial authorities.

According to Eisenbach-Stangl et al. (2008), the rapid expansion of treatment capacities in the 1980s, without adequate coordination of structures, resulted in dissatisfaction among staff, competition between rivalling groups, high staff fluctuation, strikes by patients, as well as suspension of managerial staff. Hauser and Haller (1988) state that during this time, the therapists whose personalities had initially dominated addiction treatment and in the individual drug treatment units tended to be replaced by a generation of well-trained professionals who understood themselves as providers of services rather than leaders.

Since 1985, the treatment system has been characterised by a stronger orientation towards the needs of clients, the increasing professionalisation of both doctors and other drug therapists, as well as diversification and medicalisation (see Eisenbach-Stangl and Burian 1998, and also Burian 2004). According to Eisenbach-Stangl et al. (2008), the diversification of residential treatment in the 1980s primarily resulted from initiatives by a few persons in leading positions, while hardly any data on which to base changes in the system were available.

Eisenbach-Stangl and Burian (1998) write that as of the 1990s, goals such as social adjustment by substitution treatment and harm reduction have, in addition to withdrawal and abstinence, gained in importance.

As Eisenbach-Stangl et al. (2008) describe it, in the 1970s the situation in the inpatient/residential treatment centres was characterised by small resources and the mainly unofficial nature of the services provided, which required much improvisation and personal commitment. The leadership style and treatment approaches of the 1980s are described as insufficient, and problems with regard to maintaining boundaries between staff and clients became apparent, as well as negative effects of power structures. In the 1990s, medical approaches to the treatment of addiction, as well as maintaining professional boundaries, were becoming increasingly relevant, while relationship aspects (empathy) were considered less important.

Information regarding the development of take-up of services is scarce as DOKLI (see Chapter 5.3) has provided data as of 2006 only. According to DOKLI, a total of 1 617 persons were undergoing residential treatment in 2006, with 1 403 patients entering treatment in that year. In

2011, the corresponding figures are 1 993 and 1 526, respectively.[96] The percentage of people treated in the context of treatment instead of punishment continues to be high.

1.1.2 Strategies and policy frameworks for residential treatment

The **current policy framework** of inpatient treatment is defined by the addiction or drug strategies, plans and policy papers of the individual provinces (see also SQ32 and SQ27). Furthermore, the provinces' structural plans and psychiatry plans are relevant in this context. In recent years, several provinces have updated their addiction and drug strategies/plans/policy programmes. Information on updates in Tyrol, Salzburg and Styria, as well as the current restructuring of the Vienna addiction and drug services network (SDHN) is provided in Chapters 1.2 and 5.2. The new policy developments in Carinthia and Lower Austria have been described in last year's report (GÖG/ÖBIG 2011c). A commonality of all strategies, plans and policy papers is that they point to the need for a diversified range of treatment options. Burgenland and Salzburg, however, primarily focus on outpatient services, and the small number of clients from these provinces who require inpatient treatment can visit treatment centres in other provinces. Also worthy of mention is that the goal of Vorarlberg's drug policy programme is to offer immediate support to any client who is willing to start treatment (Amt der Vorarlberger Landesregierung 2002). Under the slogan of 'treatment now', clients are to be referred to an adequate (inpatient or outpatient) treatment centre within a maximum period of 48 hours.
Funding of addiction treatment has already been discussed in the 2010 report (GÖG/ÖBIG 2010a); therefore only the most important aspects are listed here.

» Under Section 16 of the Narcotic Substances Act, the Federal Ministry of Health may provide funds for the operation of centres or units that provide treatment and support services to persons misusing drugs, provided that federal funds are available in accordance with the Act on Federal Financing as amended. Such funding is only granted if other territorial authorities (provincial and municipal administrations) also provide adequate amounts of funding. The Ministry of Health provides funding only to service providers that have been examined in accordance with SMG Section 15 and announced as accredited service providers in the Federal Collection of Statutes (BGBl). In addition, residential treatment centres may also obtain funding from the province concerned.
» Treatment centres that have hospital status usually receive financial resources through provincial funds (Federal and Provincial Governments, social insurance funds) and performance-oriented hospital financing[97], or financial support by provincial and municipal governments. During the first few days of their stay in hospital, copayment by patients may be required.
» Cost coverage on a case-by-case basis is provided by reimbursers such as the Provinces, social insurance funds or the judicial system, in accordance with lump-sum or daily-rate agreements. The cost borne by the judicial system

96 Please note that not all treatment centres described in this chapter have been registered in the DOKLI system and that changes may have occurred in the course of time.

97 Funding linked to the provision of a defined range of services.

(treatment instead of punishment, SMG Section 41), is based on the reimbursement schedule of the Austrian Insurance Fund for Civil or Public Servants.

The legal basis and applicable guidelines differ in the individual provinces, or different authorities are in charge (e.g. welfare v. health care authorities). For instance, in Upper Austria, addiction treatment[98] is defined as a complementary service in accordance with the Act on Equal Opportunities, with a particular focus on temporary housing for people who need psychosocial care (Schwarzenbrunner, personal communication). Section 4 of the Act on Equal Opportunities defines personal requirements for eligibility for these services (addiction treatment and temporary housing). In 2010, these services were provided to a total of 470 Upper Austrians (in Upper Austria and other provinces) and funded accordingly (Amt der OÖ Landesregierung 2011). The total cost was EUR 9 573 921 and was financed through the Welfare Department. In Upper Austria, addiction treatment services are also cofinanced by the Health Department (EUR 62 500 in 2010). In 2011, a quota system for treatment places was introduced, i.e. Upper Austria provides funding for a maximum of 55 places at a time, run by a total of nine service providers (Schwarzenbrunner, personal communication).

In Vienna, the second-opinion principle was introduced in 2009, i.e. an additional examination is required in order to verify and confirm the indication for inpatient treatment (SDW 2012, see also Chapter 5.2.2).

Carinthia's drug support and treatment services have registered an increase in refused applications for cost-coverage by the Province (Drogenkoordination des Landes Kärnten 2012). The developments regarding the restriction of cost-coverage to six months by the judicial authorities are described in Chapter 9.4 (see GÖG/ÖBIG 2011c).

As a matter of fact, cost coverage continues to be a problem and many experts emphasise that a solution is urgently needed (i.e. cost-sharing between provincial and federal authorities and different sectors).

1.2 Availability and characteristics

1.2.1 National (overall) availability

Table 11.1 provides an **overview** of specialised services in Austria that deliver residential addiction treatment to addiction patients and meet the criteria described in the introduction to this chapter. The majority of centres listed has been announced in accordance with SMG Section 15. Here, one needs to take into account the fact that, due to the reform of the Vienna addiction and drug services network, since mid-2012 the Baumgartner Höhe Social Medicine Centre/Otto Wagner Hospital has no longer been providing rehabilitation services in the context of addiction diseases (see Chapter 5.2.1).

The individual treatment centres greatly differ in size. The largest number of treatment places is provided by Grüner Kreis, in nine different houses. In 2011, Grüner Kreis delivered residential treatment to a total of 599 clients (including 12 children (Rohrhofer, personal communication).

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The social report focuses on treatment and housing services for addicted people (including alcohol addiction), provided by specialised centres, the cost of which is borne by the Province of Upper Austria (i.e. not by social insurance funds or the judicial system).

Map 5.2 in Chapter 5.2.2 shows the regional distribution of these specialised treatment centres in Austria. One must not, however, forget that people addicted to drugs, may in principle receive inpatient treatment all over Austria. However, in practice eligibility for treatment depends on agreements concluded between reimbursers (including the provincial health and welfare offices) and the treatment centres.

Table 0.1:

Residential addiction treatment centres in Austria, status, number of places and clients treated, in 2011

Province	Name of treatment centre	Location, year of establishment	Owned/run by	Legal structure	Accredited under SMG Section 15	Number of beds/places (total number available to addicted patients)	Number of addicted clients treated in 2011
C	Oikos – Haus 10	Klagenfurt, 1995	Oikos association	Non-profit association	√	19 (+3 for assisted external housing)	10 women, 53 men
LA	API, Mödling long-term treatment unit (special hospital)	Mödling, 1980[1]	Anton Proksch Institute Genesungsheim Kalksburg Foundation	Non-profit foundation	√	39 (+22 for residential aftercare services)	26 women, 89 men
LA	Zukunftsschmiede Voggeneder GmbH	Pressbaum, 1993	Zukunftsschmiede Voggeneder GmbH	Private limited company	√	88	42 women, 219 men
LA	Grüner Kreis – Binder (youth welfare services)	Mönichkirchen, 1992	Grüner Kreis – association for the rehabilitation and integration of addiction patients	Private association	√	20	59 women, 2 men
LA	Grüner Kreis – Waldheimat (youth welfare services)	Mönichkirchen, 1994	Grüner Kreis – association for the rehabilitation and integration of addiction patients	Private association	√	20	60 men
LA	Grüner Kreis – Marienhof (special hospital/ youth welfare services)	Aspang, 1989	Grüner Kreis – association for the rehabilitation and integration of addiction patients	Private association	√	63	36 women, 90 men
LA	Grüner Kreis – Ettlhof	Lichtenegg, 1988	Grüner Kreis – association for the rehabilitation and integration of addiction patients	Private association	√	14	31 (2010)
LA	Grüner Kreis – Berghof	Thomasberg, 1988	Grüner Kreis – association for the rehabilitation and integration of addiction patients	Private association	√	15	20 men

LA	Grüner Kreis – Meierhof	Aspang, 1991	Grüner Kreis – association for the rehabilitation and integration of addiction patients	Private association	√	20	9 women, 48 men
LA	Grüner Kreis – Treinthof	Krumbach, 1985[2]	Grüner Kreis – association for the rehabilitation and integration of addiction patients	Private association	√	16	7 women, 21 men
LA	Grüner Kreis – Villa	Krumbach, 1987	Grüner Kreis – association for the rehabilitation and integration of addiction patients	Private association	√	20	50 men
LA	Ybbs/Danube treatment centre –psychiatric hospital	Ybbs/Danube	Vienna Hospital Association (KAV)	Public hospital	√	n.a.	n.a.
UA	Erlenhof treatment centre	Prambachkirchen , 1981	pro mente Upper Austria	Non-profit association	√	18 (+7 in external shared housing)	23 women, 37 men
St	Grüner Kreis – Johnsdorf	Fehring, 2003	Grüner Kreis – association for the rehabilitation and integration of addiction patients	Private association	√	80	11 women, 170 men
St	Walkabout treatment centre (special hospital)	Kainbach/Graz	Hospitallers Order of St. John of God Graz-Eggenberg	Private centre		20	64
St	*ubuntu* (Ubuntu and ReethiRa residential houses)	Voitsberg, 2004	*ubuntu* association	Private association		28[3]	n.a.
T	Haus am Seespitz – short-term treatment for addiction patients	Maurach, 1997	Therapienetz GmbH	Non-profit limited company	√	20	11 women, 41 men
T	K.I.T association	Schwaz	K.I.T association	Association		n.a.	n.a.
VB	Carina treatment unit of Maria Ebene Foundation (special hospital)	Feldkirch-Tisis, 1984[4]	Maria Ebene Foundation	Non-profit foundation	√	15	23 women, 40 men
VB	Lukasfeld treatment unit	Meiningen, 1995	Maria Ebene Foundation	Non-profit	√	16	30 women, 80 men

	of Maria Ebene Foundation (special hospital)			foundation			
V	API, Department V (special hospital)	Vienna, 1990	Anton Proksch Institute (API) Genesungsheim Kalksburg Foundation	Non-profit foundation	√	6	24 women, 37 men
V	Schweizer Haus Hadersdorf (SHH)	Vienna, 1998	Schweizer Haus Hadersdorf GmbH (Protestant Orphan Care Association and WOBES Association)	Private centre	√	35 (+45 for decentralised treatment)	37 women, 115 men
V	Baumgartner Höhe Social Medicine Centre, Otto Wagner Hospital, Department for Drug Patients, Treatment Unit [5]	Vienna	Vienna Hospital Association (KAV)	Public hospital	√	20	n.a.

n.a. = not available. [1] Already established in 1972 but at a different location. [2] First house of Grüner Kreis (which had already been founded in 1983). [3] Total for the two houses, a maximum of 50% of patients in each house is in OST, the rest of the places is, in part, also used by people with drug problems. [4] From 1980 to 1984, both alcohol and drug addicts were treated at the Foundation's hospitals (two different departments). [5] As of mid-2012, rehabilitation services in the context of addiction diseases have ceased to be provided.

Sources: Addiction Support Compass, 2011 activity reports by the Section 15 treatment centres (Ministry of Health), websites of the treatment centres, and Friedl (personal communication); graphic representation: GÖG/ÖBIG

Patients are **referred** to residential treatment either by the preparation unit of the treatment centre (see also Chapter 11.2.2), other addiction support and treatment centres (especially drug advice centres) or the judicial authorities. As a rule, admission to residential treatment is possible if both indication for treatment and motivation on the part of the patient can be established, if the question of cost coverage is settled and if physical withdrawal has been completed. Treatment centres that run their own withdrawal departments deliver withdrawal treatment themselves after cost coverage has been ensured, and they also admit patients who have undergone withdrawal elsewhere and turn to the centre for further therapy. In addition, in a number of centres, exclusion criteria such as age or need for care have been defined (see Table 11.2).

The **available places** for residential treatment have for many years been regarded as insufficient. For instance, in 1993 Brosch and Juhnke pointed to capacity problems resulting in extremely long waiting times of several months. Since then, the situation has improved as addiction treatment services have been diversified and expanded further. Several centres report that waiting times are virtually non-existent, but this usually means only after it has been ensured that a client meets all requirements and that the issue of cost coverage has been settled. Often, a preparatory phase is deemed necessary, during which the above questions are examined as well. However, several treatment centres still have long waiting times (e.g. eight months for men and six to eight months for women at the Carina treatment unit and nine months at *ubuntu*. The reasons given for long waiting times or long preparatory stages, in addition to those listed in Chapter 11.1.2, include:

» small centres with few places, long duration of treatment and few drop-outs;
» interruption on the part of clients during the preparatory stage;
» individual factors, e.g. attempts to find the best possible composition of the therapeutic group;
» patients in situations of crisis, for whom free places are reserved, or who should/must be given priority on the waiting list;
» applications for admission from other provinces or even from abroad.

1.2.2 Types and characteristics of residential treatment units

At first glance, the **common approaches to treatment** seem to be similar at most treatment centres. All of them offer residential psychotherapy, combined with sociotherapy and occupational therapy, as well as organisation of spare-time activities. The fact that the clients are living together during residential treatment, as a therapeutic community, is a specific part of therapy in almost all centres, but considerable differences are apparent with regard to the relevance that is attributed to this component. For Grüner Kreis, the only Austrian centre that is a member of the *European Federation of Therapeutic Communities (EFTC)*, the therapeutic community is a pillar of residential treatment, and the community of clients addicted to drugs is

deemed to be a key element of treatment[99]. Other centres such as Schweizer Haus Hadersdorf and the Mödling long-term treatment unit run by API explicitly regard themselves as providers of inpatient psychotherapy, but also use elements of the therapeutic community approach, e.g. clients undertaking certain tasks, self-help settings without therapists, and the involvement of experts (Spirig, personal communication; Preinsperger, personal communication). The Walkabout treatment centre focuses on orientation towards relationships and contacts among the entire team, but (former) clients do not explicitly play an active role in the treatment process (Friedl, personal communication).
At almost all centres, psychotherapy is used for treating addiction-related disorders, in both individual and group therapy settings. However, group therapy can only be offered if the number of clients is large enough: e.g. Walkabout cannot always provide this type of therapy; while therapy oriented towards disorders such as trauma psychotherapy, and borderline therapy always takes place on a one-to-one basis (Friedl, personal communication). A wide range of methods are used, and many centres do not specialise in one orientation or method but decide which approach to pursue on the basis of the clients' needs. The following methods are applied:

» depth psychological/psychodynamic methods: psychodynamic approaches (API), analytical methods (Grüner Kreis, Zukunftsschmiede Voggeneder, Ybbs hospital); object relations psychodynamic therapy for borderline-type clients (Lukasfeld), guided affective imagery (Grüner Kreis), hypno-systemic therapy (Carina);
» humanistic-existential approaches: existential analysis (Walkabout, Carina), person-centred (client-centred) therapy (Grüner Kreis, Ybbs hospital), integrative Gestalt therapy (SHH, Walkabout, Grüner Kreis, Ybbs hospital);
» behavioural approaches: behaviour therapy (SHH, K.I.T., Carina);
» systemic approaches: family therapy (SHH, Erlenhof, Grüner Kreis, Walkabout) and couple therapy (SHH, Erlenhof, Haus am Seespitz, Zukunftsschmiede Voggeneder).

Additional forms of therapy that are also offered include body psychotherapy (Lukasfeld, Grüner Kreis), music therapy (Lukasfeld, Haus am Seespitz), psychoeducation (Lukasfeld, Walkabout), occupational therapy (Oikos, Grüner Kreis, Walkabout), logotherapy (Walkabout) and trauma psychotherapy (Walkabout). Gender-related group sessions as well as group therapy focusing on specific types of disorders (e.g. anxiety) may sometimes complement the range of psychotherapies. The approach that *ubuntu* pursues differs from the other centres, as the focus is on trauma pedagogy (based on the 'stressless trail to independence'), delivered in both individual and group settings[100].
The practical side of sociotherapy and occupational therapy depends on the individual centres and ranges from forestry and farm work (including animal husbandry) to cooking and catering, and creative work (e.g. pottery, bookbinding). The goals pursued are to detect and further talents, to learn new skills and abilities needed for responding to real-life situations and coping with everyday life after therapy (e.g.

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99 Further information on long-term inpatient treatment and the treatment system of Grüner Kreis is given in its publications and on http://www.gruenerkreis.at/ (in German).

100 For further information on this approach see http://www.ubuntu.or.at/ (website in German).

stamina and frustration tolerance), as well as to promote self-awareness and to build self-confidence. Finally, practical skills are trained to help clients become fit for work. The spare-time activities offered in the context of treatment include sports and cultural activities, while experience-based approaches are also frequent. This is aimed at encouraging clients to spend their spare time in a sensible and enjoyable way, to become aware of their bodies in a new way, to gain a new understanding of themselves and to build self-confidence.
In Austria's residential treatment centres, **typical elements of treatment** include:

» psychotherapy
» occupational therapy (learning life skills)
» medical diagnosis, advice, counselling and treatment, as well as voluntary testing and vaccination for infectious diseases
» clinical psychology diagnosis, advice, counselling and treatment
» psychosocial advice and counselling (regarding debts, social insurance and labour law questions)
» health promotion services such as nutrition education, health education, relaxation techniques (e.g. autogenic training)
» sports programmes (e.g. football, volleyball, long-distance running, climbing, ski touring, hiking)
» spare-time activities (e.g. dramatics, painting, sculpturing, dancing, creative writing)
» vocational orientation, further training programmes (e.g. literacy courses, foreign language courses, computer courses, preparation for external apprenticeship exam, vocational training in catering).

At treatment centres for young people, the clients may continue their school education and prepare for external school-leaving exams. Those centres that admit parents with their children offer play therapy for the children. A number of centres (e.g. Grüner Kreis) also employ clients in transition jobs or as key workers.
Many inpatient treatment centres have both **clients** who start treatment voluntarily and clients who have been referred to the centre by the judicial authorities to undergo a compulsory treatment. Table 11.2 and Chapter 5.3.1 provide additional information on the target groups of the treatment centres, as well as on characteristics of treated clients.
Regarding specific subgroups, several treatment centres are explicitly oriented towards diversity, many of them use integrative approaches, while others offer specialised treatment programmes within the centre (e.g. Grüner Kreis runs a programme for patients with dual diagnoses) or in separate units (e.g. *ubuntu* has one house for women and one for men). Many centres do not admit certain groups of clients (see Table 11.2), for instance persons suffering from acute psychosis. According to Friedl (personal communication), admitting such persons might work if the other clients were informed about the special situation of the person in question, and if it were possible to refer them to a hospital at short notice in the case of emergency (e.g. from the Walkabout treatment centre to Sigmund Freud Psychiatric Hospital).
At all centres, the typical **course of treatment** is that after being admitted the clients and therapists jointly draw up a treatment plan in which personal targets are defined.

Usually, treatment consists of several stages: during the first stage, no contact with others outside the centre is permitted, as the clients are supposed to focus on themselves and on life in the therapeutic community. In the course of time, external contacts can be established and intensified, while the clients undertake certain tasks and functions within the community.

Table 0.2:

Centres providing residential addiction-related treatment in Austria, target groups, duration of treatment and form of treatment, in 2011

Province	Name of treatment centre	Duration of treatment (months)	General target group (with drug addiction[1])	Specific target groups (with drug addiction)	Target groups excluded from treatment	Form of treatment
C	Oikos – Haus 10	6–18 months	Young people (over 16), young adults and adults	Couples, mothers/fathers with children, pet owners, persons in OST only towards the end of the reduction phase and under specific conditions, persons with additional alcohol or medicine addictions	Minors (aged under 16)	Long-term treatment comprising 5 stages, stage 5 (assisted housing outside the centre) as a variable stage after completion of residential treatment
LA	API, Mödling long-term treatment unit	6 or 12 months	Young people, young adults and adults	Persons with multiple diagnoses (severe psychiatric problems or personality disorders)	Minors (aged under 16), persons with care needs (including wheelchair users), acutely suicidal patients, persons needing acute inpatient treatment at a psychiatric or somato-medical hospital department	Long-term treatment
LA	Zukunftsschmiede Voggeneder GmbH	1–12 months	Young people, young adults and adults	Persons with physical disabilities	Persons with insufficient language skills; persons with severe mental disabilities that preclude psychotherapy, acutely suicidal patients, persons needing acute treatment of somatic diseases, care needs, pronounced intellectual disabilities	Short-term, medium-term and long-term treatment

LA	Grüner Kreis – Binder	3–18 months	Women (young people, young adults and adults)	Mothers with children	Clients with care needs, acutely suicidal patients	Short-term and long-term treatment as well as inpatient crisis intervention
LA	Grüner Kreis – Waldheimat	3–18 months	Men (young people and young adults)		Clients with care needs, acutely suicidal patients	Short-term and long-term treatment as well as inpatient crisis intervention
LA	Grüner Kreis – Marienhof	3–18 months	Young adults and adults	(Single) parents with children, mothers/parents undergoing opioid substitution treatment, persons with multiple diagnoses, persons requiring permanent inpatient care	Clients with care needs, acutely suicidal patients	Short-term and long-term treatment as well as inpatient crisis intervention
LA	Grüner Kreis – Ettlhof	3–18 months	Men (young adults and adults)		Clients with care needs, acutely suicidal patients	Short-term and long-term treatment as well as inpatient crisis intervention
LA	Grüner Kreis – Berghof	3–18 months	Men (young adults and adults)	Persons suffering from non-substance-related forms of addiction	Clients with care needs, acutely suicidal patients	Short-term and long-term treatment as well as inpatient crisis intervention
LA	Grüner Kreis – Meierhof	3–6 months	Young adults and adults	Current drug users, persons motivated to start substitution treatment	Persons not undergoing OST, persons who have not yet undergone partial withdrawal; persons with care needs	Residential substitution and reduction treatment
LA	Grüner Kreis – Treinthof	3–18 months	Young adults and adults		Persons with care needs, acutely suicidal patients	Short-term and long-term treatment as well as inpatient crisis

						intervention
LA	Grüner Kreis – Villa	3–18 months	Men (young adults and adults)	Persons with multiple diagnoses, persons requiring permanent inpatient care	Persons with care needs, acutely suicidal patients	Short-term and long-term treatment as well as inpatient crisis intervention
LA	Ybbs/Danube treatment centre – psychiatric hospital	3 months	Young adults and adults	Persons with multiple diagnoses (severe personality disorders)	n.a.	Short-term treatment
UA	Erlenhof treatment centre	5–15 months	Young adults and adults	Mothers with children (minors)	Acutely suicidal patients, persons showing acute symptoms of psychosis or mania, persons suffering from dementia or severe intellectual disabilities; violent persons	Long-term therapy comprising 3 stages, and interval therapy comprising 5 modules
St	Grüner Kreis – Johnsdorf	3–18 months	Young adults and adults	Persons with multiple diagnoses; persons requiring permanent inpatient care	Persons with care needs, acutely suicidal patients	Short-term and long-term treatment as well as inpatient crisis intervention
St	Walkabout treatment centre	3 months	Young adults and adults	Persons with multiple diagnoses	n.a.	Short-term treatment comprising 3 stages
St	*ubuntu* – Ubuntu and ReethiRa residential houses	18 months	Adult men (aged 18 to 30) at Ubuntu house; women (aged 15 to 30) at ReethiRa house	Persons with various types of problems and indications	n.a.	Long-term treatment comprising several stages, continuation of substitution treatment for up to

						12 months
T	Haus am Seespitz – short-term treatment for addiction patients	6 months	Young adults and adults	Couples	Minors (aged under 18), persons with care needs (including wheelchair users)	Short-term treatment
T	K.I.T association	6 months	Young adults and adults	Couples	n.a.	Long-term treatment
VB	Carina treatment unit of Maria Ebene Foundation	1–12 months	Young people, young adults and adults	Persons with multiple diagnoses (severe personality disorders such as borderline, as well as eating disorders or other psychiatric diseases)	Minors (aged under 18), acutely suicidal patients, persons with severe somatic problems	Long-term treatment
VB	Lukasfeld treatment unit of Maria Ebene Foundation	2 months (including detoxification)	Young adults	Persons with multiple diagnoses	Minors (aged under 18), acutely suicidal patients; persons who cannot take part in group therapy (e.g. because of pronounced language barriers)	Short-term treatment comprising 3 stages
V	Anton Proksch Institute, Department V	1–2 months	Young people, young adults and adults	Persons with multiple diagnoses (with severe personality disorders or other psychiatric diseases)	Minors (aged under 16), acutely suicidal patients, persons requiring inpatient acute treatment at a psychiatric or somato-medical department of an acute hospital, persons with care needs (including wheelchair users)	Short-term treatment and inpatient interim treatment while continuing opioid substitution treatment
V	Schweizer Haus Hadersdorf (SHH)	6–12 months	Young adults and adults	Persons motivated to start opioid substitution treatment	Minors (aged under 18), persons addicted solely to alcohol	Short-term to medium-term treatment, inpatient treatment for 6 months and 6 months of decentralised

						support
V	Baumgartner Höhe Social Medicine Centre, Otto Wagner Hospital, Department for Drug Patients, Treatment Unit[2]	8 months	Young adults and adults	Couples, mothers/fathers with children, pet owners	Minors (aged under 18)	Long-term treatment

n.a. = not available. 1 = In most cases, addiction to opioids or dependence on several substances involving opioids, but generally open to persons addicted to any illicit substances. 2 As of mid-2012, rehabilitation services in the context of addiction diseases have ceased to be delivered.

Sources: Addiction Support Compass, websites of treatment centres; graphic representation: GÖG/ÖBIG

Several treatment centres offer treatment as module or interval systems: clients can change between settings (residential/decentralised/outpatient) and modules either flexibly or after defined periods of time. The duration of treatment depends on the treatment approach, the individual needs of clients as well as available funding. While *ubuntu* reports an average treatment duration of 24 months, which according to Orville (personal communication) is due to the fact that many clients still need one year to complete apprenticeship or vocational school and this is possible during their stay at *ubuntu* (obviously, funding problems do not arise, as *ubuntu* is an accredited treatment centre with full-time housing), at Oikos, treatment for 18 months now seems to be possible only in exceptional cases (Witting, personal communication). The Lukasfeld treatment unit is designed for short-time treatment, but the total stay, from detoxification to rehabilitation in the assisted housing community, may extend over a period of up to two years, and even longer for patients with additional diagnoses of psychosis (Stiftung Maria Ebene 2012b). The Walkabout treatment centre reports that even though its decision to focus on 3-month treatment was made in view of the requirements of performance-oriented hospital financing, their clients are actually granted funding for periods from 50 and 90 days, depending on the referring province (Friedl, personal communication).

Relapses (i.e. drug use while undergoing treatment) are always addressed and discussed during therapy. However, the response to relapses differs at the individual centres: some centres do not deem it reasonable to continue treatment after two or three relapses and clients are thus discharged (for the time being). Usually, clients who use drugs at the centre are discharged immediately. Some centres pursue an educational approach (i.e. non-compliance with rules will have consequences) and are rather strict in this regard, others apply a system of warnings and the consequences clients face depend on their personal situation (i.e. stage of treatment, substances involved, frequency/number of relapses, open/concealed relapses). However, these centres nevertheless regard relapse as a part of the disease of addiction, and treatment can thus be continued at a later point in time. In other centres, relapse is not regarded as a reason for discharging patients but as a chance to focus on causes that have not been addressed so far. At the Walkabout treatment centre, separate drug-users' groups have been established, where occasional drug use during treatment is discussed. According to Friedl (personal communication), this helps concentrate on the current individual needs of clients and on what has already been achieved in the course of treatment. According to Orville (personal communication), at *ubuntu*, relapse is hardly an issue as the majority of clients continue maintenance treatment over a rather long time before a very slow dose-reduction process is started, assisted by therapy. However, it is also possible to take a 'rehab time-out' for several weeks or months at *ubuntu*. After the client is readmitted, the four-week initial stage is repeated and therapy is then continued from the point at which the client interrupted it.

Information on the elevated risk of overdose in the case of relapse after completing or dropping out of treatment is routinely provided during or shortly before the end of treatment (usually in the form of oral input as part of psychoeducation).

In the course of time, numerous treatment centres have established specialised branches that deliver **preparatory and after-care services**. This permits a continuity of services and has a number of advantages, as was emphasised at the opening of Walkabout's outpatient centre in Graz in June 2012:

» Clients can keep in contact with persons from the centre whom they already know and trust, as the staff in charge of preparatory and after-care also work at the treatment centre itself, and vice versa. This is a great advantage for the preparation for, as well for the time immediately after, treatment. Compared to those clients who spent the preparatory stage at other centres, the situation during treatment is more relaxed.

» At the preparatory stage, the clients already get to know (part of) the group that will undergo treatment at the centre with them. This eases the transition from preparation to treatment and has a positive influence on subsequent interactions within the group.

» In the case of crisis or relapse after treatment, it is possible to respond more quickly and more specifically as signs of such a development often become apparent beforehand, and in the context of regular contacts with the therapists, appropriate solutions (e.g. readmission to the centre) may thus be embarked upon.

ubuntu organises aftercare services individually for each case, but the clients always keep in touch with the centre, to permit "after-parenting" services (Orville, personal communication). This is a good option for

many clients, as even those who originally come from other provinces often stay in the region after treatment.
The majority of inpatient centres are oriented towards abstinence or pursue abstinence-based treatment forms, i.e. addiction-related therapy starts after withdrawal, or in the case of OST patients, after dose-reduction and discontinuation of substitution medicines. Several centres run separate withdrawal departments, and following the stage of physical withdrawal the patients may switch directly to further residential therapy.
For several years, **residential substitution treatment** has also been available. At present, maintenance treatment is delivered at Schweizer Haus Hadersdorf and the Meierhof centre run by Grüner Kreis. Oikos, at its House 10, offers low-dose maintenance treatment to clients who have relapsed several times and for whom orientation towards a drug-free life does not seem to be realistic (Witting, personal communication). Both houses run by *ubuntu* are oriented towards abstinence, but clients in opioid substitution treatment (L-methadone or buprenorphine) are also admitted, and the first small withdrawal steps are taken at a later time. Initially, partial withdrawal (e.g. from benzodiazepines) is provided whenever needed, then opioid reduction is started. The last step of withdrawal treatment never takes place before the sixth month, and in most cases only after 12 months of treatment.
Collaboration and networking between residential centres is very good as a rule, especially at the provincial level, but also beyond it. This permits **cooperation** and the sharing of tasks between different centres, particularly at the preparatory and aftercare stages, as well as regarding specific support services or referral during therapy (e.g. if clients need medical treatment or support from social workers. Clients' relatives also receive support from the preparatory and aftercare services, and if no such services are available (locally), they are referred to external service providers. As a rule, networking and collaboration are more intensive within the region than at the nationwide level. This enables intensive exchange in the context of case management and in the form of conferences of service providers (i.e. including an exchange of case-related information). As treatment centres are usually open to clients from all over Austria, collaboration and exchange structures also exist between centres in different provinces. However, several centres report that the cooperation with other provinces does not work as well as would be desirable because of the small numbers of cases and thus lack of continuity (Preinsperger, personal communication).

ÖAKDA [Austrian Working Group for Communicative Drug Work] is regarded as a very useful instrument for setting up contacts among drug support and treatment services (Witting, personal communication). Further networking bodies include Vienna's networking leaders' meeting, or regional working groups and events for regional collaboration, such as the annual meeting of drug experts held by the Lukasfeld treatment unit, to which all centres and institutions working with the clients are invited[101].

1.3 Quality management

The selected issues chapter on national treatment guidelines in the 2010 report (GÖG/ÖBIG 2010a) discusses both questions of quality management and the relevant organisational guidelines for residential treatment centres, e.g. application for announcement in the Federal Collection of Statutes in accordance with SMG Section 15[102] or funding guidelines by the Vienna Addiction and Drug Coordination. Chapter 5.2.2 of the present report provides further relevant information. Announcement in accordance with SMG Section 15 includes the obligation for centres to draw up annual reports to be submitted to the Ministry of Health. In addition, quality management systems are applied, e.g. the EFQM[103]-based system at Haus am

101 See website of Maria Ebene Foundation (http://www.mariaebene.at/) under Therapiestation Lukasfeld/Kooperationspartner (website in German).

102 See also http://bmg.gv.at/home/Schwerpunkte/Drogen_Sucht/Drogen/Einrichtungen_gemaess_15_Suchtmittelgesetz (in German).

103 European Foundation for Quality Management

Seespitz. Treatment centres with hospital status also have to meet the guidelines and regulations for public hospitals. Several centres have established quality assurance commissions.
In Vienna, a number of quality assurance measures taken in recent years are worthy of mention: for instance, a catalogue of products offered was drawn up for Vienna's entire addiction and drug services network (inpatient and outpatient services), a documentation standard was developed, and the cooperation with the Vienna Hospital Association was reorganised (SDW 2012; see also Chapters 5.1 and 5.2).
Evaluations have been repeatedly planned and, in part, also implemented, although not regularly in most cases[104]. The Carina treatment unit is an exception in this respect, as it has conducted annual catamnestic studies for several years. Recent results[105] show a retention rate/successful treatment completion rate of 66% in the total number of treatments completed in 2011 (Stiftung Maria Ebene 2012a). The average duration of treatment was 144 days, and 15 days in the case of admission due to crisis. The results of the evaluation allow one to conclude that the clients at the Carina treatment unit exactly correspond to the intended target group of the services offered. Due to its comprehensive and diversified approach to treatment, as well as its specific treatment plan for eating disorders, appropriate forms of treatment are available to clients with dual or multiple diagnoses. A problem that is being addressed, however, is that evidence-based treatment guidelines are not adequately taken into account, and that no specific services are available for young people suffering from drug-induced psychotic disorders, and that no regular non-smoking programmes being run. The waiting times of several months before admission to the treatment unit is possible have been regarded as unacceptable, and a change in the admission procedure has been suggested.
The analyses for the Lukasfeld treatment unit show a slight increase in regular completions of treatment in 2011 (Stiftung Maria Ebene 2012b). The largest number of drop-outs is registered shortly after the start of treatment, typically due to intimate relationships or craving, as well as to the pronounced instability of the clients, many of whom are very young. Clients who have successfully completed treatment indicate that their general state has improved considerably compared to the time before treatment.
According to analyses by Oikos, in 2011 33% of clients completed therapy at the treatment centre (Oikos 2012). Frequent reasons for dropping out were alcohol problems.

1.4 Discussion and outlook

The centres described here that provide inpatient/residential addiction treatment in Austria offer a wider range of treatment options and systems, and all of them finally aim at a drug-free life. They generally try to orient their services towards their clients' needs. Originally, the most long-standing of these centres were strongly oriented towards the theory of the therapeutic community, which hardly applies to the newer centres. Still, even the 'old' centres have developed further, and away from this approach, as Rittmannsberger and Ebner already described was the case at the Erlenhof centre in 1988. The trends that have emerged in recent years and in the present day include:

» integration of different forms of addiction
» shorter duration of treatment
» more flexibility in treatment (modular systems on the one hand and methods such as time-outs and individualised approaches on the other)
» admission of new/specific target groups.

Persons with multiple diagnoses are a frequent target group for residential addiction treatment. However, there are other target groups for whom only very few places, or none at all, are available – for instance

[104] Information on evaluations and outcomes is provided in the previous reports on the drug situation, as well as the EDDRA database and the EMCDDA.

[105] The present evaluation covers the year 2011 and is based on a standardised clinical psychology admission and discharge diagnosis procedures, which are carried out respectively by a team of experts approximately two to four weeks after admission and before the end of treatment, respectively. In addition, differential diagnoses are routinely provided.

persons who need care and persons with children (see also GÖG/ÖBIG 2009b and 2011c). It is not known either how many places would be needed for these specific groups. Residential substitution treatment has been increasingly offered, but to a small extent as yet.

As outpatient forms of treatment are becoming more advanced and access to outpatient OST is comparatively easy, it is difficult for providers of residential addiction therapy oriented towards (complete) abstinence to present themselves as an attractive alternative to either clients or reimbursing institutions. It has frequently been reported that the high costs of long-term residential treatment are no longer accepted or should not be covered. However, as a matter of fact, the capacities of inpatient treatment centres have not been reduced over the past few years. According to experts, long-term therapy continues to be an appropriate form of treatment for certain groups (particularly persons with pronounced psychiatric comorbidity and a long history of addiction, see, e.g. Stiftung Maria Ebene 2012b).

In their 1998 publication, Eisenbach-Stangl and Burian estimated that, as a consequence of market mechanisms, the costly, abstinence-oriented forms of long-term residential treatment would in the long run become less relevant. In the present treatment system, even though outpatient substitution treatment of opioid addicts has massively increased, the residential treatment centres continue to exist, and some of them have even been expanded. However, in view of the prerequisites for successful residential treatment defined by Burian (2004), namely variable treatment frequency, pharmacological treatment in addition to psychotherapy, and combining psychotherapy with a specifically structured treatment programme geared towards individual needs, treatment has obviously seen development.

Another factor worth mentioning is that in Austria the number of evaluations and studies on inpatient addiction treatment that are conducted and published is fairly small. It cannot be said to which extent the changes that have taken place in addiction treatment are based on academic insight, practical experience or changing framework conditions. Nor is it possible to verify the extent to which addicted patients themselves have, through their specific experience, contributed to the further development of residential services.

To offer a perspective on the future, a description will be given of both those plans for the future and those changes already at the implementation stage at a few treatment centres which point to a continuation of the trends described above. For instance, Grüner Kreis and API will be adapting their services in response to SDW's new catalogue of products. In future, they will also offer shorter abstinence-based and substitution-assisted forms of modular treatment (duration: 1, 2 or 3 months; Preinsperger, personal communication). The Mödling long-term treatment unit will also implement a modular programme extending over three, six and longer than six months (Gottwald-Nathaniel, personal communication). The Carina treatment unit will individualise treatment and explicitly offer crisis services, short-term and long-term treatment, in a cumulative form as well (Bachmann, personal communication). The Walkabout centre is considering offering inpatient opioid substitution treatment either parallel to abstinence-oriented treatment or combined with another goal (Friedl, personal communication). As of September 2012, Haus am Seespitz will also be open to clients addicted to alcohol or medicines, for treatment in groups together with persons addicted to illicit substances (Sligt, personal communication). Grüner Kreis will be intensifying its focus on non-substance-related forms of addiction and expanding its social firms (Rohrhofer, personal communication).

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ROMANIA

Chapter 11- Residential treatment offered to drug users in Europe

11.1. Overview

The offer of care services for drug users had an inconsistent evolution between 1990 and 1998, not being regulated. Only during the following year, respectively in 1999, subsequently to increase in treatment demands, the Drug Addiction Pilot-Centre within Gheorghe Marinescu Hospital in Bucharest (with a capacity of 31 beds) and the Treatment Section dedicated to the drug-addicted people within Socola Psychiatric Hospital in Iaşi have been established.
In 1999 there was only one post-cure centre in Bălăceanca Commune, Ilfov County (near Bucharest Municipality), the care services for drug users being covered at that time by 2 detoxification centres (in Bucharest and in Iaşi) and 1 counselling centre – the Crisis Centre for Children and Adolescents within the Bucharest Mental Health Laboratory, 4th District. Thus, due to the fact that the therapeutic chain was incomplete, important links such as therapeutic communities, residential-type centres or vocational centres missing, the addicted people presented several relapses/recurrences.
During the following period, the treatment system for drug users was not very different from the one in place during the previous years. The therapeutic chain was incomplete and improperly funded whilst the data collection system was weak, hindering the evaluations.
In 2003, the medical service provided in the post-cure units was very little developed. The statistics of the Ministry of Health reported certain centres as post-cure units where only the alcohol addiction was being treated. If we refer only to the post-cure units, in 2003, only Bălăceanca and Socola Centres were available, but they did not have enough staff, plus they had limited funds and inadequate premises. Moreover, two community centres existed at Vurpăr and Şura Mare (Sibiu County), coordinated by the religious communities, oriented towards the alcohol and the drug addiction. They had a small capacity (almost 8 places), not being very well-known by the drug users or by the medical community.
Also at present, at national level, the centres providing residential treatment to drug users are not very numerous and they function, independently of the state, under the form of associations or NGOs, their activity being detailed within this chapter.

11.2. Organisation of the medical, psychological and social care system for drug users in Romania

The institutional and procedural framework of the system of medical, psychological and social care for drug users at national level is defined by the following regulations:

- **Legal framework**: Law No 143/2000 on preventing and countering the illicit drug use and trafficking; Law No 522/2004 supplementing Law No 143/2000 on preventing and countering the illicit drug use and trafficking; the Government Decision No 860/2005 approving the Enforcement regulation of the provisions of Law 143/2000 on preventing and countering the illicit drug use and trafficking, further amended and supplemented.
- **Methodological framework**: The Standards of the national system of medical, psychological and social care for drug users[106].

According to the Standards of the national system of medical, psychological and social care for drug users, the centres providing residential treatment, respectively the therapeutic communities, are situated on level III, ensuring the social re-insertion through specific interventions and through services with a highly specialised level. Thus,
- 1st level involves the identification, attraction, motivation and referral of the drug users to specialised services, the approach of the basic social and medical needs of the drug users and the necessary

[106] http://www.ana.gov.ro/tratament standardele-sistemului-național-de asistență-medicală-psihologică-şi-socială-a-consumatorilorde-droguri-pdf

coordination with the resources from the 2nd and 3rd level. It represents the core level of the entire care system.
- 2nd level, the core level of the system, is made up of specialised units of the public health system and of the Anti-drug Prevention, Evaluation and Counselling Centres; it provides specialised care and ensures the monitoring and coordination between all levels of intervention and the referral to the 3rd level.
- 3rd level ensures the social re-insertion through specific interventions and through highly specialised services (detoxification, therapeutic communities, day-running centres, etc.) that support the 2nd level.

Table 11-1: Care levels, functions and resources thereof

Levels	Functions	Resources
1st Level (the main access pathway to the care system)	Identification, attraction, motivation and referral Basic medical and social needs care Coordination with the 2nd level resources	Primary medical care General social services Resources developing risk-reduction programmes Emergency services Other medical and social resources providing basic services Public, private, mixed or non-governmental system
2nd Level	Planning and implementation of the multi-disciplinary (biological-psychological-social) evaluation Design and development of individualized care programmes within the integrated care programmes. Ensuring specialised care, services concomitance and continuity and the referral to services from the 3rd level.	General specialised resources (primary medical care, specialised care or mental health - psychiatry). Specific resources Public system
3rd Level	Specific and highly specialised care Access: only by referral to resources from the 2nd level	Intra-hospital detoxification resources Residential resources, therapeutic communities, etc. Public, private, mixed or non-governmental system

Source: ***The Standards of the national system of medical, psychological and social care for drug users, Chap. 1-The integrated care system for drug users pages 21- 22.***

11.3 Objectives regarding the drug users benefiting from residential treatment in romania

The main policy documents including objectives regarding the residential treatment provided to drug users are the following:

1. **The National Anti-drug Strategy 2005-2012***, approved by the Government Decision No 73 of 2005*[107] with the two consecutive Action Plans[108], that operationalizes through activities its strategic

[107] Chapter II.2. Medical, psychological and social care, risk-reduction and social re-insertion, B- Medical, psychological and social care and social re-insertion, specific objectives: 1. "The development of the integrated care circuit for drug users and drug-addicted people on at least three levels to ensure a resource network (starting from the pattern created in the excellence centres), to guarantee .... for the access of the drug users and the general availability of these services, 2. "The increase of the availability of the services both in terms of diversity and multi-disciplinary degree and in terms of territorial spread and their adaptation to the individual needs of the drug users and to the type of use (single or poly-drug use)", 6. "The ensuring and implementation of the legal framework for the development and definition of the specific and specialised roles of the third level resources as integrant and critical part of the public system of medical, psychological and social care for the rehabilitation and social re-insertion of drug users from the

objectives regarding the care services provided to drug users undergoing/from residential treatment/therapeutic communities.

2. **The National Programme for Addiction Prevention and Integrated Care - pilot-stage 2007**[109] – The general objective "*The development of the integrated care circuit for drug users and drug-addicted people on three levels to ensure a national network of specialised resources and to guarantee the access of the beneficiaries and the general availability of these services, in accordance with the National Anti-drug Strategy (Chap. II.2.B),* based on which the rehabilitation and equipment works of the Bălan Therapeutic Community have been executed[110].

3. The National Programme of Medical, Psychological and Social Care for Drug Users - 2009-2012[111] - in ***Subprogramme 8 – "3rd level care services*"**,** with the specific objective: "The development of the 3rd level resources as integrant and critical part of the public system of medical, psychological and social care for the rehabilitation and the social re-insertion of the drug users and of the drug-addicted people" reference in made to projects regarding the therapeutic communities, respectively:

- **ensuring the functioning of BĂLAN therapeutic community (30 places)**

a. ensuring the treatment for achieving abstinence (for the opiate and alcohol addicted people) with naltrexone
b. testing the presence of drugs in the body fluids
c. average medical care services
d. vocational therapy services (ergo-therapy)
e. medical care services for psychiatric disorders
f. individual, group and family psychotherapy services
g. ensuring the standardized testing for the psychological evaluation (purchase of standardized and validated psychological tests)
h. cultural, educative and sports services
i. food ensuring services
j. accommodation services
k. 3rd level marketing services (activities for the promotion of the services provided by Bălan Therapeutic Community)

- **partial arrangement of MICA Therapeutic Community (50 places)**

a. design and arrangement/building services

4. The Government Decision No 939/ 2009 for the amendment of the Government Decision No 1102/ 2008 approving the National Programme of medical, social and psychological care for drug users – 2009-2012, where references are made to [112] the project regarding the "ensuring of the functioning of *Dejani Therapeutic Community*, with a capacity of 30 places:

a. ensuring the treatment for achieving abstinence (for opiate and alcohol-addicted people) with naltrexone;
b. testing the presence of drugs in the body fluids;
c. vocational therapy services (ergo-therapy);
d. average medical care services;
e. medical care services for psychiatric disorders;
f. ensuring the standardized testing for the psychological evaluation;
g. cultural, educative and sports services;
h. food ensuring services;
i. accommodation services;
j. 3rd level marketing services (promotion activities)"

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outpatient care centres", 10. "The development and improvement of the basic ongoing and continuous professional training of the professionals working in the field of medical, psychological and social care for drug users".

[108] The Action Plan implementing the National Anti-drug Strategy 2005-2008, approved by the Government Decision No 323/2005, respectively the Action Plan implementing the National Anti-drug Strategy 2010-2012, approved by the Government Decision No 1369/ 2005.

[109] Approved by the Decision of the President of the National Anti-drug Agency

[110] with a capacity of 28 places in residential regime

[111] The Government Decision No 1102 of 18 September 2008 approving the National Programme of medical, social and psychological care for drug users – 2009-2012

[112] Subprogramme 8 - "3rd level care services", subtitle "Main services", at section 3

11.4 Residential treatment in romania

11.4.1. PROJECTS

The institutional twinning project RO/2006/IB-JH-04 "Increase of the efficiency of the cooperation between the institutions involved in the fight against drugs", carried out with German technical assistance, whose purpose was to enhance the development of the integrated management system within the extension of the network of partners involved in the enforcement of the anti-drug policies in Romania. Within this project, on the 2nd component "***Development of county strategies and regional coordination of the services provided",*** a workshop was organised for the development of the specific work protocols within the therapeutic communities
attended by 10 professionals from the National Anti-drug Agency, 5 representatives of the non-government organisations from our country, 1 professional from Germany and 1 professional from the Czech Republic that subsequently lead to the development of a "Working procedures guide for a therapeutic community" that represents a highly significant element, if we are to consider the importance of such a facility in the re-establishment of the connection between the rehabilitated users and the community.

- **The institutional twinning project RO/2006/IB-JH-07 "Consolidation of the integrated system of medical, psychological and social care for drug users in Romania"** - carried out in cooperation with the National Research and Development Centre for Welfare and Health from Finland (STAKES), funded by the European Union, implemented over a 12-month period. The project contributed to the consolidation of the protection, welfare and social cohesion health through the prevention and reduction of the drug use, of the drug addiction and drug effects on health and society, in accordance with the European Drug Strategy 2005-2012. Within the 1st component **"*Therapeutic Community - organisation and operationalization*"** several activities have been carried out[113], materialized in 2 items: "Methodological guide for the therapeutic community functioning", respectively the "Feasibility Study".

11.4.2. PROVIDERS OF RESIDENTIAL

In Romania, the providers of medical, psychological and social services for drug users may be public, private or mixed physical or legal persons. Thus, the drug users may benefit from residential treatment provided by public providers, respectively by the public service for psycho-social care, anti-drug prevention, evaluation and and counselling, the public medical care service (emergency, primary, outpatient, specialised, etc.), the public social care service, other services or by private providers, represented through associations, foundations and through any other forms of organisation of the civil society, physical or legal persons authorised in accordance with the law, international bodies carrying out activities in the field, according to the law.[114]

The activity of these service providers is regulated by **Order No 1389 of 4 August 2008** approving the Criteria and methodology for the authorisation of the centres that provide services for drug users and the Minimum compulsory standards form the organisation and functioning of the centres that provide services

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[113] 1. Analysis of the current therapeutic community models in EU/Work visit – participants: 8 NAA professionals, respectively 2 professionals from Finland; 2. Development of the model adopted by the therapeutic community – participants: 8 NAA professionals, 2 professionals from Finland; 3. Preparation of the curriculum, course strategy and course activities for the staff members that will work within the therapeutic community in Romania – participants: 8 NAA professionals and 3 professionals from Finland; 4. Training sessions for students – participants: 20 Romanian students (medicine, psychology, social care) and 1 professional from Finland; 5. Training of the professionals within NAA and other ministries for the identification of the funding sources necessary to ensure the sustainability of the activities carried out in therapeutic communities – participants: 11 NAA professionals, 5 NGO professionals, 2 professionals from Finland; 6. Training of the professionals for the establishment and implementation of the therapeutic community development plan – participants: 20 NAA professionals, 6 professionals from Finland.
[114] The Standards of the national system of medical, psychological and social care for drug users, pages 25- 26

for drug users. The fulfilment of these standards is verified by the authorisation commission within the National Anti-drug Agency.

For the therapeutic community centre, the following standards are provided:

- **Standards for the authorisation of functioning from sanitary point of view** – 9 minimum criteria regarding to the spaces
- **Standard referring to the service coverage -** 10 criteria regarding the minimum services provided[115]
- **Standard regarding the organisation and functioning-** 6 minimum common organisation and functioning criteria:
- **Standard referring to the staff structure,** providing a series of minimum criteria regulating the staff structure and professional skills.[116]

Up to the present, in order to facilitate the social insertion/re-insertion of the alcohol and drug users, the National Anti-drug Agency took the necessary steps for the operationalizatuion of Bălan, Mica and Dejani Therapeutic Communities.

Thus, subsequent to the evaluation of the implementation of the **"National Programme of medical, social and psychological care for drug users 2009-2012",** the status of the activities carried out with regard to the therapeutic communities is the following:

- **BĂLAN Therapeutic Community**[117]:
- Arranged and equipped building;
- Documents for the operationalization and functioning of the administrative and care services have been drafted.
- **Mica Therapeutic Community**[118]**:**
- Activities to delimit the exterior space, respectively fencing activities have been executed.
- **Dejani Therapeutic Community**[119]**:**
- Arranged and equipped building.
- Documents for the operationalization and functioning of the administrative and care services have been drafted.

[115] a- accommodation for the period indicated in the contract or the agreement signed with the beneficiary; b- psycho-diagnosis and clinical evaluation, including general clinical examination and examination on medical devices to detect infectious evolving diseases that may represent a danger for other persons in the centre; c-psychological interventions; d-social care services; e- counselling for the development of the abilities to lead an independent life; f- vocational guiding, for example support for employment, training, guidance and work integration; g-functional and recreational ergo-therapy. Within the recreational and functional ergo-therapy activities the work protection standards are applied for the specific activities carried out. The beneficiary is informed before on the specific activity development conditions; h-medical care of general medicine with a frequency of minimum once/month/beneficiary, psychiatric consultation with a frequency of minimum once/month/beneficiary; i-emergency medical care if needed; j-permanent services 24 h/24 h.

[116] The centre ensures with full time: 1 psychologist for 4 to 6 beneficiaries, a social worker for 6 to 8 beneficiaries, an ergo-therapy instructor for 6 to 8 beneficiaries, 1 administrative staff member. The centre ensures 1 full or half time general/family medicine physician and 1 psychiatry specialised physician or, by contract, for general/family medicine or psychiatry services.

a) The psychologist has graduated a higher education institution and is licensed in psychology or equivalent, has an individual practice certification for one of the professional specialisations: psychology, psychological counselling and psychotherapy, in line with regulations in force.

b) The social worker has graduated a higher education institution and is licensed in social work and a member of the Romanian College of Social Workers. c) The ergo-therapy instructor has graduated high school or has post-secondary studies and carries out his/her activity in line with his/her professional training, according to the law.

d) Administrative staff, according to the needs.

[117] Subprogramme 8. 1-Ensuring the functioning of Bălan Therapeutic Community (capacity - 30 places), budget 2 100 thousand lei ≈ 488 000 EUR

[118] Subprogramme 8. 2-Ensuring the functioning of Mica Therapeutic Community (capacity - 50 places), budget 4 000 thousand lei ≈ 930 000 EUR

[119] Subprogramme 8.3- Ensuring the functioning of Dejani Therapeutic Community, budget 2 800 thousand lei ≈ 650 000 EUR

As well, services for residential treatment/therapeutic community have been developed by Christian organisations of different denominations: the Bonus Pastor Foundation, the Blue Cross Association in Romania, the Open Hand Association, the Teen Challenge Foundation in Romania.
They are part of the **Romanian Substance Abuse and Addiction Coalition**[120] *(ROSAAC*), the organisation having as an objective the rehabilitation of people with different addictions (alcohol, drugs, new psychoactive substances, tranquilisers, sleeping pills,, nicotine, gambling addiction, co-addiction, etc.).

Their activity[121] is described below, considering the following aspects:

1. *overview-description of the services provided*
2. *applied therapeutic approaches/models, target-group*
3. *funding source*
4. *quality standards*
5. *personal staff*
6. *costs incurred by the beneficiaries*
7. *number of beneficiaries*
8. *admission criteria/referral pathways*
9. *partners*
10. *studies, research activities in the field.*

1. Overview-description of the services provided:

- **Bonus Pastor Foundation**[122] - set up in 1996, with the premises in Târgu Mureş; has a *Therapeutic Centre* at Ozd (Mureş county), opened in 2005, with a capacity of 24 places where it provides residential therapy of long duration (from 3 to 9 months), focusing on obtaninh the skills necessary to lead a normal life and to have normal relationships, without addictions.
- **BLUE CROSS Association in Romania** established the first two rehabilitation centres under the form of therapeutic community in Romania:
    - *"Nazaret" Settlement in Şura Mică* [123] (Sibiu County) – the first rehabilitation centre for men addicted to alcohol or to other drugs in the country, officially inaugurated in 1996, with a capacity of 22 places (25 with reservation).
    - *„Insula Speranței" Settlement of Şelimbăr* [124] (Sibiu County) – rehabilitation centre for women, inaugurated in 1997, with a capacity of 12 places (15 with reservation).
- **OPEN HAND Association**[125] - with its premises in Câmpina**,** set up in 2000, provides services for drug users since 2009 and it disposes of 16 places in the *Therapeutic Centre* and 8 places in the Rehabilitation Centres (24 places totally).
- **TEEN CHALLENGE Foundation in Romania** - set up in 2001, operational since 2003; it disposes of the post-cure Teen Challenge Residential Centre for men, located in Grădiştea Locality, Ilfov County, with a capacity of 16 places.

2. With regard to the ***applied therapeutic approaches/models and with regard to the target group,*** it is noticed:

• **BONUS PASTOR Foundation**- complies with Portage therapeutic model (adopted according to the original version of Canada), offering 2 types of programmes:

- *residential therapy of short duration* (a 12-day programme) - intensive group therapy, with a success rate of 25-30%; *target group* : addicted people and co-addicted people, men and women, of minimum 18 years old;
- *residential therapy of long duration* (2 to 9-month programme) within the Therapeutic Centre in Ozd; *target group*: addicted men, between 18 and 50 years old

[120] http://www.rosaac.ro/
[121] based on the data sent by ROSAAC
[122] http://www.bonuspastor.ro/index.php?lang=RO
[123] http://www.asezamantulnazaret.cabanova.ro/
[124] http://www.insula-sperantei.net/
[125] http://www.manadeschisa.ro/Contact.html

The Foundation also provides post-therapy care through *post-therapy conferences and an annual post-therapy summer 10-day programme* for former addicted people and their families.

- **BLUE CROSS Association in Romania** - combines the Blue Cross Model, Hoop Model and Minnesota Model etc.; it provides psychological counselling, group and individual psychotherapy, medical and social care, spiritual assistance, ergo-therapy, family and community re-integration (occasionally also prevention and training activities) within rehabilitation cures with a duration of 2 to 4 months, sometimes even of 6 months. *The target group* is represented by men and women, according to the specific of each centre, a distinction being made between two categories of persons under care: alcohol-addicted persons of 35 to 45 years old, respectively drug-addicted people of 20 to 25 years old (exceptionally, there are beneficiaries of 15 to 16 years old).
- **OPEN HAND Association** offers a 14-stage programme, resulted from several models, with a minimum duration of one year. The programme is intended to women and young mothers, the services being provided to those having an addiction behaviour (related to tobacco, drugs, alcohol, gambling, pornography, etc.) or to those suffering from depressions, physical, emotional and sexual abuse or experiencing other emotional problems.
- **TEEN CHALLENGE Foundation in Romania** - offers a residential programme of 1 year, *the target group* being represented by men of 18 to 40 years old that went through the detoxification stage.

3. With regard to the **funding sources**, the following aspect are highlighted:

- the most part of the organisations receive financial support from physical persons, companies, organisations, churches, predominantly from other countries, but also from Romania.
- The Ministry of Labour, Family and Social Protection, offers support under the form of subsidies, existing also exceptions (the OPEN HAND Association not receiving support from the Government of Romania).

4. The quality standards envisaged are those requested by the Ministry of Labour, Family and Social Protection which its own standards are added to.[126]

5. Generally, **the staff members** of the organisation is made up of employees and volunteers, trained in the addiction field, thus:

- **The BONUS PASTOR Foundation**- 13 employees, of whom 10 work with the customers (2 social workers, 3 psychologists and 3 pastors).
- **The BLUE CROSS Association in Romania:**
  - *"Nazaret" Settlement in Şura Mică* (for men) - 5 employees (1 psychotherapist/ physician - director, 2 psychotherapists/ psychologists, 1 ergo-therapy instructor/consultant in addictions, 1 administrator/ paramedic) and 2 volunteers (1 spiritual consultant, 1 cook).
  - *"Insula Speranței" Settlement in Şelimbăr* (for women) - 3 employees (1 psychotherapist/psychologist, 1 ergo-therapy instructor, 1 addiction consultant) and 2 volunteers, one being a spiritual consultant.
- **The OPEN HAND Association** - 8 employees, 4 volunteers, 2 workers under collaboration contract, of different professions (social workers, medical care assistant, psychologist, physician).
- **The Teen Challenge Foundation in Romania** - 3 employees, 8 volunteers, psychology, theology graduated or workers with other profiles.

6. The costs [127] **incurred by beneficiaries** are between 350 RON and 1 800 RON/monthly.

- **The BONUS PASTOR Foundation**
  - residential programme of short duration: 600 RON/month
  - residential programme of long duration: 800 RON / month
- **The BLUE CROSS Association in Romania**

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[126] For example, the Blue Cross Association in Romania - sets up and applies very clear indicators for: the evaluation of (human, material and financial) resources used in the service provision process, the measurement of the financial results, the organisational performance evaluation, it uses a reporting and publishing system for the results obtained and ensures their dissemination among its own staff members, beneficiaries, funding bodies, social partners and other decision-making factors, it monitors and assesses systematically the objective achievement and the implementation of its own policies and strategies, its staff members being involved in the analysis and evaluation of the results.

[127] Average annual rate in 2011: 1 Euro = 4,23 RON

- *"Nazaret" Settlement in Şura Mică* (for men) - 1 700 RON /month
- *"Insula Speranței" Settlement in Şelimbăr (for women)* - 1 800 RON /month

In some cases reductions are negotiated, taking into account the beneficiaries' possibilities, respectively those of the association.

- **The OPEN HAND Association** - 600 lei/ month for the customers in the Therapeutic Centre and 350 lei/month for the customers in the rehabilitation centres which 400 lei are added to as tax for programme admission .
- **The TEEN CHALLENGE Foundation in Romania** - 500 lei/month (more than 70% of the beneficiaries incur no charges, due to the precarious financial situation).

7. Number of beneficiaries

Table No 11- 2: Distribution of the number of beneficiaries[128] between 2002 and 2011

Organisation	Drug type	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
BONUS PASTOR Foundation	Drugs				1 PSD[129] 1 PLD[130]					3 PLD	2 PSD 10 PLD
The Blue Cross Association- "Nazaret" Settlement of Şura Mică (for **men**)	Heroin	9	10	4	6	8	5	8	3	5	
	Cocaine									1	3
	Cannabis			1	2	1				2	2
	Volatile substances[131]					1	4[132]	3	3		
	SNPP[133]								1	24	23
The Blue Cross Association- *"Insula Speranței" Settlement in Şelimbăr (for women*)	Drugs	1	2	1	1	2	2	2	2	1	1
	Polyuse				1	2	2	2	1	2	2
Open Hand Association	-								1	10	17
Teen Challenge	Heroin						18	27	28	37	41
	SNPP										

Source: ***ROSAAC***

8. The admission criteria are those provided by the Standards of the national system of medical, psychological and social care of the drug users[134], and criteria of the therapeutic community.[135]
Generally the customers are referred by psychiatrists, family physicians, pastors of the churches, former customers, partner organisations within ROSAAC or mass-media **.**

9. The "partnership" principle may be found within the policies of these organisations. In this sense a special attention is paid to the cooperation with the state authorities on central and local level, with other sanitary and social care units, with other non-governmental organisations and with the Christian cults, and last but least with foreign partners working in the same field.

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[128] The data refer only to the drug users, despite the fact that the organisations concerned provide also services for alcohol users
[129] Residential programme of short duration
[130] Residential programme of long duration
[131] Glue
[132] It represents the number of users of volatile substances, which alcohol and medicaments users are added to.
[133] New psychoactive substances
[134] http://www.ana.gov.ro/vechi/rom/standarde.pdf
[135] In the case of the OPEN HAND Association - the availability of the beneficiary to contribute to a part of the therapy costs; recommendation that beneficiary should be accompanied by another person to assist and help him/her during the treatment .

Table No 11- 3: Organisations' partners

	NATIONAL PARTNERS	INTERNATIONAL PARTNERS
The BONUS PASTOR Foundation	• Blythswood Cluj, • The Blue Cross Association , • The Open Hand Association, • The Preventis Association, • The "Identitatea" Association, • Teen Challenge, • Tha Ministry of Justice – the Probation Service nearby the Mure; Court of Justice • Caritas Alba Iulia	• De Hoop Foundation, Netherlands • The Therapeutic Centre in Zsibrik, Hungary • The Portage Foundation, Canada
The BLUE CROSS Association	• The ROSAAC Foundation, of which are part • The National Anti-drug Agency , • The Ministry of Labour, Family and Social Protection • The Psychiatry Hospitals (in Sibiu, Bucharest, etc.), • The Probation Service, • The Anonymous Alcoholic Movement, • The "Bonus Pastor" Foundation of the Reformed Church, • The Project "Casa Bună" for homeless (Fortotschka Foundation, Sibiu), • Direction for Public Health from Sibiu.	• The International Blue Cross Federation (with headquarters in Berne), the association being its affiliate. • De Hoop Foundation of Netherlands .
OPEN HAND Association	• ROSAAC- of which are part	• De Hoop Foundation, Netherlands, • The OPEN HAND Association, Indianapolis USA • "Europa I Focus" Foundation, Norway
The TEEN CHALLENGE Foundation	• ROSAAC- of which are part	• The International Teen Challenge Foundation

Source: ***ROSAAC***

CONCLUSIONS

The therapeutic community is considered a costly method of treatment, oriented towards a limited segment represented by users motivated to give up the use, that have already gone through the detoxification stage.

After collecting the data on the services of residential/therapeutic community treatment for drug users at national level, the following conclusions may be drawn:

1. The national system of medical, psychological and social care for drug users does is well represented at theoretical level, but it recorded significant gaps in the development of services for the three levels of nurse, which leads to obvious difficulties in its operation in the unit.

2. The small number of providers of services of residential/therapeutic community treatment reflects the insufficient development of 3rd level services.

3. National Anti-drug Agency, during the year 2011, took steps for operationalization of two therapeutic communities that work in the public system. The vast majority of residential treatment / therapeutic community services type are provided at this time in Romania, by the representatives of the civil society (private providers, represented through associations and foundations, authorised physical and legal persons in accordance with the legal provisions, international bodies carrying out activities, in accordance with the law).

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10. Institutional care for drug users in Finland

The purpose of this chapter is to discuss trends and the current situation in institutional drug use treatment in Finland as illustrated by a variety of materials – treatment statistics, documents, strategies and previous studies on the treatment. Specialised drug use treatment in Finland dates back to the early 1970s, at which time the treatment of people with drug problems was transferred from psychiatric care to social services together with other substance abuse care. At the time, some of the care facilities specialising in substance abuse care took responsibility for drug user care too. (Kuussaari 2007; Hakkarainen 1986.) In the following decades, trends in drug use treatment and also in the institutional care for drug users in Finland have followed shifts in treatment philosophies, drug policy, welfare policy and the funding and structures of services. Key determinants of treatment have included central and local government, which provide funding for services and also maintain care facilities of their own, and in particular the NGOs providing substance abuse services specialising in drug use treatment. Drug use treatment has also been determined from time to time by drug users' family members, the drug users themselves, and certain individual persons and experts in the public eye.

11.1. History of institutional care, and legislation and recommendations on care

The history of drug use treatment in Finland is an under-researched area. Also, there have not been very many clinical studies exploring drug use treatment methods in Finland. (Selin 2012; Kaukonen 2005.) The paucity of research may be partly due to the fact that Finland did not really acquire a drug use treatment system separate from the treatment of alcohol problems until the 1990s; prior to that, drug use will have been subsumed in the broader history of substance abuse services. (Kaukonen 2002.)

Generally, care provided for drug users in Finland has been analysed into various phases in previous studies, touching on trends in institutional care along the way. In their article Finland: Drug Treatment at the Margins (1998), Aarne Kinnunen and Juhani Lehto identify four phases in drug care from the early 1960s to the mid-1990s: 1) the psychiatric care phase (late 1960s to early 1970s); 2) the social therapy phase (early 1970s); 3) the separate drug use treatment decline phase (1975 to 1986); and 4) the pluralist phase (1987 to 1996). Olavi Kaukonen (2002) later augmented Kinnunen and Lehto's analysis by identifying a drug use treatment expansion phase from the mid-1990s onwards, influenced by significant changes in the drug use situation and drug policy in Finland towards the end of the decade. The following is a review of institutional care for drug users in light of the aforementioned phases.

1970s to 1990s

At the psychiatric phase of drug use treatment (late 1960s to early 1970s), drug problems were principally defined as medical problems, and responsibility for treatment for drug users rested with the health care system. Institutional care was provided primarily at psychiatric hospitals. No prior research exists concerning the contents and practices of drug use treatment applied during this phase, but it may be assumed that it involved psychiatric care practices typical for the era, such as various combinations of therapy and medication. In the mid-1970s, an experimental methadone treatment programme for people with chronic opiate addiction was begun in psychiatric medical care. (Ahokas, Kajesalo & Holopainen 1998.) The use of coercive measures was more common during the psychiatric care phase than it is now. This was due not so much to principles of psychiatric care as to principles of social order. According to the then valid Act on the Care of Abusers of Intoxicating Substances and Vagrants Act, "abusers of intoxicating substances" – not differentiated by the substance(s) used – could be committed to a sanatorium or an institution if this was considered necessary because the patient was dangerous, a burden to society or in need of social assistance. Also, persons suffering from psychosis and severe withdrawal symptoms could be put in psychiatric care pursuant to the Mental Illness Act. At the turn of the 1960s–1970s, psychiatric hospitals treated up to 900 drug users in inpatient care each year. (Kinnunen & Lehto 1998.)

In the social therapy phase of drug use treatment (early 1970s), a move was made to shift drug use treatment away from psychiatric care, together with the treatment of problem users of alcohol. According to Kinnunen and Lehto (1998), the motivating force behind this was the deinstitutionalisation trend that had

arrived in Finland through international influences in the late 1960s; one of the aims of this trend was to move certain groups of patients out of psychiatric hospitals who did not belong there, such as those with chronic substance abuse problems. As a result, the treatment of both drug problems and alcohol problems was transferred from general social services to the gradually emerging specialised substance abuse services, and social workers became a key professional group in drug use treatment and more generally in substance abuse services. (Kinnunen & Lehto 1998, 53.) In terms of institutional care, responsibility for drug use treatment was transferred to two care facilities with a tradition of specialising in substance abuse problems: the Järvenpää Social Hospital and the A Home in Mikkeli. (Kinnunen & Lehto 1998, 53; see also Kuussaari 2006.) Both facilities received funding from the central government specifically earmarked for drug use treatment.

What was remarkable in the social therapy phase compared with practices in the preceding decades was the emphasis on voluntary treatment and outpatient care for substance abusers, as outlined in two key reports on drug policy published in 1969 and 1971. These principles are still alive and well. The reports also stressed how similar alcohol problems and drug problems are; it was feared that creating special services just for drug users would enhance their sense of a separate identity and thereby the drug culture. (Kuussaari 2006; Hakkarainen 1999.) This practice too can still be detected in the practices of care institutions, even though the treatment of patients with alcohol problems and those with drug problems have gradually become differentiated, particularly since the 1990s.

In the separate drug use treatment decline phase (1975–1986), the professional identity and practices of drug use treatment declined, and dedicated drug use treatment wards began to lose clients. (Kuussaari 2006; Kinnunen & Lehto 1998.) According to Kinnunen and Lehto (1998), there were three key factors behind this decline. Firstly, it was becoming increasingly rare to encounter clients who only had drug problems. For instance, many young people who sought treatment had experimented with drugs, but their main problem was with alcohol. In other words, demand for specialised drug use treatment shrank. This strong downward trend can also be seen in the statistics on drug experimentation and use after the middle of the 1970s. (Kontula; Idänpää-Heikkilä.) Secondly, the decline was facilitated by the principle of the essential similarity of alcohol and drug problems based on the aforementioned committee reports, which in turn influenced the ongoing reform of substance abuse legislation. There was a reluctance to single out drug use and related problems in this process, and it was therefore considered that substance abuse problems of whatever kind could be treated at the same locations. There was thus seen to be no need for separate drug use treatment units. The third change that significantly contributed to the reduction in drug us treatment capacity was in the funding of care facilities. With the major Finnish administrative reform known as VALTAVA in the 1980s, local authorities were charged with added responsibilities in providing services, and the central government no longer provided funding 'earmarked' for drug use treatment; instead, local authorities were required to arrange their funding themselves. For NGOs, this reform involved a transfer to performance-based funding, which meant that it was not worthwhile to maintain empty beds for drug users, who by that time were rarely encountered in treatment situations (e.g. Ahonen 1999).

However, after the mid-1980s the number of beds for drug use treatment began to increase again. Kinnunen and Lehto (1998) describe the phase beginning at this time as the pluralist phase, referring particularly to the diversification that began to emerge in drug use treatment services in the 1980s. At that time, new players entered the field of drug use treatment, and new treatment ideologies emerged alongside the traditional social therapeutic approach. (see also Kuussaari 2006; Kaukonen 2002.) For instance, three new institutional care facilities were founded that have been specialising in drug use treatment ever since: the Hietalinna Community, the Kisko Clinic and the Drug Detoxification Unit at Helsinki University Central Hospital (HUCS).

This change, too, was enabled by several factors. Firstly, a new Act on Welfare for Substance Abusers entered into force in 1986; this Act emphasised the similarity of alcohol and drug problems. As a reaction to the new Act, parents of children suffering from drug problems began a public campaign to gain more beds for drug user treatment and particularly an enhancement to measures aimed at young drug users. They asserted that treating drug problems specifically required measures different from those used to address alcohol problems. Families' organisations played an active role for instance in establishing the HUCS Drug Detoxification Unit. At the same time, a more general public debate was being conducted on drug policy and drug use treatment in Finland. Kinnunen and Lehto (1998) note that in the 1980s drug policy became a more important area in national politics because of international trends, and it was now considered essential for various authorities to allocate more resources to dealing with drug problems.

Increasingly, a broader drug policy reform was called for in public, including a reform of drug use treatment. All of the above led, as Kinnunen and Lehto describe, to a paradoxical situation where the number of drug use treatment beds was being increased even though the newly minted Act on Welfare for Substance Abusers insisted that alcohol abuse treatment and drug use treatment should not be considered or provided for separately, and even though drug use and related problems had not grown by very much at all. (Kinnunen & Lehto 1998; Hakkarainen & Kuussaari 1996.)

According to Kristiina Kuussaari (2006), the number of new drug use treatment units began to increase at this point due to yet another change in the central government's funding practices. Because of a 1987 amendment to the Decree on the Finnish Slot Machine Association, which has a monopoly on gaming machines in Finland, it was possible to allocate funds from the Association to NGOs. This enabled NGOs providing substance abuse services to improve their expertise in drug use treatment even if local authorities, which were otherwise responsible for funding these services, would not invest in it. (see also Kaukonen 2002.) Indeed, international comparisons (Klingeman et al. 1992) show that at the end of the 1980s Finland had one of the world's most comprehensive networks in specialist substance abuse services in the world relative to population and the level of drug use. Another key feature of Finnish substance abuse services at this time was the predominance of institutional care.

Kinnunen and Lehto's survey extends up to the year 1996. After that, major changes occurred in Finnish drug policy and drug use treatment, leading to a proliferation of the number of specialist drug use treatment units in the 2000s. The following is a discussion of trends in this period, described by Olavi Kaukonen (2002) as the expansive phase of drug use treatment, drawing on earlier analyses of changes in drug use treatment prompted by the second wave of drug use.

2000s

At the expansive phase of drug use treatment, specialist services increased in volume and diversity. At this time, the drug use treatment system was being developed as a consistent whole, and continuity of treatment was addressed through networking and training, with a view to increasing the capabilities of social welfare and health care professionals in particular in how to encounter and treat clients with drug problems. This trend was fuelled by a sharp increase in drug use with the arrival of the 'second wave' of drug use in Finland in the 1990s, particularly in the use of opiates. The harmful impacts of increasing drug use prompted a need for a reform of Finnish drug policy and drug use treatment, as can be seen in a substantial increase in the number of reports, documents, regulations and action plans produced between the 1990s and the 2000s. (Hakkarainen & Tigerstedt 2002.) In terminology, this change is reflected in the transition from general substance abuse services towards specialist drug use treatment. (Kaukonen 2002; see also Weckroth 2006.)

The central government allocated more than EUR 15 million to the development of drug use treatment in its budgets for 2002 and 2003; these funds were used both to augment the operations of existing treatment facilities and to set up completely new units. (Kaukonen 2005.) Funds were allocated specifically to the development of opiate substitution treatment and low-threshold health counselling centres for intravenous drug users, the latter being intended to reach the most disadvantaged drug users. (Kaukonen 2005; see also Villikka 2004.)

Key documents governing drug use treatment in this period were the Report by the Finnish Drug Policy Committee (1997) and the related Government Resolution (1998), both of which highlighted the need for developing drug use treatment and a more diverse drug policy. Also, several memoranda on care for problem users were published, discussing issues related to the development of opiate substitution treatment in particular. (Hakkarainen & Tigerstedt 2002.) According to Pekka Hakkarainen and Christoffer Tigerstedt (op.cit), many of these documents show a 'medical-liberal' outlook focusing on pharmaceutical treatments.

What is interesting from the perspective of institutional treatment is that the development of institutional drug use treatment was not separately discussed at this point. On the other hand, a 're-psychiatrisation' of drug use treatment occurred in the 2000s, as witness the increasing number of clients at addiction psychiatry inpatient wards. (Kaukonen 2005.)

Despite the proliferation of drug use treatment units, drug use treatment was the focus of critical discussion as well, even in this expansive phase. NGOs and treatment units subscribing to the social therapeutic approach, and also certain scientists researching substance abuse services, particularly criticised the dominance of substitution treatment in various drug use treatment strategies, as it was feared that this would eclipse discussion of the psychosocial issues related to drug use and lead to an unduly narrow

definition and treatment of drug problems. Uncontrolled spreading of substitution treatment was also seen as a threat, leading in the long term to chronic drug use problems.

In short, the development of drug use treatment in Finland may be described as a transition from generic control and treatment of substance abuse problems towards more specialised drug use treatment. Another major trend has been the transition from the social therapeutic approach originating in the 1970s to more medically oriented forms of drug use treatment. (Selin 2012; Tammi 2007; Kuussaari.) This can be considered to have influenced the development of institutional care too, as rehabilitative institutional care has had to yield to outpatient substitution treatment in the first decade of the present century.

At the level of legislation and strategies, drug use treatment like all substance abuse services has become more client-oriented in terms of content; at the same time, the legislation has become broader, allowing more leeway for local negotiation and discretion as far as the providing of the services is concerned. (Kaukonen 2005.) The following is a more detailed discussion of the current legislation, strategies and recommendations that govern drug use treatment, with specific reference to the status of institutional care. The section concludes with a survey of current funding arrangements for substance abuse services.

11.1.2. Legislation, key strategies and recommendations underlying institutional care

In Finland, the responsibility for providing drug use treatment, as with all social and health services, rests with local authorities. The Act on Welfare for Substance Abusers (14/1986) requires municipalities to ensure that the provision of substance abuse services meets local needs as regards content and scope. The goal is to prevent and reduce problem use of intoxicants and related social and security issues. The Act is complemented by the Decree on Welfare for Substance Abusers (653/1986), which contains more detailed provisions for instance on providing substance abuse services, drawing up rehabilitation plans, official appointment procedures, treatment of clients under 18 years of age and isolation of clients.

The Act on Welfare for Substance Abusers also allows for a client to be committed to involuntary treatment pursuant to the Mental Health Act, the Act on Welfare for Substance Abusers or the Child Welfare Act. Involuntary treatment is indicated when a substance abuser client is unable to make informed decisions because of his/her illness or intoxicant addiction. Traditionally, this provision has been invoked only very rarely in Finland. However, there is currently a lively public debate on increasing the commitment to involuntary treatment of pregnant substance abusers, and a Government bill is being prepared to this effect.

Other principal legislation relevant for the providing of substance abuse services include the Communicable Diseases Act (583/1986), the Decree of the Ministry of Social Affairs and Health on the detoxification and substitution treatment of opioid addicts (33/2008) and the Act on the Rehabilitation Benefits and Rehabilitation Allowance Benefits of the Social Insurance Institution of Finland (566/2005). The implementation of substance abuse services is provided for in concrete terms in the Act on Health Care Professionals (559/1994) and the Decree on Qualification Requirements for Social Welfare Personnel (804/1992), both of which govern substance abuse services employees, and also in the Act on the Status and Rights of Social Welfare Clients (812/2000) and the Act on the Status and Rights of Patients (785/1992). In 2005, a treatment guarantee was introduced in Finland in amendments to the Public Health Act and the Act on Specialist Medical Care, specifying maximum waiting periods for access to non-urgent examinations and treatment. In the area of drug use treatment, the treatment guarantee covers opioid substitution treatment, to which a client must be provided access within six months of seeking treatment. (For further information on acts and decrees, see also Kekki & Partanen 2008.)

Principal strategies and recommendations underlying the providing of drug use treatment include the ‘Quality recommendations for substance abuse services’ published by the Ministry of Social Affairs and Health (2002) and the Current Care guidelines for drug abusers drawn up by Duodecim and the Finnish Society of Addiction Medicine (2006). The national plan for mental health and substance abuse work (MIELI), published in 2009, outlines the key principles and focus areas for mental health and substance abuse work up to 2015. What is interesting in the MIELI plan from the perspective of institutional care is an emphasis on outpatient care and the explicitly stated aim of reducing the need for institutional care in both mental health services and substance abuse services. These recommendations will be discussed below in section 3.

11.1.3. Funding of institutional care and various means of funding

In Finland, liability for funding institutional care rests with local government. Where a local authority does not provide statutory services itself, it may outsource them through competitive tendering, augment its own services by entering into strategic partnership agreements with the third sector, or set up a joint authority with other municipalities, a hospital district, third-sector NGOs and/or the private sector. At the moment, the most common means for funding institutional care is the purchaser-provider model, where a local authority buys the services it needs from a private service provider, an NGO or a private care enterprise. In 2010, more than 60% of all substance abuse services were provided by NGOs or private service providers.

Some local authorities still have care facilities of their own, and in some municipalities substance abuse services have been converted into foundations. For instance, there is a substance abuse service foundation in operation in the Jyväskylä area in central Finland and another in the Kuopio area in eastern Finland; local authorities sign annual purchase agreements with these foundations or issue guarantees of payment for their clients. The principal aim in setting up substance abuse service foundations is to bring together substance abuse service professionals in a single organisation for better coordination of services. (See also Inkeroinen & Partanen 2005.)

In recent years, funding of substance abuse services in municipalities has been governed mainly by the Act on Public Contracts (348/2007), which requires local authorities to subject all outsourced services to competitive tendering. Some people feel that this has undermined the resources available for substance abuse services, as local authorities have only considered the financial aspects of tenders submitted. Increasing competitive tendering is also considered to erode the volume of institutional care, as local authorities seek to cut costs. (For more on this debate, see Perälä 2010; Kekki & Partanen 2008.) Indeed, local government politicians are considered to exercise a huge influence on the content of substance abuse services provided to citizens. (Ministry of Finance 2012; Kaukonen 2005.)

11.2. Organisation of drug use treatment and availability of institutional care

Institutional care for drug users in Finland is largely a social service. Only addiction psychiatry wards and detoxification treatment beds at health centres fall within the domain of health care. Social welfare services on the one hand and health care services on the other are governed by different legislation, and the statistics on these operations are also compiled in differing ways.

11.2.1. Recent developments in institutional care in the light of statistics: number of treatment units, treatment days and clients treated

In 2012, there are between 70 and 80 facilities providing 24h treatment for substance abusers.[136] The number of rehabilitation institutions has somewhat decreased in recent years. (Forsell 2012b, unpublished MS.)

In 2010, there were an estimated[137] 2,000 to 3,000 individual clients in institutional care because of drug use: 1,000 to 2,400 clients in social welfare institutions and 700 to 1,700 clients at hospitals in the health care system (treatment periods longer than one week). The number of social welfare rehabilitation clients in particular has been decreasing since 2006 (by 10% to 25%). (Forsell 2012b.) At the same time, however, both the number of clients in residential substance abuse services and the number of treatment days have increased (by 10% to 25%). (Yearbook of Alcohol and Drug Statistics 2011, National Institute for Health and Welfare.)

In the annual survey for collecting information from drug-related treatment conducted by the National Institute for Health and Welfare, 66% of clients in institutional care were men, about the same percentage as in outpatient care. The average age of clients was 30 years. Clients in institutional care are on the

[136] This estimate is based on TOPI, the Register of Institutions in Social Welfare and Health Care maintained by the National Institute for Health and Welfare. The majority of institutions in the TOPI register are in the social welfare sector, because health centres and hospitals are entered as single entities, not analysed by specialisation. Comparison over time is difficult because practices have changed. In actuality, the number of substance abuse rehabilitation institutions has decreased by a dozen since 2006.

[137] The estimate was obtained by comparing data on substance abuse clients in the statistics on 'Finances and activities of municipalities and joint municipal boards', in the Care Registers for Social Welfare and Health Care, and in the information from drug-related treatment compiled by the National Institute for Health and Welfare. The number of drug user clients was calculated by using a coefficient based on the census of intoxicant-related cases conducted by the National Institute for Health and Welfare.

whole somewhat younger than those in outpatient care. No fewer than 17% of the clients in institutional care were homeless (vs. 8% in outpatient care), and only 4% of them had a job (11% ditto). Supported housing is not included in this survey. (Forsell 2012a.)

According to the survey for collecting information from drug-related treatment, opiates were the reason for seeking treatment for half (49%) of the clients in institutional care. The percentages of problem users of stimulants (18%), tranquillisers (8%) and alcohol (17%) were somewhat higher in institutional care than in outpatient care, and 78% of the clients in institutional care had used intravenous drugs at some point in their life. Problem users of opiates and cannabis were more common among clients in inpatient care in health care services (treatment periods lasting more than one week), while problem users of stimulants were more common in institutional care in social welfare services.[138] (Forsell 2012a, 2012b.)

11.2.2. Forms of institutional rehabilitation

Substance abuse service facilities in Finland offer detoxification, short-term care intervals and long-term rehabilitation. Drug users with severe mental health problems are treated in addiction psychiatry wards. Supported housing has become more common in recent years. It is a sort of combination of outpatient care and institutional care, with clients living in their own apartments or rooms but participating in day-centre activities integrated with the housing facility.

In most cases, rehabilitation for problem users of alcohol on the one hand and drugs on the other is not separated; services at rehabilitation facilities are aimed at both groups. Within these institutions, however, functions may be differentiated. Also, some rehabilitation facilities specialise in drug use treatment, while others do not accept drug users as clients at all. There are also beds and wards exclusively for men, women, families or adolescents.

Treatment of drug addiction or drug problems begins with a course of detoxification. Detoxification treatment is provided at inpatient wards at municipal health centres, at detoxification centres specialising in withdrawal treatment, and at major rehabilitation facilities. The size of these units varies from a couple of beds to a couple of dozen beds. Especially at detoxification centres and rehabilitation facilities, the detoxification treatment includes rehabilitative elements in addition to the detoxification proper. In health care services there are addiction psychiatry wards at major central hospitals, where dual-diagnosis patients are often treated and assessments of treatment needs are conducted.

After a course of detoxification, the client may seek entry to institutional rehabilitation by applying for a payment guarantee from the social services office of his/her home municipality. Having been through detoxification is often a requirement for being admitted to rehabilitation. Rehabilitation facilities in Finland vary in size from small institutions with a dozen beds to major hospitals with almost 100 beds. The larger facilities are sub-divided into wards.

Rehabilitation is followed by post-rehabilitation, typically in outpatient care or supported housing.

Typical forms of treatment

Institutional withdrawal treatment almost always involves medication and 24h monitoring. Other methods used include rest, monitoring of physical condition, one-on-one and group therapy sessions, and planning of further treatment. Detoxification is based on a treatment plan, which is drawn up following an investigation of the severity of the intoxicant problem and an interview with the client. Many treatment facilities also employ a care agreement that determines the progress of detoxification: how long it will be, what medication will be administered and what examinations carried out, and what the rules of the treatment facility are concerning outdoor exercise, visitors, personal items and confiscation of intoxicating substances.

No separate study has been conducted on detoxification treatment for drug users, although detoxification and withdrawal treatment have been discussed at a general level in some theses and reports. (Lampela 2010; Mikkilä 2010; Makkonen 2005.) Teija Makkonen's report from 2005 also outlines a number of development proposals. One of the flaws and development needs highlighted is the lack of integration of detoxification with other substance abuse rehabilitation services, which according to

[138] The estimate was obtained by comparing data in the Care Register for Health Care and in the information from drug-related treatment compiled by the National Institute for Health and Welfare. Comparing the data from the former to data from the latter is rather difficult, because alcohol problems are not included in the health care statistics, and on the other hand the 'combined use' diagnosis, F 19, is rather common.

Makkonen is a challenge due to the fragmented nature of the substance abuse service system. The quantity and quality of detoxification services varies from one municipality to another, and it is difficult to obtain a comprehensive overview of the state of detoxification in the country as a whole.

Institutional rehabilitation is traditionally set up as a variety of therapeutic communities that often apply the 12-step programme and community treatment principles. The operations of the Kisko Clinic of the Kalliola Settlement Youth Association founded in 1986 and the Mikkeli Community founded in 1998, for instance, are based on these principles. The operations of the Kisko Clinic have been registered as a brand; the concept combines the ideals of the Daytop therapeutic community model, the NA programme, social rehabilitation, and individual and group therapy according to the transactional analysis framework. The work of the Mikkeli Community is based on community treatment, combined with the NA programme and cognitive and creative methods. Both facilities have a non-medicinal approach.

The work of the Kisko Clinic and the Mikkeli Community have been studied previously. (Selin 2010; Heikkilä 2004; Kylmälä 2001; see also Hakkarainen & Kuussaari 1996.) Jani Selin (2010) noted the ritual dimensions of community treatment in both these communities in his research, the purpose of the treatment being to ‘normalise’ the clients into becoming upstanding citizens and decent members of the community once again. Heikkilä highlights the “stressful” nature of the treatment at the Kisko Clinic, which he describes as both an advantage and a disadvantage. The disadvantage is that many clients drop out of the treatment programme, but the advantage is that those who do go through with it generally achieve good results. Indeed, Heikkilä notes that the Kisko Clinic is suitable for drug users who are themselves motivated to make a change in their lives.

There is also a number of small communities around Finland operating on the ‘halfway house’ principle, combining the 12-step programme with community treatment on a small scale. Many of these also rely on strong peer support, and some employees have a history of substance abuse themselves.

Numerous rehabilitation facilities combine various models of psychosocial rehabilitation in their work. Therapeutic combinations are typical for instance of the services provided by the A Clinic Foundation, a national substance abuse service organisation. Rehabilitation facilities supervised by the A Clinic Foundation include: the Hietalinna Community, which relies on community therapy without medication; Järvenpää Social Hospital, which combines multi-professional treatment with medication and various forms of psychosocial rehabilitation; and the A Home in Kankaanpää, which relies on the ‘ASTA work’ concept, combining various forms of individual, pair and group therapy with recreation, manual skills and job assignments. These rehabilitation programmes often employ a client-oriented approach.

Organisations with a Christian background have traditionally played a key role in Finnish substance abuse rehabilitation. Seukkala, a rehabilitation home owned by a private association, is a currently active facility with a Christian orientation. The work done at Seukkala combines the principles of community treatment with Christian ethics. (see also Asikainen et al. 2004.) The Karismakoti facility operates on the same principle but is for men only. Clients usually have the option not to attend the spiritual functions at rehabilitation facilities with a Christian orientation. However, the Christian faith often has a strong presence at such facilities, and this is clearly indicated in their presentation. In recent years, the use of facilities with a Christian orientation in substance abuse rehabilitation has decreased. It has been suggested that this is due to a lack of trained personnel. (See e.g. Perälä 2010.)

Rehabilitation facilities and programmes based on the cognitive framework have become more common in the 2000s. Some of them market themselves as an alternative to community treatment in particular. Another type of service that has increased in popularity is supported housing. This is a service typically intended for long-term substance abusers, combining accommodation with low-threshold psychosocial support services. Post-rehabilitation services may also be provided in the context of supported housing. Some treatment programmes and substance abuse service NGOs have their own sheltered housing, admission to which may be gained with a payment guarantee from the local authority.

There are dedicated treatment facilities for women only and adolescents only in Finland. There are also separate rehabilitation services for pregnant women and for mothers and families with substance abuse problems. The latter are provided particularly by the nationwide Federation of Mother and Child Homes and Shelters. The treatment principles at rehabilitation facilities for women and adolescents usually follow the diverse approaches described above, but there is also a specific focus on womanhood or parenthood in the case of women and on regularity of lifestyle, healthy diet and self-care in the case of adolescents.

Health care services have addiction psychiatry wards intended for drug users with severe mental health problems. The Department of Addiction Psychiatry of the Hospital District of Helsinki and Uusimaa, for instance, provides psychosis treatment, detoxification in severe cases, evaluation periods, care intervals to

support outpatient care, and initiation periods for substitution treatment. Treatment periods vary from a few weeks to a few months, depending on the client's needs.

Combinations of treatments and services

Finnish institutional rehabilitation typically combines various forms of individual and group activities with the principles of community treatment. Group therapies often rely on the 12-step programme or occupational therapy, while individual therapies tend to involve various form of cognitive or social therapy. Facilities also offer opportunities for various leisure activities and in some cases also employment activities. In community treatment, clients are coached in responsible behaviour towards themselves and their community and to commit to the rules of the community. In facilities with a Christian orientation, spiritual activities and pastoral therapy form an essential part of the treatment (cf. the previous section).

Rehabilitation facilities typically offer health care services, for instance for controlling clients' medication. Major facilities also have their own detoxification wards, from which clients are transferred to rehabilitation. The services of a social worker are often also available. Personnel often include professionals specialising in substance abuse services and mental health care, with training in social and behavioural sciences (e.g. social workers, psychologists, occupational therapists) or in health care (e.g. physicians, nurses, psychiatric nurses, physiotherapists). Smaller facilities often have personnel trained in substance abuse services and mental health care and a nurse, for instance.

Substitution treatment in institutional rehabilitation

Some facilities in Finland have integrated substitution treatment into their care programmes, particularly substitution treatment initiation periods. Sometimes substitution treatment clients are transferred to institutional care if they exhibit too much additional substance use in outpatient care. Substitution treatment at institutions is provided pursuant to the relevant Decree of the Ministry of Social Affairs and Health. Clients also participate in other activities at the institutions, such as community treatment as described above, individual or group therapy, or occupational therapy.

There is one prior study on the providing of substitution treatment in institutional care. (Weckroth 2006.) An extensive study on the provision of substitution treatment in Finland was commissioned by the Ministry of Social Affairs and Health last year but has not yet been published. This study was intended to explore which parties currently provide substitution treatment in Finland and how many of them there are. At the moment, it is not known exactly who all the service providers are.

Post-rehabilitation and care pathways

Extended periods of rehabilitation always involve the drawing up of a treatment plan and visits to post-rehabilitation facilities. Some institutions and some types of treatment have their own post-rehabilitation programmes or supported housing services. No comprehensive study has been conducted on post-rehabilitation or its effectiveness in Finland.

11.3. Quality control of institutional care

The key recommendations underlying substance abuse services and drug use treatment were discussed in section 1. There is no current study on the quality of drug use treatment, nor indeed of substance abuse services in general. However, the current state and arrangements in substance abuse services have been touched upon in various articles and reports. (Finnish Government 2012; Partanen & Kekki 2008.) Flaws identified in the providing of services include the fragmented nature of the service system and the resulting difficulty in coordinating and monitoring services; also, it has been considered that services rely too heavily on outpatient care.

11.3.1. National and local recommendations

The purpose of the quality recommendations for substance abuse services (2003) is to support the planning, providing and development of substance abuse services by local authorities. These recommendations are based on the key legislation governing substance abuse services, discussed in section 1. The quality recommendations cover both general principles in providing substance abuse services and more detailed recommendations for instance regarding the number of employees at

treatment units or accommodation arrangements. The following is a brief discussion of the recommendations.

Firstly, the quality recommendations require services to be provided in such a manner that the fundamental rights, human rights and legal protection of the client are safeguarded. The need for help, support and treatment by the client and by people close to him/her is considered the basic principle in substance abuse treatment and services. The treatment itself is based on respect of self-determination, support for the client's own initiative, and confidentiality. The client's participation in the planning and content of his/her treatment and related decision must also be ensured, and the physical and mental health of the client, the social situation and the need for support must be taken into account. An individual rehabilitation plan must be drawn up for each client.

There are concrete recommendations for substance abuse services for instance regarding institutional accommodation. In institutional, group or dormitory-type sheltered housing, the target standard is to provide clients with a private room with a floor area of at least 15 sq.m. The minimum floor area for a room with twin occupancy is 20 sq.m. The accommodation may be smaller in short-term institutional care such as detoxification. The client's right to privacy must be taken into account when designing and building a treatment facility.

The personnel numbers require 0.8 employees with social welfare or health care qualifications per client in 24h detoxification and withdrawal treatment. For some client groups, such as underage children, drug users and multidrug users, clients with mental problems or intoxicated clients, the requirement may be 1.5 qualified employees per client. The personnel requirement for a rehabilitation facility is 0.5 employees with social welfare or health care qualifications per rehabilitation client. A sufficient number of personnel not involved with client work (administration, cleaning, catering, etc.) must also be present.

Personnel qualifications must comply with the Decree on the Professional Qualifications of Social Welfare Personnel and the Act on Health Care Professionals. Also, in general social welfare and health care services and in specialist substance abuse services it must be ensured that employees have sufficient professional expertise acquired through basic, further and continuing education for the early identification of substance abuse problems, care needs assessment and high-quality professional treatment and rehabilitation of substance abuse clients.

Quality assessment forms for substance abuse treatment units have been prepared on the basis of the recommendations; local authorities, for instance, can assess the quality of the substance abuse services they use with these forms. Quality assessment forms invite units to describe the basic features of their operations: what kind of treatment they provide, how clients are admitted to the unit, and how much care personnel the unit has and of what kind.

No research has been done in Finland on how well the quality recommendations are followed. There are great differences between municipalities, and it is difficult to gain an overall impression of the situation.

The purpose of the Current Care guideline on the treatment of drug abusers is to provide information to clarify treatment of drug problems, to improve cross-discipline co-operation, to promote networking and to influence attitudes. This guideline was drawn up by a working group appointed by the Finnish Medical Society Duodecim and the Finnish Society of Addiction Medicine, consisting mainly of physicians. The guideline notes among other things that various psychosocial methods are the foundation of drug use treatment but that there is no scientific evidence of their efficacy. For opioid addiction, medication is considered an effective treatment.

In addition to national recommendations, there are also substance abuse strategies drawn up locally by local authorities themselves. Some of these may be found in the Neuvoa Antavat online service of the National Institute for Health and Welfare. According to the quality recommendations, each local authority must have a substance abuse strategy forming part of the municipal health and wellbeing strategy. The strategy must determine how the local authority intends to prevent the emergence of harmful impacts of substance abuse, how substance abuse services are provided and how the division of duties between social welfare and health care in substance abuse services is managed. A local authority may prepare its substance abuse strategy together with other local authorities.

Some local authorities have only entered the title of their strategy in the online service, or a note to the effect that there is a strategy. Some strategies are regional, jointly drawn up by several municipalities. There are also some regional substance abuse service development centres, planning and monitoring substance abuse services and policy in a given region.

11.3.2. Monitoring and quality assessment of institutional care

Finnish public services are highly fragmented, and it is very difficult to monitor how substance abuse services are provided in municipalities. (Stenius et al. 2010.) This applies to institutional care for drug users too. Service quality control is also diffuse.

Principal responsibility for quality control and monitoring of services rests with the local authorities, which under the Act on Welfare for Substance Abusers have responsibility for organising these services. Quality control may be undertaken for instance by the social workers responsible for outsourcing the services, or any municipal officials or committees formed of same. Various regional government bodies also supervise the providing of services together with the National Supervisory Authority for Welfare and Health.

Finland also has an Ombudsman for Substance Abusers, overseeing clients' interests in issues related to substance abuse services and policy. Clients may file a complaint with the Ombudsman for instance if they have been poorly treated in the services or have had difficulty accessing the services.

Today, the quality of substance abuse services is often monitored in the context of competitive tendering. In the tendering process, the quality level of services is often predetermined in the call for tenders, and only service providers fulfilling specific procurement criteria are invited to the tendering process. Service providers that do not fulfil the criteria listed in the call for tenders are excluded from tendering. In Finland, outsourced services are usually put to tender by local authorities, municipal federations or hospital districts. Service users generally do not make procurement decisions or engage in competitive tendering themselves.

Some NGOs and local authorities still have traditional partnerships based on negotiation and involving a commitment for development of services according to mutually agreed goals.

11.4. Conclusions and discussion

The present chapter is a discussion of the current state of institutional care for drug users in Finland. The discussion reveals that there is very little scientific information available on this. There is a clear need for a study of institutional care. Gaining new research findings would be important especially considering that the use of institutional care has been decreasing in recent years, as local authorities seek to cut costs in substance abuse services and invest in cost-effective and proven forms of treatment such as substitution treatment.

Also, some quite critical public comments have been made about the state of drug use treatment in recent years, and there has been some civic activism demanding the upholding of institutional treatment. One of the issues is how favouring outpatient care has influenced the social status of drug users. One of the threats identified is that substance abuse problems may become chronic in the absence of sufficient psychosocial rehabilitation.

Another often-mentioned flaw, which is referred to in this chapter too, is the fragmented nature of Finnish substance abuse services. This makes it difficult to gain an overall impression of the state of substance abuse services, to assess the quality of services or to ensure the equality of citizens in the system. For instance, municipal service policies have a great impact on the substance abuse services produced in their respective municipalities and the availability of those services. Secondly, substance abuse services are frequently outsourced to private service providers, which aggravates fragmentation and further complicates monitoring of the services. In a qualitative study on the providing of substance abuse services, representatives of both local authorities and NGOs considered it difficult to monitor and maintain quality in substance abuse services under current circumstances: municipal officials felt quality assessment to be difficult because of the large number of service providers and a lack of resources for monitoring, while NGOs felt that local authorities are pushing service providers' revenues down by focusing only on what the services cost. (Perälä 2010.)

On the other hand, the diversity of the Finnish substance abuse service system may be seen as a strength, as witness the client-oriented approach of rehabilitation facilities and the wide range of options available. But because institutions largely operate according to their own principles, coordinating functions between institutions is often difficult. Because of their heterogeneous nature, it is also difficult to establish exactly what kind of treatment they provide on a day-to-day basis, and which types of rehabilitation work and which ones do not.

BACK TO TOP

SWEDEN

11. Residential treatment for drug users in Europe

11.1. History and policy framework

A description of institutional inpatient care for substance abuse-related problems can be based on several, more-or-less limiting perspectives. The objective of this report is to describe Swedish narcotics-related inpatient care based on the guidelines provided by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Such an approach can, at best, provide good insight into the situation of the most vulnerable substance-abusers. This report touches upon all forms of institutional care targeted at those with narcotics abuse and dependence, regardless of principal.

An assumption in the survey is that the target group (adults from 20 years of age), especially the problematic substance abusers, move between different treatment systems as their living situation and misuse leads to serious problems of various kinds. The way in is problematic, however, since there is currently no personal data that makes it possible to identify a single individual in the various systems, which makes it difficult to count the number of individuals who have received inpatient care over a year. There is a risk that the number of individuals is overestimated. Another problem is the hidden statistics that all surveys of substance abuse and dependence struggle with, i.e. that the number of people who received care is underestimated due to the number of unreported cases through e.g. under diagnosis or as the need for inpatient care in society.

Another complication is the number of "pure" illicit drug abusers, i.e. people who only use narcotics tend to decrease over time. Depending on availability and price, increasing numbers of substance abusers combine different substances of abuse. In several contexts, the concept of a "primary drug" is used, but this concept can lose its meaning if the preference for the drug is increasingly an issue of accessibility. In reference to the wide-spread mixed substance abuse, some data regarding pharmaceutical dependence has been included.

Since 1997, patients have been categorised in the patient register in terms of International Statistical Classification of Diseases and Related Health Problems (ICD) codes, and thereby substance types (alcohol, narcotics and pharmaceuticals), which likely improves the conditions of extracting care data.

There is no corresponding categorisation in the statistics that comprise the social services' clients, which is why a division into different substance groups is more difficult (exceptions are clients from the age of 20 who are covered by care under the Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents Act - LVM). Consequently, the social services do not register what substances of abuse are involved, which means that people with problems of substance abuse and dependence are lumped together and reported as a collective. The studies available for illustrating what substances of abuse those in inpatient care use are also beginning to become out of date.

In Sweden, the social services are an important actor in institutional care. Consequently, social services' clients are included in this survey with the reservation that the substance of abuse has not been possible to fully survey. The increased mixed substance abuse naturally begs the question as to whether the diagnosis systems match real social, psychological or other differences in the individual, and if it is reasonable on the long term to attribute the substance in itself a more subordinate significance. The registers that are currently of interest and are largely administered by the National Board of Health and Welfare are based on data from various sources with partially different aims and contents, which makes the overview more difficult. Another problem is the lack of personal data in parts of institutional care.

In brief, the above means that the possibilities of coordination of registers in the area are limited and that there are also no possibilities of tracing individuals in the various care systems (an exception is, however, the data concerning those in compulsory care under LVM). This also impedes or makes it impossible to tie

various care and treatment activities that are current at the same time or closely related to one another in time to a single individual. Studies of the consumption of care of individuals and over time can therefore only be conducted at a local level. In one such more limited study, it came forth for instance that those in compulsory care had been subject to medical care to a very high degree[i139]. The lack of coherent national data is a strong incentive for more in-depth studies of the area.

11.1.1 History of residential treatment

Alcoholic care and drug addict care had previously come to represent two different socio-political fields. The differences were primarily manifested in various areas of policy; alcohol and narcotics policy have included different legislation and means of incentive. The care of drug addicts has its origins in the pilot programmes with the prescription of narcotics and methadone maintenance treatment that began in 1965 and 1966, respectively. The first investigative committee, the Drug Addict Treatment Committee (SOU 1969:53), initiated its work in 1966 and led to proposals regarding the development of drug-free treatment centres. From the care and treatment perspective, the efforts culminated in the effort called Aggressive Drug Addict Care. It was based on the Government bill 1984/85:19 "Aggressive care of addicts", which aimed for a rapid build-up of both outpatient and inpatient care in light of a feared HIV epidemic. The expansion came to become temporary, in part due to a questioning of how public care should be organised, but also due to a budgetary crisis at the end of the 1980s. At the beginning of the 1990s, these specialised addict care units gradually began decreasing in number or developing into other forms of activities and caregivers began to turn to both the client categories. The Minnesota model began to rapidly expand in this period (Blomqvist and Olsson, 2011).

Institutional care with the consent of the individual is a form of care intervention that essentially coincides with the establishment of the Temperance Act in the mid-1950s. Prior to this, it was solely compulsory care, psychiatric or somatic care that was dominant in the treatment of substance abuse.

The development of institutional care can be seen as a result of the abolition of the alcohol ration book at the same time and a gradual increase in alcohol-related harms. During the so-called "alcohol ration book period" (1917-1955) when purchases of alcohol were rationed, Sweden had a decreasing and low frequency of alcohol-related harms and disease, also compared with other countries. Institutional care was then conducted for individuals within psychiatric or internal medicine clinics, primarily as compulsory care. The care institutions that conducted compulsory care were supplemented by municipally operated care institutions or treatment centres for voluntary care. Several of these had NGOs as a base.

Since the 1960s, the narcotics issue has been subject to several investigations and socio-political discussions. Care and control efforts have been two parallel lines in the narcotics policy that is presumed to lead to a drug-free society. The starting point has been to not distinguish between narcotics use and narcotics abuse (Blomqvist and Olsson, 2011).

From a care and treatment perspective, the large number of investigations and efforts related to narcotics policy in recent decades essentially played a minor role in relation to addict care as a whole. The individual substance abuser has been relegated to the same "care apparatus" and regulations regardless of their substance of abuse. The care legislation and care structure presented in the following section are therefore relevant to the care and treatment of both alcohol and drug abusers.

The latest local study that covers addict treatment was conducted in the Stockholm County Council[140]. The county accounts for around one fifth (approx. 2.1 million people) of Sweden's population. The study was based on information in a database over all registered care consumption concerning alcohol- and

[139] Status report 2006 and 2007 (pages 48 and 44, respectively), Individual and family care, National Board of Health and Welfare 2006 and 2007.
[140] Alcohol- and narcotics-related care consumption and mortality in various age groups in Stockholm County 1998-2008, Karolinska Institutet School of Public Health, 2010:7

narcotics-related diagnoses over an 11-year period. (1998-2008). What attracts interest here are the changes that have occurred in the consumption of inpatient care in a large number of alcohol- and narcotics-related diagnoses and are probably representative for Sweden as a whole. Data shows that the number of people treated for *alcohol-related* diseases has increased by 10% per 100,000 residents and by 20% in absolute figures. The increase is particularly tangible in the younger age groups, 15-24 years – among both men and women, at around 100 and 150%, respectively. Alcohol poisoning is the most prominent diagnosis. The number of people treated for *narcotics-related* diseases is, however, largely unchanged, except for women in the 15-24 year age group and men in the 50-64 year age group. In these groups, the increases per 100,000 residents are 18 and 60%, respectively.
In this context, it should be added that a high proportion of correctional treatment clients have alcohol and/or drug problems. Like somatic care, correctional care has not previously had the express aim of treating or caring for this group. In recent decades and particularly in the 2000s, special programmes including pilot programmes with pharmaceutically assisted treatment have done so, however.

Care without consent
The care and treatment of substance abusers arose as a concept in connection with the adoption of the first social care act by the Swedish Parliament in 1913 (see inter alia *The Substance abusers, social services and compulsory care,* report by the Social Committee, SOU 1987:22, *Care of alcohol abusers*, National Board of Health and Welfare reports 1978:4).

The Act on the Treatment of Alcoholics became a reality when Sweden's first state care institution (Venngarn) opened in 1916. This law was replaced by the Act on the Treatment of Alcoholics (1931:233) with a somewhat stronger emphasis on the care of the individual. However, it only pertained to severe cases and was still focused on confinement.

In the 1930s, socio-political reform efforts began in Sweden, which encompassed labour market and housing policy measures, the creation of a system of social insurance and the development of health and medical care. A certain shift in the view of the individual substance abuser occurred towards a somewhat less moralising attitude. It allowed for the possibility of connections between social deviations and the social environment. The explanatory model of the alcoholic as a *social ne'er-do-well* gave way to some extent to a more liberal view. Substance abuse increasingly came to be seen as a disease that required both medical and social treatment.

In 1954, a new law entered into effect, the Temperance Care Act (1954:579), with a greater emphasis on preventive measures. Compulsory care would be resorted to only when it was established that voluntary care efforts were inadequate. The previous concept of reversion was complemented by the concept of substance abuse and the possibilities of opting for both helping intervention and monitoring. If these were insufficient, there was a possibility of resorting to compulsion and admission to a public care institution.

The Social Commission, which was appointed in 1967, issued a report in principle in 1974 (1974:39), which established the principle that the care and treatment of individuals with problems of substance abuse and dependence should take place in voluntary forms to the furthest possible extent. A discussion was conducted as to whether compulsory intervention could take place within the Act on Institutional Psychiatric Care (LSPV), but it was believed, however, that care in the framework of the healthcare system would provide an excessively medical orientation and not address the need for solutions to social problems. The conclusion was that compulsory measures had to take place within the scope of a separate law.

In the Social Commission's final report (SOU 1977:40), it was agreed to repeal the Temperance Care Act and that the substance abusers not covered by compulsory psychiatric care would instead receive voluntary care under the proposed Social Services Act. This proposal was subject to several reviews, however. One took place in connection with an inspection by the National Board of Health and Welfare of the psychiatric compulsory care legislation, where a joint law was again proposed to be included (Psychiatric Care Act), in which substance abusers in dire need of detoxification and psychiatric care would be included. In a later bill (1979/80:1), a model with compulsory psychiatric care was proposed (largely in accordance with the inspection's proposal), but the Social Committee asserted that it was

necessary for the issue of the compulsion of adult substance abusers to be decided with broad political unity. A special parliamentary committee (the Social Drafting Committee) hereby came to be appointed to again review the issue of compulsion. The committee issued its interim report (SOU 1981:7) proposing the Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents Act (LVM), which came to be a compulsory law within the scope of the social services. The main principle of the law is that the abusers of alcohol and narcotics that cannot be enticed to participate in voluntary efforts under the Social Services Act shall be provided care under LVM.

This exposé over society's position on care without consent and individual substance abusers with severe problems is of particular principle interest. Is severe, occasionally life-threatening substance abuse to be considered a psychiatric matter, i.e. can it be viewed, at least temporarily, as a mental illness? Or should substance abuse primarily be seen as a social and psychological problem? The issue has again come to the fore with the Substance Abuse Commission, a government commission with the task of conducting a review of the care and treatment of people with problems of substance abuse and dependence. In a discussion memorandum *Better care and support for the individual* (S 2008:04), the commission proposed that LVM should be repealed and regulations regarding compulsion should be integrated into the current Compulsory Psychiatric Care Act (LPT). In the ensuing request for comment process, a division again came forth in the responses to the proposal. However, the Substance Abuse Commission proposed in its final report (Better interventions for substance abuse and dependence, SOU 2011:34) that LVM should be integrated into LPT. The issue is still controversial and does well in reflecting a watershed in Swedish social policy as to how social discrepancies should be interpreted and handled. A bill will probably be presented during the 2012 parliamentary year.

Narcotics treatment has been developed to meet the needs of internees for rehabilitation. In the assessments and estimates made by correctional care of its operations, it is believed that around 60-70% of the internees have problems with narcotics or other drugs. In total, it involves approximately 10,000 people within correctional care (both non-institutional care and institutional care) who are assessed to abuse or be dependent on narcotics.

11.2 Availability and characteristics of residential treatment

In Sweden, different terms are used to describe such care that takes place after admission and a 24-hour stay at a special care and treatment unit. In health and medical care, the term of inpatient care is regularly used. For such care where the social services have decided on assistance in the form of inpatient care, the term of institutional care is more common. In the statistics over the social services' efforts, this care is called full-time care. However, the term inpatient care is used in continuation for all forms of "round-the-clock" care, regardless of caregiver.

Inpatient care in substance abuse and dependence care is primarily financed by taxes with a number of different providers. The most important providers are county councils, municipalities, the state, private actors, foundations and NGOs. Providers alongside of the municipal, county council municipal and state sphere (care and treatment under public management) as a rule have been procured and contracted in free competition. According to surveys by the National Board of Health and Welfare, private companies and NGOs accounted for around 60% of inpatient care (42 and 18%, respectively), while the publicly operated care accounted for the remaining 40%[141].

Inpatient care in county councils

County councils finance all substance abuse and dependence care, where medical complications or psychiatric problems are in the foreground. The care is primarily conducted at special clinics, often within psychiatric services, to treat severe abstinence problems and co-morbidity (substance abuse or dependence and simultaneous mental and/or somatic problems). Specialised treatment for substance abuse and dependence is also conducted in the special clinics. This is also the case with regard to the operations that conduct needle exchanges. In some cases, people with substance abuse and dependence

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[141] In outpatient care, publicly operated operations are dominant. Around 80% of them are operated by municipalities, county councils and the state.

problems are subject to compulsory care under the Compulsory Psychiatric Care Act (LPT) or the Forensic Mental Care Act (LRV).

The detailed costs of the county councils' inpatient care are unknown, since a large number of care episodes are not budgeted or are reported as alcohol or drug-related. However, the estimates show that they amount to approximately SEK 2.8 billion[142].

Inpatient care in the social services

Homes for care and living

Inpatient care in the social services is in principle conducted at three different institutions. *Homes for care and living* (HVB) constitute the dominant component. In accordance with available register data, there are currently around 300 homes[143] that receive individuals with problems of substance abuse and dependence. The homes have been entered in a special register (the HVB register at the National Board of Health and Welfare). A high proportion of these homes are operated under private management. According to a previous study (JKB, 2003), around 65% of these are run by private actors or organisations. Municipalities and county councils operate 25% while around 6% are operated by the state.

Family homes

The other form of inpatient care is carried out in so-called *family homes*[144]. Like HVB, these operations are regulated by the Social Services Ordinance (Chapter 3, Section 2). Among others, the family homes accept adults for care and nursing. Family homes are not normally operated as professional operations. A so-called reinforced family home care can, however, include supplementary support in the form of guidance, special round-the-clock support, training and relief. In a few cases, LVM care (see below) has converted into family home stays under Section 27 of LVM. There is a large uncertainty as to the number of family homes and the number of people who receive such support. One is related to the fact that the family homes are sometimes recruited directly by municipalities, sometimes through special private stakeholders. The latter can sometimes arrange more family homes. How many homes they have at their disposal is unknown, however. The other is related to correctional care procuring a relatively large number of placements that are not registered as assistance under the Social Services Act. This care is financed by correctional care. Except for the homes recruited directly by the municipalities, the operations are conducted under private management or by NGOs.

Compulsory care

Compulsory care (LVM) lastly constitutes the third form of inpatient care. The social services petition for such care with the administrative court if the individual does not consent to voluntary care. The statistics are relatively extensive and consist of applications for LVM care, decisions on LVM care, immediate custody and discharges from LVM care. Today, there are 11 homes that conduct care under LVM[145].

Compulsory care has undergone relatively large changes in recent decades. In the beginning of the 1980s, the number of people in compulsory care was at around the same level as today. As a result of legislative changes, which entailed a changed responsibility for investigations, the number of people in compulsory care more than tripled at the end of the 1980s and the beginning of the 1990s. A gradual decrease has

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[142] See the inquiry, Better interventions in substance abuse and dependence (SOU 2011:35), volume 2, page 591. According to a study by the National Board of Health and Welfare *Cost of alcohol and narcotics, estimate of society's direct costs 2003*, National Board of Health and Welfare 2010, the cost amounted to nearly SEK 2 billion.

[143] In total, a survey in spring 2006 was able to identify around 680 units in both outpatient and inpatient care.

[144] In legislation, a family home is understood as ”a private home that, on behalf of the social welfare board, takes in … adults for care and nursing and the operations of which are not conducted professionally” (Chapter 3 Section 2 of the Social Services Ordinance (SoF)). Family home care can be provided in the form of support, work or occupational training, either pursuant to Chapter 4 Section 1 of the Social Services Act as voluntary care or as compulsory care pursuant to Section 27 of LVM for adults with substance abuse and dependence problems.

[145] http://www.stat-inst.se/

since occurred with the changes this has entailed. The number of LVM homes declined by nearly half during this period[146]. In this context, it can be mentioned that the women's proportion of the number of internees increased from around 14% to 36%. At the same time, a significant change in the substance abuse patterns of internees occurred. The proportion with only alcohol abuse decreased from 93% to 46%. Narcotics abuse increased from 2% to 34% and mixed substance abuse increased from 5% to 19%.

In 2010, a total of 952 people were subject to a decision on an LVM care intervention from the administrative court. Around one fourth of them (235) were only subject to immediate custody, while the others (717) had decisions of immediate custody and preparation of care or only preparation of care. The total number of care days amounted to nearly 160,000.

The costs of the social services' total and direct interventions for substance abuse and dependence care amounted to approx. SEK 5.8 billion in 2010, of which nearly half, nearly SEK 2.7 billion pertains to inpatient care . The costs of LVM care are borne by the municipalities, which pay a special daily fee. How large a proportion of the municipalities' costs for inpatient care that can be linked to LVM care is unclear, however.

The Swedish National Board of Institutional Care, administrator of LVM, has delivered TDI-data to EMCDDA for many years by the use of the assessment instrument DOK being compatible with the TDI-protocol.

11.2.1 National (overall) availability

In accordance with the narcotics index[147] used by the National Board of Health and Welfare to monitor the primary trend with regard to hospital care, the number of patients amounted to 7,792 people in 2010, of which 5,092 were men and 2,700 women. For women, the trend has been relatively stable since 1998 (approx. 57 people/100,000 residents). The number of men in hospital care during the same period increased from around 89 to 109 people per 100,000 residents, or an increase of approx. 18%.

Table 11.1: The number of patients according to the narcotics index and existing compound-specific diagnoses as per DSM IV.

Diagnosis and index	**Compound**	**Code as per DSM IV**	**Number of patients 2011**
Narcotics index		Some 20 diagnoses	7,792
Mental disorder/ behavioural disorder	Opiates	F11	1,247
” –	Cannabis	F12	511
” –	Sedatives/soporifics	F13	1,308
” –	Cocaine	F14	30
” –	Other stimulants	F15	740
” –	Hallucinogens	F16	90
” –	Several drugs combined	F19	3,994

Number of people in care and care episodes
Considering all people in care with narcotics-related sub- or primary diagnosis, the number is higher, however. In 2010, nearly 11,200 people received inpatient care, of which nearly half, around 4,900, were in first-time care - an increase of approx. 20% since 2005. According to the statistics, women accounted for one third of the inpatient care instances, which in absolute figures would mean 370 people.

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[146] The changes are discussed in depth in Compulsion and change, content of care and after-care, Interim report by the LVM Commission, SOU 2004:3.
[147] The index constitutes a summary of some 20 narcotics-related diagnoses in inpatient care. Consequently, it does not comprise all narcotics-related diagnoses.

Since 1997, when a new classification (ICD 10) was introduced, the total number of people in care increased by approx. 30%.

The trend among young people (defined here as the age group 0-24) exhibits a somewhat dramatic tendency. According to the narcotics index, the number of patients in this age group increased from 1,351 in 1998 to 2,225 in 2010, or nearly 65%. This increase is remarkable even considering the population increase. The most important explanation should be the increased use of cannabis (F12) and other stimulants (F15). Cannabis-related illnesses have increased by more than 100% since 1998.

The number of clinically reported cases of *hepatitis C* with an intravenous infection pathway amounted to a total of 2,086 cases in 2011, according to the Swedish Institute for Infectious Disease Control.

Lastly, the number of cases of intravenous *HIV infection* should be mentioned. According to the Swedish Institute for Infectious Disease Control, 24 people were reported as being infected by HIV in 2010 and only 14 people in 2011.
The total number of people treated for alcohol and narcotics diagnoses in the county councils' inpatient care amounted to around 26,800 and 11,200, respectively, in 2010 Accordingly, there were a total of around 38,000 patients who received care one or more times as a result of their alcohol- or drug-related diseases or damage.

Social services' inpatient care
The social services' reporting and the statistics kept by the National Board of Health and Welfare do not differentiate between type of substance abuse. This means that it is impossible to distinguish different groups that receive inpatient care for problems of substance abuse and dependence from each other. However, according to assessments, more than half of the clients have a so-called mixed substance abuse. According to IKB 2003[148], approx. 33% of those treated in various forms of outpatient and inpatient care had mixed substance abuse. A larger proportion of those cared for in inpatient care than those in outpatient care were mixed substance abusers, however. The study showed that, depending on the type of the inpatient care unit, between 13% and 60% of the clients/patients only abused narcotics and between 25% and 59% abused both alcohol and narcotics.

The statistics for inpatient care in municipal social services are not based on personal ID numbers or another identity system except for compulsory care, which means that certain statistics cannot report the number of unique individuals. As previously emphasized, this means significant difficulties of coordinating data from different registries and obtaining a more complete picture of the care consumption.

The total number of admissions in the form of care pertaining to *Homes for care and living* (HVB) amounted to 10,688 in 2011, according to the official statistics. The number of unique individuals that spent time in HVB (or family homes) in 2011 was a total of 7,345, of which 5,516 men and 1,829 women. The total number of care days amounted to nearly 800,000 with an average care period of 108 days.

The total number of admissions to *family homes* amounted to 543 in 2010, of which 132 were women and 411 men. On 21 November 2011, 213 clients were in family homes, of which 58 were women and 155 men. The total number of unique individuals that received such care during one year is unknown, however. An assessment is that it is around 300-500 clients, including the clients of corrective care. The total number of granted care days with assistance under the Social Services Act amounted to nearly 75,000, with an average number of care days per admission/person of 137 days.

The number of people who were admitted to compulsory care (LVM) on 1 November 2011 was 276, of which 106 women and 170 men. Seen over the entire year, 931 people spent time in compulsory care pursuant to LVM at some time during 2011, of which 619 men and 312 women.

[148] Interventions for clients in treatment units in substance abuse care on 1 April 2003, National Board of Health and Welfare 2004.

Table 11.2: Overall inpatient statistics in healthcare and the social services for 2010, or also for 2011 insofar as data is available, are summarised in the table below.

Forms of inpatient care	Healthcare	Social services[149]
Men cared for alcohol related diagnoses	19,578	
Women cared for alcohol related diagnoses	6,879	
Men with narcotic related diagnoses	7,500	
Women with narcotic related diagnoses	3,700	
Men in voluntary inpatient care[150]		5,516
Women in voluntary inpatient care		1,829
Men in compulsory care		619
Women in compulsory care		312
Women cared for pharmaceutical dependence[151]	1,940	
Men cared for pharmaceutical dependence	2,982	
Total number of patients/clients	42,579	8,276

In total, about 50,000 individuals can be assumed to have received inpatient care in some form in 2010. However, one reservation is that a single individual can be presented at more than one care provider.

With the hidden statistics that are discussed in the estimates that were previously done by the National Board of Health and Welfare regarding the heavy narcotics and alcohol abuse, the figures in the table appear reasonable. The hidden statistics may primarily be comprised of those who do not receive an adequate diagnosis (under-diagnosis) in contacts with primary care or who seek assistance from the social services as a result of financial problems and do not receive attention for their problems with substance abuse. Another group could be those who have sporadic and recurring contacts with care providers (e.g. primary care) as a result of their substance abuse problems, but who for various reasons do not receive the perhaps more adequate treatment effort in inpatient care. Those who receive care at private clinics are another and probably somewhat small group. Lastly, we can assume that there are individuals in the population with very large needs for care who never or very rarely come into contact with inpatient care. Some of these people would probably be "captured" if one chose longer periods of observation of five years or more with the support of individual-based information.

Other information concerns the number of people who are deemed to have a serious problem of dependence in correctional care (approximately 8,000 people). Correctional care's clients are interned to serve sentences, not to undergo treatment (with the exception of the special locations mentioned above). This group can therefore be seen as a care-demanding group and a potential target group for inpatient care otherwise.

Mortality of Narcotics and Pharmaceuticals

The death rate is an important indicator for reading changes, particularly in the groups subject to more extensive care interventions and perhaps especially for inpatient care efforts. This can, among other things, involve which compound triggered the death, age and gender distribution and the development over the time. One could possibly also draw conclusions on the care systems and their ability or inability to provide adequate interventions to prevent death.

In Sweden, a discussion is being held about the deaths in which methadone/buprenorphine were indicated in a forensic examination. Some claim that the deaths are due to a relatively extensive leak from

[149] Statistics pertain to 2011

[150] All who voluntarily spent time in institutional care are presented here, except for correctional care's placements in family homes.

[151] All information regarding inpatient care for pharmaceutical dependence is estimated information that may also comprise outpatient care.

substitution treatment or from irresponsible prescriptions by private doctors, while others believe that these substances are smuggled into the country. According to statistics, a total of 77 people (63 men and 14 women) died as a result of methadone poisoning in 2010. Nearly half of them are between the ages of 20 and 34. According to the Swedish Cause of death register, 420 deaths were related to use of narcotics in 2010.

Mortality as a result of pharmaceuticals coincides to some extent with the narcotics-related causes of death, particularly opioids. In connection with this survey, information on deaths was gathered for the following diagnoses F11 and, respectively, T400-T404 (Analgesics), F55 (which can include pharmaceuticals involved), T42 (Hypnotics) and F13 (Sedatives). According to the Swedish Cause of Death Register, a total of 605 people (207 women and 398 men) died as a result of the pharmaceuticals in question in 2010.

The total known and registered mortality as a result of substance abuse-related causes in 2010 encompassed a total of 1,025 people. It can be assumed that a significant proportion of those who die received inpatient care in some form and close to death and should therefore be included in the inpatient care statistics presented above.

11.2.2 Types and characteristics of residential treatment units

The care and treatment currently provided in inpatient care can roughly be categorised into three specific groups: *psychosocial treatment*, *medical treatment* and *psychosocial supportive measures*. This categorisation is based on the information gathered from publications previously issued by the National Board of Health and Welfare and the division that was applied in the national guidelines for problems of substance abuse and dependence (National Board of Health and Welfare 2007). The information sources primarily comprise *Outpatient care in substance abuse and dependence care (ÖKART)* 2008, *Organisation, resources and efforts within public addict care (ORION)* and Interventions for *Clients in Treatment* (IKB) as well as *Clients in substance abuse treatment*,(KIM), 2003. ÖKART indeed concerns outpatient care, but the content of the activities exhibited considerable similarities in the comparisons made with the inpatient care units registered in IKB.

At the beginning of an admission or stay in inpatient care, some form of investigation or diagnosis of the problems, the social situation and mental health is now regularly performed. However, the scope of this is unknown. In IKB 2003, it came forth that a large proportion of the studied treatment units, 73-100%, conducted investigations or assessments of substance abuse problems. A smaller proportion (47-80%) investigated the social situation and between 8-80% investigated mental illness. According to Open Comparisons[152], an annual comparison between municipalities and county councils with regard to quality indicators since 2008, the proportion that uses more extensive assessment instruments (e.g. ASI, DOK, MAPS) has, however, gradually increased. In 2011, an average of two thirds of the municipalities and county councils used such instruments, mainly in outpatient care. In 2003, approx. 50% of the large municipalities used these instruments. At the individual level however, it is not known what proportion of patients/clients that are assessed through these instruments. It is our perception that the responses also reflect inpatient care's use of assessment instruments, particularly since the National Board of Health and Welfare has issued national guidelines that also cover them.

[152] http://www.socialstyrelsen.se/oppnajamforelser/missbrukochberoende

11.2.2.1 Common approaches

Psychosocial treatment
In the Swedish national guidelines for substance abuse and dependence care (National Board of Health and Welfare 2007), psychosocial treatment was defined using four criteria: the evidence criteria, intention criteria, competence criteria and therapeutic context criteria. This definition has not yet found general acceptance. However, if there is reason to believe that the core of the definition has broad support, i.e. that psychosocial treatment is a systematic and theoretically based method or technique supported by research, with a particular emphasis on the substance abuse and dependence, and which is practised by individuals with specific expertise.

With this starting point, a total of eight methods were identified that were assessed to have a high level of evidence and relevance for alcohol and narcotics problems. In the screening of outpatient and inpatient care units done in IKB 2003, it was confirmed that a total of 22 different methods were practised. Most of them were without a scientific foundation and orientation towards alcohol or drug problems. A similar picture came forth in the survey conducted in ÖKART in 2008. Several of the methods/techniques also lacked support in the activities by being practised by trained or certified personnel.

The number of evidence-based methods that are practised is limited. Less than one third of the activities use psychosocial treatment methods with strong evidence.

Medical treatment
Various medical treatment measures occur in a number of different operations, particularly in inpatient care and regardless of the form of ownership. The medical efforts are often procured by county councils or private actors. This may involve medical examinations, testing, detoxification and abstinence treatment, smoking cessation treatment or health information, which are most often conducted in outpatient contexts.

The purely medical measures that as a rule also comprise nursing mainly take place, however, at inpatient care wards at hospitals, outpatient care clinics, combinations of these and private clinics. It is then often a matter of more invasive efforts such as continuous medical monitoring, care and nursing during relatively limited care episodes. A typical example is detoxification and abstinence treatment, where the initial medical intervention often takes place in inpatient care to then convert to outpatient activities. Treatment of many different somatic, occasionally acute conditions (pancreatitis, liver failure, esophageal varices with bleeding, etc.) that are related to substance abuse and dependence is begun, for example, at intensive care, surgical or medical clinics with follow-up and after-controls in outpatient care. The medical measures can vary depending on illnesses.

Pharmaceutically assisted treatment
Pharmaceutically assisted treatment is provided upon the indication of opiate abuse (LARO), which in Sweden is subject to special regulations (SOSFS 2009:27) or alcohol abuse/dependence. Pharmaceutically assisted treatment for opiate abuse presupposes that it is conducted at a medical care facility and that such treatment is prescribed by a physician with specialist expertise in psychiatry. Treatment is normally provided in outpatient care, but can be provided in inpatient care as long as the patient is not subject to compulsory care under LVM. As a pilot project, correctional care has started programmes (ITOK) in which internees assessed to be suitable are contacted by a special team - a collaboration between the county council, correctional care and the social services - which conducts an examination and begins treatment - if deemed appropriate - in special departments. According to the most recent estimate by the National Board of Health and Welfare, the number of people who receive LARO in Sweden amounts to nearly 4,000. Pharmaceutical treatment for alcohol dependence concerns approximately 28,000 people (see table below).

Table 11.3: Pharmaceutically assisted treatment 2011. Type of pharmaceutical and number of people by gender.

Type of compound	Men	Women	Total
Narcotics dependence			
Methadone	1,332	539	1,871
Subutex/Suboxone	1,472	593	2,065
Alcohol dependence			
Disulfiram	10,180	3,911	14,091
Akamprosat	4,970	2,502	7,472
Naltrexon	4,103	2,142	6,245

Needle exchange

Needle exchange activities for intravenous drug abuser are currently conducted in Sweden in Malmö/Lund and Helsingborg. Planning is under way in Stockholm County Council to open another clinic in Stockholm. These activities were conducted in an outpatient format in close connection with infectious disease clinics. In the beginning of the 2000s, just over 1,500 injection abusers have regular contact with the two operations. The objective of the operations is primarily to prevent blood-borne infections, but also comprises various medical care efforts: treatment of infections, vaccinations against hepatitis B, etc. and social welfare efforts. The target group for the needle exchange is largely included in the group of heavy substance abusers with recurring needs for various inpatient care efforts.

Psychosocial supportive measures

Uncertainty has existed and does exist with regard to what is or what characterises psychosocial supportive measures. Most would likely agree that substance abuse and dependence care is highly characterised by various forms of supportive measures that either complement treatment efforts or are prerequisites to them. In the aforementioned national guidelines, an attempt was made to define psychosocial support compared with psychosocial treatment (see above). Psychosocial support was then defined as supportive measures both in regard to the individual's *social situation* (work, housing, etc.) and *living situation* otherwise (relationships, self-esteem) and which are not based on a specific, often evidence-based method or technique.

In the revision of the national guidelines for the area now under way, the recommendations being prepared for prevention and assessment instruments will be supplemented with a special guide or decision support concerning psychosocial support. In the preliminary working report prepared for this purpose, a distinction is made between the psychosocial support's organisational form and its contents. Sometimes, these aspects or parts of them can be streamlined. The organisation of the psychosocial support is occasionally attributed the nature of a method and vice versa. Here, organisation refers to issues concerning the choice between outpatient and inpatient care, coordination in various forms, specialisation, case-management, peer and self help (AA, NA, etc.). In terms of content, in Sweden, this most often means:

- Counselling
- Motivation
- Housing assistance/sheltered living/housing
- Financial assistance
- Occupational rehabilitation/sheltered employment
- Public support effort (e.g. contact person)
- Family/relative support
- General curative efforts

Many of these efforts are a result of decisions made pursuant to the Social Services Act and are regularly carried out under the auspices of the social services/municipality. However, psychosocial supportive measures in a broad sense are carried out in virtually all of the aforementioned activities with an emphasis on problems of substance abuse and dependence, sometimes with the support and cooperation of the social services under the Social Services Act.

11.2.2.2 Typical mix/integration of services

In the survey done by the National Board of Health and Welfare in 2003 (Interventions for clients in treatment units, IKB), a number of efforts came forth under the heading "other efforts", such as school education, vocational guidance, contact persons, legal advice, residential training, etc. Such supportive efforts were conducted in the roughly 300 units designated as inpatient care and were relatively common. Between 40% and 80% of the units had such a range of efforts.

The dominant element, according to ÖKART (National Board of Health and Welfare, 2008), appears to be various kinds of counselling and motivational interviewing, regardless of the type of unit. Looking at various combinations of efforts, which appear to be natural in all supportive and treatment activities, the combination of *counselling and motivational interviewing* is the most frequent combination of efforts (87%) followed by *psychosocial support* (62%), *psychosocial treatment, psychotherapy and environmental therapy* (55%), *testing* (55%), relapse prevention (55%) and various *healthcare efforts* (54%). This study largely confirms the findings that came forth in a previous, more limited study by the National Board of Health and Welfare (Organisation, resources and efforts within public addict care, ORION, National Board of Health and Welfare 2003).

The studies that have more closely surveyed the treatment units' offerings of support tend to present an extensive and diversified arsenal of efforts, probably to appear as competent, resourceful and attractive operations in competition with other units. A general impression from questionnaire studies of treatment units is the wide-spread desire to meet all kinds of needs. Whether this is possible without compromising on specialisation is unclear, however.

Types of drug misuse in general and in the population of residential care

In Sweden, personal use or misuse of narcotics is criminalised, which is why opinion is divided as to how to study the extent of the misuse in the population. This applies primarily to experimental, risk or recreational misuse, which pertains to temporary or spontaneous use or use that cannot be classified as abuse or dependence under DSM IV (Diagnostic and Statistical Manual of Mental Disorders, version four). The selection of naming and approach to this kind of use/misuse is particularly reflected in studies of school adolescents, where the less stigmatising expression of use was chosen. Criminalisation probably is of significance to the inclination to report one's use related to both experimental and heavy drug misuse. An overview is provided in the following section on what we know about both of these forms of misuse and its potential connections to care and treatment.

Experimental and regular drug use among adolescents

School student studies and earlier military conscript studies (until 2006) constitute the main information about narcotics use among school students. The school student studies are targeted in part on students in year 9 of compulsory school (15-16 years of age) and in part on students in the second year of upper secondary school (17-18 years of age). Among the compulsory school students, 3% of the boys and 2% of the girls had experience of narcotics in the past month (2010). Among the upper-secondary students, 5% of the boys used narcotics in the past month, while the girls were on the same level as those in year 9 (2%).

The dominant drug is cannabis. Approximately two-thirds of all respondents only have experience of cannabis. A small group uses amphetamines and benzodiazepines (see The Drug trend in Sweden, 2011, CAN report 130). Data on the adult relationship to regular drug use is largely lacking[153].

Problematic drug use

According to the most recent estimate (Statens folkhälsoinstitut, 2010c), which is based on a mathematical model with the support of various care data/indicators, the number amounted to approx. 29,500.

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[153] According to a population study by the Swedish National Institute of Public Health STATENS FOLKHÄLSOINSTITUT 2010c. *Narkotikabruket i Sverige,* Östersund, Statens folkhälsoinstitut., approx. 23% of the men and 12% of the women had used narcotics at some time. Of them, 60% had only used cannabis and between 5-10% had only used another drug.

According to a report recently made by the National Board of Health and Welfare to the Swedish National Institute of Public Health[154] based on the annual survey Clients in substance abuse care (KIM), drug misuse for those under treatment is distributed over the following main types: Cannabis, opiates, central nervous system stimulants (mainly amphetamines) and sedatives (barbiturates and benzodiazepine). This picture agrees well with the information prepared by the Swedish Council for Information on Alcohol and Other Drugs (CAN) which is mainly built on population studies. Through the patient register, it is possible to derive what the dominant drugs are, at least for those cared in inpatient care (also see the previous section). Here, the picture is somewhat different, probably as a result of various means of admission, drug culture patterns and differences in the harm trend. Various drugs in combination dominate the inpatient care pattern, followed by opiates, sedatives and barbiturates, cannabis and other stimulants. A reasonable assumption is, however, that opiates, cannabis and compounds such as GHB, etc. play an important role, as treatment comes up as a result of the use of several different drugs.

Pharmaceuticals

In a few places, including Stockholm, Gothenburg and Malmö, there is specialised care and care programmes for people with pharmaceuticals dependence. The TUB clinic (Therapy and Evaluation of Addictive Substances) is perhaps the most well-known of these specialised clinics started in 1984 as a three-year pilot project targeted at patients with pharmaceutical dependence. Today, TUB is a permanent operation with an outpatient unit and a care ward with inpatient care primarily targeted at individuals who misuse or are dependent on hypnotics and sedatives (primarily benzodiazepines or analgesics).

The Substance Abuse Commission makes the judgement, with support of a 2010 survey by the Swedish National Institute of Public Health, that approximately 65,000 people are dependent on narcotics-classed pharmaceuticals. In international studies, this dependence is considered to be the largest misuse problem second only to alcohol dependence. At the same time, it can be confirmed that the misuse of pharmaceuticals is often combined with alcohol. The knowledge of the problem is, however, limited in Sweden. Pharmaceuticals dependence has not yet been subject to a more extensive knowledge review in Sweden, often with the motivation that there is an insufficient knowledge base.

The majority of the problems can be considered to be a result of doctor prescriptions or over prescription. According to the commission's analysis, the basic education of physicians is inadequate with regard to competence in substance abuse and dependence.

According to one analysis (SOU 2011:35), 13,000 unique individuals in Sweden are estimated to receive care for misuse/harmful use or dependence on pharmaceuticals. This applies primarily to pain relievers (analgesics of the opiate type), soporifics and sedatives (sedatives and hypnotics, including benzodiazepines). The analysis is based on patient data from Stockholm County Council and includes both outpatient and inpatient care and has been scaled up to a national level. Whether or not the number of people in care in Stockholm can be considered to be representative for Sweden as a whole is unclear, however.

Another study utilised the National Board of Health and Welfare registrations in the pharmaceutical register (pharmaceutical withdrawals) and coordinated them with information concerning care for harmful use or dependence on hypnotics/sedatives and opiates in the patient register during the years 2006-2008. During these years, just over 85,000 people made at least four withdrawals of the aforementioned compounds, which corresponds to two or more normal daily doses on average per day and during one year. Of them, a total of 5,480 people received inpatient care during the same period.

[154] Concerning Annual Report Questionnaire (ARQ), drafted by the United Nation, Commission on Narcotic Drugs. Statistics pertain to 2011.

Another approach was to study how many patients received care according to the National Board of Health and Welfare patient register for misuse or dependence of these compounds. The results are presented in the table below. The opioid group includes pharmaceutically assisted treatment for opiate abuse.

Table 11.4: Persons treated for the misuse of or dependence on sedatives, hypnotics and opioids 2006-*2008* (ICD 10: F13.1, F13.2)

Year	**Hypnotics/Sedatives**	**Opioids**
2006	2,422	3,463
2007	2,720	3,954
2008	2,971	4,539
2009	3,202	5,179
2010	3,260	5,598

As presented, the number of people treated in the two groups increased in the period 2006-2010 by nearly 26% and 38%, respectively. Somewhat more men than women were treated as a result of the misuse of or dependence on hypnotics/sedatives, while the men clearly dominated the opioid group. Excluding those who receive pharmaceutical treatment against opiate abuse leaves around 1,600 people (of a total 5,598) in the opioid group. In total, the number of people treated for pharmaceutical misuse or dependence (except for pharmaceutically assisted treatment) was around 4,860 people in 2010.

11.3 Quality management

Legal prerequisites

Inpatient care in Sweden is mainly covered by the National Board of Health and Welfare regulations and general guidelines on management systems for systematic quality work (SOSFS 2011:9). Chapter 3, Section 1 states that a management system for the operations shall be in place at the care provider to be used to systematically and continuously develop and secure the quality of the operations. This includes planning, managing, controlling, following up, evaluating and improving the operations. The regulations are relatively new and how it is applied is unclear. Government supervision exercised by the National Board of Health and Welfare shows how the adaptation to and compliance with the regulations looks. However, it can be noted that there is now a structure set forth in the legislation for how the quality work shall be structured.

As noted above (see Chapter 11.2.2.2), in terms of the content and quality of treatment, there is a lack of real opportunities to steer the emphasis towards e.g. evidence-based methods or techniques. Many operations use non-evidence-based methods or develop their own solutions with theoretical or practical elements from different treatment models that have not been subject to follow-ups or evaluations. Many have previously claimed that the treatment sector is generally governed or influenced by strong trends or fashion trends. This is particularly true of the 12-step model or cognitive behavioural therapy (CBT), which have had a major breakthrough in Sweden in recent years at the same time that other less serious methods or techniques are practised to a large extent.

11.3.1 Availability of guidelines and service standards for residential treatment

National guidelines

However, many are convinced that the treatment sector will on the long term be influenced by the national guidelines drafted for substance abuse and dependence care. They primarily pertain to treatment methods for substance abuse and dependence and in co-morbidity and pregnancy, primarily substance abuse and psychiatric morbidity. In the guidelines, there is also a presentation of tests and assessment methods. A revision of these guidelines is currently under way, which will also comprise adolescents and young adults. It is scheduled for completion in 2014.

National guidelines have no legal content, i.e. there are no possibilities to hold the treatment operations responsible if they do not follow them. However, there are reasons to assume that they have a strong corrective effect when an independent and authoritative agency evaluates the methods' scientific foundation. In the supervision exercised by the National Board of Health and Welfare, it can also be perceived as embarrassing or troubling if one states that methods are used without scientific legitimacy.

Research

The inquiry, Better interventions in substance abuse and dependence (SOU 2011:35), reported a relatively extensive review of the research in the substance abuse field. It shows that state-financed research (through the national research councils) in terms of clinical research, particularly the evaluation of treatment, is relatively modest. The Swedish Parliament also noted in a report that little research is conducted that concerns the Social Services Act and the field of substance abuse care. In the summary of the Substance Abuse Commission, it is confirmed that the research is divided over many financiers, universities and research bodies and that it appears to be fragmented. It points out particular areas of inadequacy, including interdisciplinary treatment research, clinical treatment research and forms of treatment for the special needs of women. It is believed to be necessary to organise the research and knowledge distribution in a more effective manner.

The conclusions are also largely confirmed by an evaluation of Swedish research in the area (Swedish Council for Working Life and Social Research, 2012). Proposals included a greater concentration of research resources and cooperation between institutions, as well as increased efforts in the research field of psychotherapy and pharmaceutical treatment.

Altogether, the pure treatment research in terms of systematic evaluations of programmes in inpatient care environments appears underutilised in Sweden. Quality development with the support of research results is virtually non-existent, except for the national guidelines' potential impact.

Open comparisons

Open comparisons[155] is a recurring publication of an amount of data, primarily questionnaire data, but also health and mortality data, on the municipal and county council substance abuse and dependence care. In total, some 30 indicators are assessed to represent the quality of the operations. This is true, for example, of the use of evidence-based methods and assessment instruments, the occurrence of user surveys, operational follow-up, etc. The data collection targets the care providers - municipalities and county councils - substance abuse and dependence treatment operations and not units that conduct 24-hour care. The reporting shall also be viewed as an aggregation and assessment of the municipalities' and county councils' operations in the field and therefore provide no detailed knowledge.

The intent of open comparisons is to achieve processes (through annual comparisons) at the care providers to develop quality. Whether or not these processes reach out to the inpatient care units is unclear. However, one assumption is that individual municipalities' and county councils' procurement of 24-hour care is indirectly affected by the published comparisons.

Local standards and guidelines

Many municipalities, county councils and even regional confederations have established guidelines for their substance abuse and dependence care. They often have the nature of policies or goals of emphasis that have sought to increase or limit one type of resources. One of the more noted of these is the limits on placement in inpatient care, preferring outpatient or so-called "home field" solutions. The reasons have occasionally been a mistrust of the rehabilitation potential of inpatient care, although they have often been financial. The costs of the efforts for those most in need of care have been able to be reduced in the short-term perspective.

Today, there is no collective overview of local standards and guidelines, but several of the larger municipalities with more extensive operations have probably adopted such standards and guidelines.

[155] http://www.socialstyrelsen.se/oppnajamforelser/missbrukochberoende

11.4 Discussion and outlook

Except for the information that could be gathered from registries, the epidemiological knowledge in the area is inadequate. Consequently, we know little about the extent of substance abuse and dependence in various groups. However, for healthcare, the patient and pharmaceutical registries can provide a relatively good view of the use of inpatient care. Otherwise, the information is limited.

A mapping of the use of inpatient care would be substantially simplified if there were access to personal ID number-based data and the potential for coordination of the relevant registries. In Sweden, there is a number of registries that are useful, but cannot be used in part because of ethical regulations and legislative provisions.

Today, there is data from the TDI-compatible assessment instrument DOK used both in compulsory and in voluntary care – the latter administered by the Linnaeus University with a total of 55,000 treatment episodes. Also, more than 54,000 ASI interviews have been conducted in treatment contexts in Sweden in recent years. These constitute an example of data that can be used and linked with information from the patient register, among others. It should also be possible to conduct a nationwide study with a random selection to examine the connections between various forms of inpatient care utilisation.

This more overall survey shows that inpatient care utilisation is extensive. This applies to care related to alcohol, narcotics and narcotics-classed pharmaceuticals. The majority of people with alcohol and drug problems do not seek treatment however and constitute hidden populations. This applies especially to alcohol problems. Furthermore, many individuals receive treatment without their alcohol or drug problems being recognised or acknowledged. This form of underreporting, which probably is most extensive for alcohol-related harms and conditions, can be assumed to be significant. This primarily involves somatic care, where alcohol has played a role, but for various reasons has not been indicated on the physician certificate and thereby not been noted in the patient register. However, it has not been possible in this survey to estimate the extent of this underreporting.

For natural reasons, the medical and psychiatric inpatient care account for the most extensive effort counted in number of people. The available data indicates that more than 40,000 received care for alcohol and drug-related reasons in 2010. Medical and psychiatric harms and complications in substance abuse and dependence forces close contacts with healthcare services, even if it involves shorter care episodes and, to a large extent, short-term somatic efforts. In this context, detoxification and abstinence treatment can be seen to be a typical or characteristic measure and a measure more limited in time.

The care efforts of the social services are at roughly the same level as those of the healthcare services in terms of costs, but comprise substantially fewer people and significantly longer periods of care. In 2010, more than 8,000 people received services in the institutions run or procured by the social services. Of them, more than 900 people received compulsory care. These efforts are by nature more long-term and often have the goal of fundamentally changing the individual's living situation. This often also includes health and medical care in a broad sense and, alongside the therapeutic elements, even social welfare or psychosocial supportive measures. One issue that has not been possible to clarify is whether the healthcare efforts that take place in this part of inpatient care – occasionally through agreements with a medical care facility, primary care or contracts with private operations – are registered in the patient register.

Corrective care also accounts for extensive inpatient care that is often brought about by narcotics crimes and personal misuse. A large proportion of the interns have alcohol and/or drug problems. The operations in correctional care are not explicitly designed for the care and treatment of substance abuse and dependence, except for the special, professional programmes worked out for the clients who are motivated.

The three named care providers are fundamentally independent systems with somewhat underdeveloped cooperation. Where such cooperation has developed, it is generally in geographically limited projects. For

the future, compulsory cooperation will be important, where criminality, illness and social problems are seen as parts of the very same living situation.

In total, nearly 50,000 people are assumed to have received some form of inpatient care in 2010 as a direct or indirect result of alcohol and drug-related problems. This group should also include a large part of the registered deaths, just over 2,300, where the cause was long-term and extensive substance abuse and where the deaths occurred after one or more inpatient care episodes. However, in this survey, it has not been possible to establish if those who died in 2010 were also consumers of inpatient care or other care during the same period. For this, a coordination of patient registers is necessary.

Substance abuse and dependence care in Sweden is to a relatively limited extent an operation guided by well-developed quality standards. A national regulation exists regarding quality systems, but how it is applied at a local or regional level is unknown. The quality of this area has repeatedly been questioned. National guidelines and quality comparisons may possibly play an important role in improving quality.

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UNITED KINGDOM

Residential treatment for drug users

Drug treatment is provided using a range of different methods and settings. In the UK, residential rehabilitation services are provided by voluntary and private sector organisations. They offer structured programmes that may include psychosocial interventions, individual and group therapy, education and training, and social and domestic skills. These programmes and services may differ in their philosophy, inclusion criteria and delivery, but most share the common factors that residents have to stay overnight at the facility to receive treatment and that they are expected to be drug free before they start the programme.

Historically residential treatment services were located in large residences away from inner city areas of drug use, taking many users out of the environment in which they became dependent. Some providers in the UK are now implementing more innovative responses by offering "quasi–residential" drug treatment within urban centres by combining local accommodation and housing support with an off-site treatment programme. Other providers also offer detoxification as a first stage of treatment meaning that patients can be referred to these residential services prior to becoming drug free in community based drug treatment services.

11.1 History and policy frameworks

11.1.1 History of residential treatment

The Advisory Council on the Misuse of Drugs (ACMD)'s report, *Treatment and Rehabilitation*, published in 1982 (ACMD 1982) reported that there were 14 drug free rehabilitation houses in the UK with a total of 229 places, which could be divided into three categories: Christian-based houses; concept-based therapeutic communities (TCs); and community-based hostels (see section 11.2.2). The concept-based TCs were the most common type of residential establishment, accounting for half of the available beds at the end of the 1970s (Yates 2003). However, the report's analysis of referrals and admissions to eight rehabilitation houses showed that demand appeared to outstrip supply with four out of five applicants not gaining admission. The main reasons provided in the report were: no vacancies; applicant being imprisoned; or delays in obtaining funding.

The dominant model of drug treatment at this time was hospital-based Drug Dependency Units (DDU), which offered mainly outpatient treatment. Findings from a survey of outpatient DDUs carried out in 1982 showed that around three-quarters of DDUs made referrals to concept-based TCs and around one-third to Christian-based houses (Smart 1985). However, the majority made referrals infrequently and evidence from the ACMD's 1980 survey showed that only 17% of referrals to the eight rehabilitation houses came from drug treatment clinics or GPs (ACMD 1982).

Following advice from the ACMD to increase funding, the Government made £17.5m available for treatment services between 1983 and 1989 under the Central Funding Initiative (CFI). Sixteen per cent of these monies went to residential rehabilitation services with the majority going to community services (Mold and Berridge 2007) many of which were new establishments. Yates (2003) contends that it is this proliferation of community services, partly as a result of the HIV/AIDS scare, that was responsible for the decline of the TCs influence in drug treatment. Indeed, the ACMD's 1988 report on AIDS and drug misuse (ACMD 1988) called for community services to be "substantially developed and expanded" in order to attract clients who hitherto would not have been in contact with services and to have harm minimisation as its main focus. The ACMD estimated that there were 36 residential rehabilitation services in England and two in Wales at this time.

By the late 1980s it was estimated that there were around 50 units providing residential rehabilitation for drug users, many voluntary organisations with modified concept houses dominating and around 20%

Christian based houses with some facilities offering the Minnesota Model[156] (Franey et al. 1993). At this time, a small number of private residential clinics existed with fee-paying clients using largely 12-step approaches. Previously, residential rehabilitation services, like the DDUs, were predominantly located around London and the South-East of England but services had been opened in other areas of the UK. In 1992, the ACMD estimated that there were 72 residential rehabilitation services, with the Minnesota Model becoming increasingly popular. These facilities had changed in that many now accepted those on bail or parole and they were now likely to use community services to assess clients on their behalf. Cook (1988) contends that, while the Minnesota Model has no historical links to the therapeutic community movement it, nevertheless, was a continuation of the change in approach to psychological treatment. He also highlighted the fact that no two programmes are the same and while labelled MM, the emphasis may be different.

In 1993, community care reforms enacted through the *NHS and Community Care Act 1990* saw local authorities become responsible for allocating funds for residential care and therefore controlling access to residential rehabilitation (see section 11.2.1). This meant that drug treatment became part of community care budgets, which were under intense pressure from spiralling demands for elderly residential care and funding cuts. Furthermore, there were some doubts about the effectiveness of residential treatment, particularly the cost-effectiveness (Curson 1991). This has continued into the 21st Century with the Effective Interventions Unit (EIU) in Scotland finding in 2002 that there was inadequate evidence of the effectiveness of residential rehabilitation (EIU 2002).

Throughout the 1990s most treatment services were aimed at opiate users with the preferred method of treatment being community prescribing services. This limited the use of residential rehabilitation services, although there is some evidence that they were used more commonly in the treatment of the growing, albeit relatively small, number of cocaine users (Seivewright et al. 2000). Mold and Berridge (2010) claim that the advent of HIV and the *NHS and Community Care Act* created financial difficulty for residential rehabilitation services.

During the 2000s, reviews of residential services were undertaken in England (NTA 2005), Scotland (Scottish Government 2007) and Wales (Wilkinson and Mistral 2008) and there have been calls for an increase in the number of beds in use in residential treatment (Best et al. 2005) and improved accessibility (WAG 2008a). The National Treatment Agency for Substance Misuse (NTA) state that the lack of effective commissioning processes for inpatient and residential services impeded their growth in the late 1990s and early 2000s with spot purchasing rather than strategic commissioning the norm (NTA 2008). Residential treatment and rehabilitation services are recognised as an integral part of the treatment system. In England, the Department of Health made £54.9 million available for capital investment in Tier 4 services[157] (see section 11.1.2) in 2007/08 and 2008/09.[158]

11.1.2 Strategy and policy frameworks

Drug strategies

Across the United Kingdom, residential rehabilitation is seen as an important component of an integrated care pathway (NTA 2006a; Scottish Government 2008a). As such, all local teams responsible for drug services are expected to provide access to residential services. Residential services are explicitly mentioned in the drug strategies of Scotland (Scottish Government 2008a) and Wales (WAG 2008a) but not in the Home Office strategy (HM Government 2010) or the Northern Ireland strategy (DHSSPSNI

[156] The Minnesota Model is a holistic grass roots model that aims to address the needs of the individual seeking help for addiction, and their caregiver. It originally focussed on alcohol addiction.

[157] The NTA's *Models of Care* guidelines (NTA 2006a) set out a four-tiered framework for providing drug treatment. The tiers refer to the level of interventions provided. The degree of individual need and support usually increased with each tier. Tier 4 services typically included specialised residential substance misuse units/wards (NTA 2006b; see UK Focal Point Report 2010).

[158] See: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4137601.pdf

2011). The Welsh strategy document, *Working together to reduce harm* is the only strategy with an objective explicitly related to promoting access to residential rehabilitation services (WAG 2008a). Nevertheless, all recent drug strategies place an emphasis on recovery (see section 1.1; SQ32) and value the potential of residential services to support recovery as part of an integrated drug treatment system.

In England, the 2010 *Drug Strategy* (HM Government 2010) set out to bring together all aspects of substance misuse treatment and to tackle drug treatment in all settings, whether community, in-patient, residential or prison. It led to a consultation on a national framework for recovery to replace the previous tiered model set out in *Models of care for treatment of adult drug misusers,* which was published in 2002 and updated in 2006 (NTA 2002; 2006a). The response to consultation put aside the concept of separate tiers for community and residential drug treatment services placing residential treatment alongside other treatment interventions as an integrated part of local treatment systems. The Home Office's document, *Putting Full Recovery First* looks to develop patient placement criteria to provide commissioners with clear cost-effective rationale for referring to residential services (Home Office 2012e).

Financing of residential treatment

The *NHS and Community Care Act 1990* shifted responsibility for funding residential rehabilitation to local authority social care services (see section 11.1.1). Social services departments continue to play a major role in funding residential services for drug users. In 2010/11, of the £42 million estimated by local area expenditure reports[159] as being spent on residential rehabilitation in England, £20.2 million was reported to come from social services budgets with a further £1.8 million reported to come from other local government funds. The pooled treatment budget (PTB) contributed £12.8 million for residential rehabilitation, which accounts for less than five per cent of PTB expenditure.

Similarly, a review in Scotland found that social services department contributed two-thirds of the funding made available for residential rehabilitation in 2005/06 with the remainder coming from NHS Boards (Scottish Government 2007).

The Welsh Government ring-fences £1m of its £22m Substance Misuse Action Fund budget for Tier 4 Inpatient Detoxification and Residential Rehabilitation services. This budget is allocated to the 22 Community Safety Partnerships across Wales and is required to be signed off by the Substance Misuse Area Planning Boards, which are co-terminous with the seven health Boards in Wales. In addition, Local Authorities may utilise their ring-fenced social care budgets to fund additional residential rehabilitation places.

Other sources of funding for residential rehabilitation include the Supporting People grant and Drug Interventions Programme (DIP), which are more likely to be used for homeless clients or those clients engaged with the criminal justice system respectively.

Funding is consistently mentioned as a barrier to accessing residential rehabilitation (Best et al. 2005). In the NTA's *Models of residential rehabilitation* document (NTA 2006b), it states that a mixed economy of care is necessary to secure the provision of residential rehabilitation and that over-reliance on finance from community care funding leads to financial difficulties. It also suggests a mixture of spot purchasing and block contracts to provide services with some degree of security and to maintain flexibility for commissioning.

Unit costs of residential rehabilitation

The unit cost of residential rehabilitation in England in 2010/11 is estimated to be £647 per resident per week or a cost of £92.43 per day (Curtis 2011).[160] This compares to a unit cost of £7.33 per person per day

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[159] Self-reported funding and expenditure profiles were provided by each local Drug Action Team as part of their local treatment plans. The data were of varying quality and the requirement to provide a breakdown no longer exists.

[160] Estimated from a sample of 34 residential rehabilitation services. Costs have been uprated from 2007/08 using the Gross Domestic Product (GDP) index.

for specialist prescribing and £5.84 per person per day for structured psychosocial treatments: two possible components of community drug treatment (see UK Focal Point Report 2010).[161]

Role and performance of residential rehabilitation
The NTA (2012i) looked at the role and performance of residential rehabilitations as part of the wider treatment system in order to identify the groups of service users for whom they are likely to be able to offer added value over cheaper community options. In light of the high cost of each residential rehabilitation place[162], the NTA aimed to better inform commissioners as England moves towards outcomes based payments. Data from the National Drug Treatment Monitoring System (NDTMS) show that 4,166 individuals in treatment in 2010-11 had attended residential rehabilitation as part of their latest treatment pathway. Out of 3,972 individuals (194 were recorded as still in treatment), 1,110 (28%) left the treatment system directly after residential rehabilitation having overcome their dependency, 898 (23%) continued treatment with a community-based provider (of these 457 then left the treatment system following continued support from a community provider), 144 dropped out and 279 were still in treatment in the community as of March 2012. Just over one-third (1,441, 36%) of the original cohort were recorded as dropping out of residential rehabilitation. The findings indicate that residential rehabilitation is an integrated part of the whole treatment system and is not always an 'exit door' from treatment. A total of 428 clients (11%) were lost to the treatment system following unplanned discharges from treatment. Drop-outs could be due to drug users being put forward for residential rehabilitation before they are ready, or the complexity of those who are referred to residential rehabilitation. They are often using both crack cocaine and heroin, injecting, more likely to be offenders and more likely to have had a higher number of previous unplanned episodes of treatment than other users. Therefore, it is important that clients are adequately prepared by community services before going into residential services and for residential services to ensure they can meet the needs of clients to minimise early drop outs. The data also highlight differences between individual providers as some achieve nearly 80% success rate (measured by numbers of successful completion) and some achieving below 10% success rate. The authors argue that residential rehab is a vital component of the drug treatment system that it can add value to the treatment system by concentrating on the most complex cases and that providers will have to demonstrate their cost effectiveness to ensure their services continue to be commissioned.

11.2 Availability and characteristics of residential treatment

This section includes directories, registers and any ad-hoc assessments that provide details of residential rehabilitation availability in the UK, or parts of the UK. The numbers drawn from these sources will only be relevant for the time at which they were collated and may not reflect the current situation. This is due to the fluidity of the residential rehabilitation sector.

11.2.1 National (overall) availability and accessibility of residential treatment

Treatment directories
There is no central register of residential treatment services for drug users in the United Kingdom. However, there are a number of directories produced by government agencies, charities and independent organisations, which aim to list all the services available.

Drink and Drugs News (DDN)[163] have compiled and published a directory of residential treatment services for drug and alcohol users throughout the UK and the Channel Islands. DDN also provides information on programmes and additional services available in each unit. As DDN offers advertising space within the directory, non-statutory providers are more likely to include their details in this directory and pay for additional advertising space. Compilation of the directory is carried out by DDN staff who source information and rely on organisations approaching DDN to request a listing and, possibly, advertisement space (personal correspondence – DDN). DDN's (2011) autumn publication reports a total of 164 drug and

[161] Prices have been uprated 2007/08 data reported in UK Focal Point Report 2010. The GDP index has been used.
[162] Residential rehabilitation accounts for 10% of central funding for two per cent of people in adult drug treatment.
[163] See: http://www.drinkanddrugsnews.com/

alcohol, residential rehabilitation services in the UK. However, the directory also includes detoxification only and supported accommodation services in its listings.

In 2010, the NTA established ‘Rehab Online’[164], an online directory of residential drug and alcohol treatment providers in England and Wales. This superseded the NTA’s ‘BEDVACS’: an online listing of residential treatment vacancies and a residential treatment directory. All residential treatment providers can register on the website and submit details regarding their services, facilities and number of beds on a voluntary basis. The NTA had envisaged that the information would be updated weekly to keep records of vacancies up-to-date; however, they are reliant on the service providers to update their own information. In February 2012 *Rehab Online* listed 112 residential rehabilitation services for adult drug users, although this includes some detoxification-only units and some quasi-residential (support housing) services where accommodation is contractually linked to a programme of treatment provided elsewhere.

The Scottish Drugs Service Directory, hosted by the Scottish Drugs Forum, maintains an online directory of drug services in Scotland, including residential rehabilitation units. Information about the specific programmes and additional services they offer is also included. Services can add their own information and continue to update it through an online form, which is submitted for approval to the Scottish Drugs Forum before being updated online. This website also relies on service providers to update their information voluntarily. In February 2012, the directory listed 17 residential rehabilitation units, although it also lists supported housing units and units offering inpatient detoxification only.

All four Northern Ireland Drug and Alcohol Co-ordination Teams (DACTs) have produced a directory of drug and alcohol treatment services available in their respective areas. These directories suggest that there is only one residential rehabilitation unit for drug users in Northern Ireland. However, an additional unit was identified through personal correspondence with the Department of Health, Social Services and Public Safety (DHSSPS), Northern Ireland.

The directories described above and information gathered through personal correspondence with the NTA, devolved administrations and treatment services, have been used to estimate the availability of residential rehabilitation units in the UK (Tables 11.1 and 11.2; Figure 11.1).[165]

Residential units

Across the UK it is estimated that there are 120 residential rehabilitation services with a further 18 private hospitals providing residential rehabilitative treatment. The majority of residential treatment programmes have a minimum length of less than six months (70.2%, n=85) with just over half of these (n=48, 56.5%) offering programmes[166] with a minimum length of between three and six months (Table 11.1). Those offering treatment programmes of more than 12 months accounted for six per cent of the services (n=7). Data taken from the National Drug Treatment Monitoring System (NDTMS) and the Welsh National Database for Substance Misuse (WNDSM) estimate that during 2010/11 there were 2,938 clients in residential treatment and 2,118 clients entering treatment. Of the 2,938 clients in residential treatment in England and Wales, approximately three-quarters (75.6% n=2,222) were male and approximately one quarter (24.4% n=716) were female, a similar pattern to outpatient treatment centres. Three residential rehabilitation units in Wales reported to the WNDSM in 2010/11 while 93 units reported to the NDTMS in 2010/11. According to the *Census of Drug and Alcohol Treatment Services in Northern Ireland* carried out on the 1st March 2012, there were 14 individuals in residential treatment services for drug misuse and a further 33 who were in residential treatment services for drug and alcohol misuse. Together, the two groups accounted for 2% of all those in treatment for either drug, or drug and alcohol use on 1st March 2012 (NISRA 2012a).

[164] See: http://www.rehab-online.org.uk

[165] Directories and information were cross-referenced to ensure that information was not duplicated, or omitted. Service websites were checked to ensure that services had not closed down since directories had been published.

[166] For an explanation of these programmes see 11.2.2

Table 0.1: *Availability and uptake of residential rehabilitation services in the UK and minimum duration of programmes.*

<table>
<tr><th colspan="2">Generic term: Residential treatment</th><th colspan="3">Programmes included and specific national terminology</th></tr>
<tr><td>Number of units in the country</td><td>120</td><td colspan="3" rowspan="2">12-Step, Cognitive Behavioural Therapy (CBT), social learning, Therapeutic Community (TC), Eclectic/Integrated programmes, Christian philosophy.</td></tr>
<tr><td>Number of clients in 2010/11</td><td>2,938[167]</td></tr>
<tr><td>Minimum duration</td><td>< 3 months</td><td>3 < 6 months</td><td>6 < 12 months</td><td>> 12 months</td></tr>
<tr><td>Number of units</td><td>21</td><td>66</td><td>27</td><td>6</td></tr>
</table>

Source**:** Rehab Online (NTA), DDN (2011), Scottish Drugs Services, personal correspondence – DHSSPS, Northern Ireland, NDTMS and WNDSM

Most of the 18 independent hospitals offering residential treatment for drug users in the UK run programmes with a minimum length of three months or less (16). A small number (2) offer programmes with a minimum length of three to six months (Table 11.2). None of the independent hospitals offer programmes of more than six months.

Table 0.2: *Availability of hospital rehabilitation services in the UK, number of clients and minimum duration of programmes.*

<table>
<tr><th colspan="2">Generic term: Hospital (private) treatment</th><th colspan="3">Programmes included and specific national terminology</th></tr>
<tr><td>Number of units in the country</td><td>18</td><td colspan="3" rowspan="2">Independent hospitals that offer residential treatment for drug users provide greater access to medical staff, including consultant psychiatrists and access to doctors and nurses 24-hours a day. Hospital based residential treatment units also incorporate psychosocial interventions such as CBT.</td></tr>
<tr><td>Number of clients in 2010/11</td><td>*</td></tr>
<tr><td>Minimum duration</td><td>< 3 months</td><td>3 < 6 months</td><td>6 < 12 months</td><td>> 12 months</td></tr>
<tr><td>Number of units</td><td>16</td><td>2</td><td>0</td><td>0</td></tr>
</table>

*Treatment data are not broken down for private units.

Source: Rehab Online (NTA), DDN (2011), Scottish Drugs Services, personal correspondence – DHSSPS, Northern Ireland.

Residential rehabilitation units are either non-profit organisations or commercial organisations. In the UK, 56% (77) of the estimated number of residential rehabilitation units are run by not-for-profit, charitable organisations (including registered charities). Commercial organisations account for 44% (61) of the

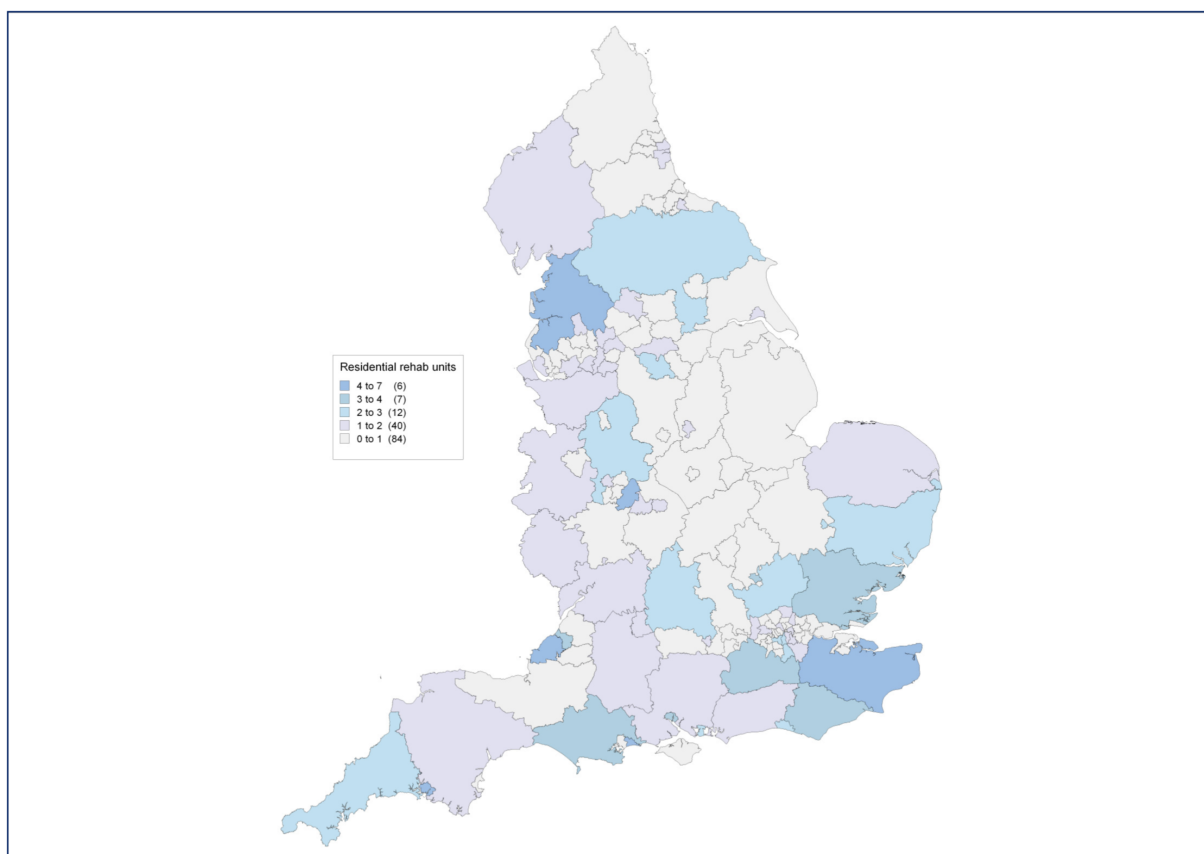
[167] Includes data for 93 residential rehabilitation units reporting to the NDTMS in England during 2010/11 and three units reporting to the WNDSM in Wales during 2010/11. Most cases from residential rehabilitation units in Northern Ireland relate primarily to alcohol and therefore are not added to the Northern Ireland Drug Misuse Database.

estimated number of residential rehabilitation units in the UK. Almost all the commercial organisations are situated in England. In England, half (58) of the identified residential units are commercial organisations and half (58) are charitable organisations. However, in both Wales and Northern Ireland, all of the identified residential rehabilitation units are charitable organisations. In Scotland, 12 of the identified units are charitable organisations and three are commercial organisations.[168]

Geographical availability

Figure 11.1 shows the geographical availability of residential rehabilitation services in England. The South East and North West have the highest concentration of residential rehabilitation services with lower numbers in the Midlands. Nevertheless, residential rehabilitation is often a national resource with clients accessing residential rehabilitation outside of their local area and Community Safety Partnerships in Wales also referring clients to English services.

Figure 0.1: Map of residential rehabilitation units in England.



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Source: Rehab Online (NTA), DDN (2011)

Ad hoc studies

Other sources of information on availability of residential drug rehabilitation services are ad-hoc needs assessments and service reviews.

[168] Estimates are based on information from DDN (2011), Scottish Drugs Service, NDACT Directories, personal correspondence with the devolved administrations and services. They have been cross-referenced with service websites.

Needs assessment for Tier 4 services in England
The NTA (2005) carried out a needs assessment for Tier 4 drug treatment services in England and sent questionnaires to 105 residential rehabilitation services identified through the NTA's residential directory 'BEDVACS'. Sixty-five of these services responded to the survey. The authors estimated that 6,090 residential rehabilitation spaces were available in 2003/04.[169] However, NDTMS returns were lower, at 4,531 for the same period, giving a mean occupancy rate of 74%. Despite this, services reported that one of the key needs was an increase in the number of beds.

The NTA's latest audit of residential rehabilitation services found that 4,166 individuals in drug treatment in 2010-11 had received residential rehabilitation as part of their latest treatment pathway. Three-quarters of them (76%) had treatment in community services before accessing residential rehabilitation.

Review of residential rehabilitation in Scotland
A review by the Scottish Government found that there were 22 residential treatment services for drug and alcohol misuse in Scotland in 2005/06, with an estimated total of 352 beds, ranging from two beds to 104 beds per service (Scottish Government 2007). The estimated capacity per year in Scotland was 1,670 clients. This number includes alcohol only services, so the number providing services for illicit drug users will be lower.

Tier 4 treatment in Wales
The Welsh Government is currently conducting a survey of providers and commissioners to assess the availability of Tier 4 treatment units/beds, to improve the referral process and to ensure that clear referral pathways are in place. A report summarising the outcome of the questionnaires will be taken to Ministers in late 2012.

Referral pathways
In England, each local area is expected to have clear referral pathways and protocols in place for people wishing to access residential treatment. Eligibility for funding is determined by a community care assessment. An initial assessment will also be carried out by the service to establish whether residential rehabilitation is the most appropriate treatment for a client (NTA 2006b). Clients who wish to self-fund their treatment will undergo an assessment by the residential facility to determine their needs.

In additional analyses requested by the UK Focal Point, data on referral source for those in treatment were taken from the NDTMS and the WNDSM. In 2010/11, just under half (45.9%) of all clients in residential rehabilitation in England and Wales were referred to a unit by a hospital or another medical source. Self-referrals or referrals from family and friends accounted for 14.7%, while social services and court/probation/police accounted for 11.9% and 12.4% of referrals, respectively. Other drug treatment centres accounted for 10.8% of the referrals and the least common referral source were GPs at 0.8% (Table 11.3).

[169] Estimate based on 58 drug patients being treated by the 48 agencies, who returned the questionnaire, extrapolated up to the 105 residential rehabilitation services identified.

Table 0.3: *Source of referral for clients in residential rehabilitation in England and Wales in 2010/11*

Source of referral	2010/11	
	n	%
Self-referred/family friends	431	14.7
Other drug treatment centre	317	10.8
GP	23	0.8
Hospital/other medical source	1343	45.9
Social services	350	11.9
Court/probation/police	362	12.4
Other	103	3.5
Sub total	*2929*	*100*
Not known/missing	9	
Total	**2938**	

Source: NDTMS and WNDSM

The financing of residential rehabilitation plays an important role in determining access (see section 11.1.1). In view of the increased cost and comparable outcomes of residential treatment with community based treatment, NICE recommend that community services should be the frontline treatment option and that residential rehabilitation should be considered particularly for people with co-morbid physical, mental health or social problems. The NICE guidelines on psychosocial interventions also state that all community treatment options should have been exhausted before residential rehabilitation is considered (NICE 2007b).

Waiting Times

ISD Scotland waiting times data for drug and alcohol treatment (ISD Scotland 2012d) show that in the first quarter of 2012 (January to March), 92% of all those seeking residential rehabilitation or residential detoxification started treatment within one week of being ready for treatment and 4.2% were placed two weeks after being ready for treatment. The remainder were placed between three weeks and 16 weeks. During the second quarter of 2012 (April to June), 87.6% of clients seeking residential rehabilitation or residential detoxification started treatment within one week and a further 7% started treatment in two weeks.

11.2.2 Types and characteristics of residential treatment units

Common approaches

The NTA's *Models of residential rehabilitation for drug and alcohol misusers* identifies two sub-sets of rehabilitative programmes: long stay (six-months or more for long-term and entrenched addiction) and short stay (less than 12 weeks) (NTA 2006b). It also lists approaches used in residential rehabilitation services in England and the number of services adopting each approach. Although the list is not exhaustive, it does include commonly used approaches:

- 12-Step views addiction as a disease and originates from the 12-Step Alcoholics Anonymous model. Clients will often complete the programme in the community after exiting a residential service;
- Cognitive Behavioural Therapy (CBT) is a psychosocial treatment and is based on the idea that a person's thoughts cause their behaviour. CBT aims to teach the patient to recognise when they are likely to take drugs and to avoid these situations;
- Therapeutic Communities (TC) - In a TC, both staff and clients participate in a social and learning community and tend to be approximately six months long; and
- faith-based (i.e. Christian Philosophy) services employ staff with religious beliefs and may require residents to share that particular faith.

Many services do not use one approach exclusively, but use a mixture of approaches tailored to a client's needs. The NTA's Rehab Online Directory lists 37 services that use, what they describe to be, an eclectic/integrated approach by combining some of the above listed approaches.

In their treatment framework guidance, the WAG[170] identified three main approaches to residential rehabilitation: Social Learning Theory[171] based programmes; 12-step programmes; and faith-based Therapeutic Communities (TCs) (WAG 2004b). In contrast to the NTA, the Welsh Assembly Government identified TCs as faith-based, whereas the NTA separated the two approaches.

Powis et al (2012) explored the treatment integrity of custodial addiction therapeutic communities by exploring current delivery in four prisons (see section 9.6.1). TCs were seen to be functioning well and adhering to the model of an addiction TC.

Age of first drug use and access to residential rehabilitation

In 2010/11, the average age of those in treatment for heroin use in Wales was 33 years old while the average age in England was 35 years old. The average age of first use of heroin amongst this group was 19 in Wales and 20 in England resulting in an average time lag of 14 years and 15 years respectively. In England, those in residential rehabilitation for primary cocaine use also had an average age of 35 and an initiation age of 20. However, those in treatment for primary cocaine powder use were younger (32 years old) than those in treatment for primary crack cocaine use (36 years old) and had a shorter time lag between initiation and being in residential rehabilitation (13 years for cocaine powder users and 16 years for crack cocaine users). The average age of primary stimulant users was the same as cocaine and heroin users; however, their average initiation age was much younger at 17, resulting in an increase of three years in the time lag from initiation to being in residential treatment. Primary cannabis users had a much younger initiation age of 14 and an average age of 32 while in treatment in 2010/11.

Typical mix/integration of services

OST and detoxification

Residential rehabilitation services in the UK are based predominantly on an abstinence model, where residents are required to be drug free and the end goal is that of continued abstinence. Some residential rehabilitation services are just one of a few services offered by an agency. NICE guidelines on psychosocial interventions for drug misuse state that anyone entering residential treatment should already have completed a residential or inpatient detoxification programme (NICE 2007b). A number of residential rehabilitation services offer detoxification for those who are still taking drugs, as the first step within the residential unit. The NTA's (2005) needs assessment found that 22 out of 65 services (34%) offered an additional detoxification service. According to the Drink and Drugs News directory (DDN 2011), there are 72 residential rehabilitation units offering detoxification in England. The DDN directory does not provide details of whether this is community-based, in-house or by referral. The Scottish Drugs Service lists the type of detoxification available with: two units offering in-house detox only; one offering in-patient detox only; five units offering both in-house and inpatient detox; two units offering both inpatient and in-house detox as well as detox by referral: two offering detox by referral only; and one offering support for home-based detox only. Two units in Wales offer in-house detox to residents. Neither of the units in Northern Ireland offer detoxification programmes.

Infectious diseases

The Scottish Drugs Service provides space for residential rehabilitation services to include information on any infectious disease screening services that they offer. Four of the services listed offer counselling for infectious diseases, one service offers a testing service and three offer testing and vaccinations (hepatitis A and B).

Aftercare

In a joint review carried out by the NTA and the Healthcare Commission (now the CQC) (2007), it was found that 88 per cent of inpatient and residential services had policies to enable service users to

[170] Now the Welsh Government.

[171] Social Learning Theory asserts that people learn within a social context

effectively integrate into the community and to provide appropriate aftercare following the service user's exit. Out of the 164 drug or drug and alcohol residential rehabilitation services listed by DDN (2011), 85 units offer aftercare and 69 units offer resettlement. The NTA's report on the role of residential rehabilitation in an integrated drug treatment system found that residential rehabilitation is not an automatic door from the treatment system, but an integral part of a network of services and the majority of residential rehabilitation clients return to community-based treatment services for further structured support afterwards.

Mental Health
The DDN directory states whether a service deals with dual diagnosis clients or not. A total of 79 of the listed residential rehabilitation units are able to accommodate dual diagnosis clients.

The Scottish Drug Service website provides details of which mental health issues each service is capable of assessing and the mental health interventions available in each service to deal with such issues. According to the NTA's (2006b) *Models of residential rehabilitation* publication, most residential rehabilitation services are able to work with those who have co-existing mental illness as long as they are not severe and enduring. A needs and risk assessment will determine if the mental illness is too severe for the client to participate fully in the rehabilitative programme.

Specific subgroups
A number of services listed by the residential treatment directories are gender specific. For example, DDN (2011) lists 16 services that are for men only and four services that are for women only. One unit in Wales provides services specifically for women and accepts pregnant women and women who wish to have their young children stay with them at the unit. In these units, additional services are provided and a greater number of service standards and regulations need to be met in order to safeguard residents' children.

Families
DDN (2011) lists 71 residential rehabilitation units in the UK offering family services. One particular service in England is specifically for single mothers, fathers or couples who wish to have their children living with them while they address their substance misuse issues. They cater for children up to the age of 10 and pregnant women are considered for admission. The NTA (2006b) states that, for services in England, specific standards need to be met for units offering family services.

Young People
The last remaining residential rehabilitation service specifically for young people (aged between 11 and 18) closed in 2010 due to a reported lack of funding as commissioners responded to evidence that, for most teenagers with drug problems, residential rehabilitation is not the only solution for their drug problems and often they can receive more appropriate care closer to home. The service, in England, offered a 12-week programme of rehabilitation and offered additional education, therapy, family medication services and activities. The service could house five residents at a time and treated over 400 young people from 1995 to 2010. It was registered as a children's home and was also inspected by Ofsted: the official body for inspecting schools.

Outcomes of residential rehabilitation
Keen et al. (2001) explored the short-term outcomes of residential rehabilitation in a therapeutic community setting using a records-based retrospective cohort study.[172] Retention in treatment for 90 days or more was used as the predictor of long-term success and therefore, the main outcome measure. Reason for departure, categorised as either completed treatment, planned or unplanned departure or expulsion from the programme, was chosen as a secondary outcome measure. Completed treatment and planned departure suggested a favourable outcome and constituted a 'success'. The number of days for which patients stayed in treatment ranged from one to 394 with a mean of 80.2 with 34 individuals (25%) completing 90 days or more. One hundred and thirty-eight entrants were categorised as failures and 18

[172] One hundred and thirty-eight drug users, who attended therapeutic communities in Sheffield, England over 12 months, were sampled.

were categorised as successes. Those who were drug free on admission were more likely to succeed than those who required detoxification. No other patient characteristics were found to be predictive of outcome.

11.2.3 Client characteristics

The majority (75.6%) of clients in residential rehabilitation in 2010/11 in England and Wales were primary opiate users and 17.9% were primary cocaine users. Two per cent were primary stimulant users and 2.5% were primary cannabis users.

Table 0.4: *Number and percentage of clients in residential rehabilitation by primary drug in 2010/11 in England and Wales*

Primary drug	n	%
a) Opiates (total)*	***2,201***	***75.6***
heroin	*2,010*	*69.0*
methadone	*126*	*4.3*
b) Cocaine (total)**	***521***	***17.9***
cocaine powder	*144*	*4.9*
crack	*376*	*12.9*
c) Stimulants (total)***	***63***	***2.2***
amphetamines	*57*	*2.0*
d) Hypnotics & sedatives	***33***	***1.1***
e) Hallucinogens	***17***	***0.6***
f) Volatile inhalants	***3***	***0.1***
g) Cannabis	***72***	***2.5***
h) Other substances	***2***	***0.1***
Sub Total	***2,912***	***100.0***
Not known/missing	*26*	
Total	***2,938***	

*breakdown does not add up to total as ‘other opiates’ are not included
**breakdown not provided for Wales
***breakdown does not add up to total stimulants as ‘other stimulants’ are not included
Source: NDTMS and WNDSM

11.3 Quality management in residential treatment

11.3.1 Availability of guidelines and service standards for residential treatment

National and/or local guidelines

THERE ARE A LARGE NUMBER OF GUIDELINES IN THE UK COVERING A WIDE RANGE OF TOPICS, SETTINGS AND CLIENT GROUPS. THE DEVOLVED ADMINISTRATIONS, THE NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE (NICE) AND THE NTA ARE THE MAIN SOURCES FOR GUIDELINES RELEVANT TO RESIDENTIAL REHABILITATION.

NICE IS A SPECIAL HEALTH AUTHORITY FUNDED BY DEPARTMENT OF HEALTH. IT IS RESPONSIBLE FOR PRODUCING NATIONAL GUIDANCE DOCUMENTS TO PROMOTE GOOD HEALTH AND TO

TREAT AND PREVENT ILL HEALTH. ALL NICE GUIDELINES[173] ARE BASED ON AN ASSESSMENT OF THE AVAILABLE EVIDENCE ON CLINICAL AND COST-EFFECTIVENESS AND ARE DEVELOPED THROUGH EXTENSIVE CONSULTATION WITH EXTERNAL ORGANISATIONS. NICE WAS ORIGINALLY ESTABLISHED IN 1999 TO PROVIDE GUIDANCE TO THE NHS IN ENGLAND AND WALES. HOWEVER, SCOTLAND AND NORTHERN IRELAND HAVE BOTH IMPLEMENTED NICE GUIDANCE WHERE RELEVANT AND/OR APPROPRIATE. CONSEQUENTLY, THE STATUS OF NICE GUIDANCE DIFFERS THROUGHOUT THE UK (SEE TABLE 11.2 IN UK FOCAL POINT REPORT 2010).

National clinical guidelines on psychosocial interventions produced by NICE (2007b), state that psychosocial interventions including contingency management, behavioural couples therapy and CBT, should be available in residential settings just as they are in community settings. The guidance also states that clients should have already completed a detoxification programme and have exhausted other community-based treatment options before being considered for residential rehabilitation. In the case of relapse to opioid dependence, the residential unit should offer an urgent assessment with prompt access to further treatment.

Commissioning guidelines

Residential treatment is classified within the Models of Care document (NTA 2006a) as a Tier 4 treatment service and therefore, wider guidelines on Tier 4 provision apply to residential rehabilitation services. Guidelines on how to improve quality and provision of Tier 4 interventions for adult drug users in England, provided by the NTA, aim to help Drug Action Team (DAT) partnerships to improve the commissioning and delivery of Tier 4 services by addressing specific problems with accessing and facilitating access to services (NTA 2008).

The NTA's (2006b) framework *Models of residential rehabilitation for drug and alcohol misusers* also aims to support the commissioning of residential rehabilitation services, primarily, at a local level. It lists the types of residential rehabilitation services available in England, sets out the standards that providers should adhere to, and describes funding mechanisms and monitoring arrangements.

Residential Drug Treatment Services: good practice in the field (NTA 2009a) provides evidence of good practice in both commissioning and provision of residential drug treatment. The report's focus is on eligibility criteria for Tier 4 treatment, developing and reviewing contracts, using data to inform commissioning decisions and funding sources for residential rehabilitation. The report is based on evidence from interviews with local drug partnerships that had performed well in the NTA's 2007-2008 service review (NTA 2009b).

Northern Ireland

The Department of Health, Social Services and Public Safety (DHSSPS) has tasked the Public Health Agency and the Health and Social Care Board with developing a Regional Commissioning Framework for Addiction Services in Northern Ireland. The purpose of this work is to create a greater consistency of approach and access to services across Northern Ireland and to ensure that agreed care pathways and protocols are in place.

Clinical Governance

England

The NTA (2009c) has published guidelines on clinical governance for drug treatment services. All providers are expected to designate a clinical governance lead in their service and to adhere to the clinical governance activities of their parent or commissioning body. Similarly, clinical staff have a duty to participate in clinical governance as outlined by the professional body with which they are registered.

[173] The *Health and Social Care Bill 2011* sets out plans for NICE to become a Non Departmental Public Body and for its remit to expand so that it produces quality standards for the social care sector.

Although all providers of residential services and other regulated activities are required to register with and are assessed by the Care Quality Commission (CQC)[174], some providers will have more specific criteria to meet. Mental health and foundation trust substance misuse services are required to operate in accordance with, and actively participate in, their Trusts' clinical governance processes. The requirements for non-statutory service providers can be complex. Services commissioned by Primary Care Trusts (PCTs) are likely to be accountable to the commissioner for clinical governance, and assured against the *Standards for Better Health* (or future standards). Non-statutory services may additionally become answerable to commissioners outside healthcare organisations, funding bodies and, in the case of seconded NHS staff, NHS trusts.

Wales
The Welsh Government has an agreement in place with NICE covering technology appraisals, clinical guidelines and interventional procedure guidance, which all continue to apply to Wales. Although clinical guidelines issued by NICE are not subject to the Welsh Government's three months funding direction, NHS bodies in Wales are generally expected to take full account of the recommendations made by NICE when commissioning and delivering services to patients. The health standards in Wales, set out by the Welsh Government, ensures that, across the health care setting, services are provided in line with the clinical guidelines and technology appraisals produced by NICE.

11.3.2 Service standards and regulations for residential treatment provision

As health and social care are devolved responsibilities in the UK, there are different regulatory bodies for residential treatment provision in each of the four countries, as shown in Table 11.5.

Table 0.5: *Regulations and regulating bodies*

Country	Regulating Body	Regulation
England	The Care Quality Commission (CQC)[175]	*Health and Social Care Act 2008 (Regulated Activities) 2010*. For clients under the age of 18, *Supplementary Standards for Care Homes Accommodating Young People Aged 16 and 17*
Scotland	The Care Inspectorate[176]	*Regulation of Care (Scotland) Act 2001*
Wales	Care and Social Services Inspectorate Wales (CSSIW)[177]	*Registered Care Homes Act (1984) now the Care Standards Act (2000)*
Northern Ireland	Regulation and Quality Improvement Authority (RQIA)[178]	*The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003*

England
The CQC published guidance for residential substance misuse treatment/rehabilitation services (RSM) to follow, in order to comply with the *Health and Social Care Act 2008 (Regulated Activities) 2010* (CQC 2010) and to achieve registration with the CQC. The guidance provides details of the regulation in set outcomes. They include: respecting and involving people who use RSM services; consent to care and treatment; fees; care and welfare of clients; meeting nutritional needs; co-operating with other providers; safeguarding clients from abuse; cleanliness and infection control; management of medicines; safety and

[174] The CQC is responsible for checking all hospitals, care homes and care services to ensure they meet government standards.
[175] See: www.cqc.org.uk
[176] See: www.scswis.com/
[177] See: www.wales.gov.uk/cssiwsubsite/newcssiw/?lang=en
[178] See: www.rqia.org.uk/home/index.cfm

suitability of premises and equipment; and the suitability and requirements of workers. Staff must have experience and the necessary qualifications; they must also be registered with the relevant professional body for their role, have a full and satisfactory Criminal Records Bureau (CRB) check, be of good character and mentally fit for work. Residential rehabilitation services that provide any other healthcare, such as detoxification, may be required to meet PCT standards if they are commissioned for the purpose of detoxification (NTA 2009c).

Service standards and staffing levels

Northern Ireland

The Regulation and Quality Improvement Authority (RQIA) assesses health and social care providers against essential service standards set out in the *Quality Standards for Health and Social Care* (DHSSPSNI 2006b). The five key quality themes are corporate leadership and accountability of the organisation; safe and effective care; accessible, flexible and responsive services; promoting, protecting and improving health; and social well-being and effective communication and information.

WALES

In 2004, the Welsh Assembly Government produced a *Service Framework for Residential Rehabilitation* within a wider *Substance Misuse Framework* (WAG 2004b). The document states that residential rehabilitation services in Wales should prioritise relapse prevention and details the stages of residential rehabilitation programmes, from the preparatory stage, to the longer-term residential rehabilitation and through to low intensity and move-on rehabilitation. In 2011, the Welsh Government produced a *Substance Misuse Treatment Framework (SMTF) Guidance for the Provision of Evidence Based Tier 4 Services in the Treatment of Substance Misuse* to replace the frameworks published in 2004 (Welsh Government 2011e). The new framework was developed to outline the best evidence on which interventions work for whom and in what circumstances, to inform decisions about Tier 4 services. The framework also aims to develop the Tier 4 workforce by highlighting their education and training needs.

A seminar was held in Llandrindod Wells in February 2011 to review Community Safety Partnerships' progress against implementing the Tier 4 guidance issued by the Welsh Government in July 2008 and to provide an overview of the changes made to the revised SMTF (Welsh Government 2011e). Following the seminar, a letter was issued in March 2011, tasking Substance Misuse Area Planning Boards with responsibility for implementing the revised SMTF and any remaining actions within the guidance yet to be implemented.

Scotland

The Scottish Government set up the National Care Standards Committee (NCSC) to develop national standards, which are relevant to residential rehabilitation for drug and alcohol users (Scottish Government 2011f). The standards were developed over 10 years when a national care regulator, the then Care Commission, was first set up in Scotland. Some of the regulatory functions of the Care Commission were taken over by the Care Inspectorate, which was established on 1st April 2011 under the *Public Services Reform (Scotland) Act 2010*. There are 16 standards; the first five concern the period before a client uses a service, standards six to 15 concern the period while a client is using the service and standard 16 is concerned with 'moving on'. The aim of the standards is to set out the minimum expectations of service providers and to guide the owner/manager on building requirements, staffing requirements and on how to manage the service. These are taken into account, amongst other criteria, by the Care Inspectorate when visiting and assessing a service. The standards are based on a number of principles: dignity; privacy; choice; safety; realising potential; and equality and diversity. Scottish Ministers recently announced a review of the standards to ensure that the needs of service users continue to be met. The Scottish Government are therefore currently undertaking initial development work on the scope and process of the review.

11.4 Discussion and outlook

Residential rehabilitation for drug users has been recognised across the UK as an important element of the whole treatment system and an individual's treatment journey. It can add value by concentrating on the most complex clients who require more intensive help and its potential to lead to recovery has been recognised in drug strategies across the UK. All frameworks and guidelines recognise that commissioners and service providers need to consider a multiagency approach in order to address the needs of the client. As suggested in the NTA in England's *Role and performance of residential rehabilitation* report, a multiagency approach can help improve residential rehabilitation success rates by ensuring clients are prepared before entering residential services by community services and that their transition out of such services is supported. The challenge for service providers will be to demonstrate the cost-effectiveness of residential rehabilitation as the commissioning of drug treatment in England moves towards a payment by results framework.

BACK TO TOP

CROATIA

11 Residential treatment for drug users

11.1. History and legal framework

Residential treatment for drug users in Croatia is carried out within the Croatian health system in psychiatric hospital wards and therapeutic communities, according to special programmes.

11.1.1. History of residential treatment for drug users

Residential treatment for drug users within the health system

Residential treatment for drug users within the health system is organised according to the principles of law and justice pursuant to which addicts, as well as all other categories of patients, need to be provided the same quality health care at all levels. In the long-term course of drug addiction treatment, drug addicts should often be provided with even more professional and structured care within hospital treatment programmes. Intensive and high-quality residential treatment of persons addicted on psychoactive drugs helps to reduce the need for treatment of a number of secondary somatic health consequences (hepatitis, liver cirrhosis, cardiomyopathy etc.), which occur as a progression of the disease among the addicts who have not been treated. High-quality and specialised hospital interventions contribute to the quality of addiction treatment, decrease in mortality rate, protection of public health and public safety.

In the Republic of Croatia, the addiction treatment in the hospital conditions takes place at psychiatric wards. Currently in the Republic of Croatia, there are 33 institutions (clinical, psychiatric, general or county hospitals) providing care to psychoactive drug addicts. Annually 500 to 1000 addicts are treated in hospital institutions in Croatia. Only three institutions have specialised hospital programmes for addiction treatment (Department of Psychiatry of the Clinical Hospital Centre ”Sestre milosrdnice”, Clinical Hospital Centre Rijeka and Psychiatric Hospital Vrapče). A significant number of patients are also treated in psychiatric hospitals Rab and Sv. Ivan. Patients who are treated in psychiatric hospitals have the possibility to stay there up to ninety days, while the length of stay in other institutions is significantly shorter, providing only a detox programme.

In the late sixties, prof. dr. Hudolin began to develop treatment and rehabilitation of drug addicts with a very modern perception of prevention at the Centre for study and control of alcoholism at the neurological psychiatric ward of the hospital "Dr.Mladen Stojanović" (today - Clinical Hospital Centre “Sestre milosrdnice” in Zagreb). The first specialised department for addiction treatment was opened in 1971. At that ward, along with detoxification, a six-month withdrawal treatment with the drug-free approach was conducted. The Centre was the place where many professionals, who later worked in the field of addiction prevention and treatment, were educated. Since 1980 prof. Slavko Sakoman has been the head of the drug addiction treatment department in the Hospital "Sestre milosrdnice" and since 1996, only detoxification - a programme that lasts 16 days, has been carried out at the ward.

Despite the growing number of addicts and the need for specialised residential treatment, hospital facilities for specialised treatment programmes had not been developed until 1997, when the Department for addiction treatment at the Psychiatric Hospital "Vrapče" in Zagreb was opened. At the beginning of 2012, in the same institution a new department - Department for dual disorders was opened, at which addiction in comorbidity with other psychiatric disorders is treated (mostly schizophrenia, delusional disorders and schizotypal and delusional disorder).
Regarding the fact that there was no significant interest for the development of hospital capacities, in the early nineties a network of outpatient treatments organised within the Services for Mental Health Promotion, Addiction Prevention and Outpatient Treatment was established. Transitional changes have affected the increase in the number of addicts who need treatment and the network of established

Services for Mental Health Promotion, Addiction Prevention and Outpatient Treatment has been gradually expanding. The first centre opened in Split (1992), followed by Poreč (1994), Čakovec (1993), Rijeka (1995), Zadar (1996), Pula (1996), Dubrovnik (1996), Varaždin (1997), Šibenik (1997), Vinkovci (1999), Karlovac (1999), Virovitica (1999), Osijek (2000) and the city of Zagreb opened its first centre in 2006.

Although the Service network was established, inpatient treatment was still available to addicts to whom this kind of treatment was a better solution to cure their addiction.

Until 2002, the detoxification programme was implemented only in KBC "Sestre milosrdnice" in Zagreb and in the Psychiatric Hospital Vrapče. For this reason, the Ministry of Health developed and funded the programme for organisation of special regional detox units. The goal of the programme was to open detoxification units in clinical and county hospitals and to increase the bed capacity for treating addicts: Split (5 beds), Rijeka, Osijek, Pula, Zadar and Dubrovnik (4 beds), Zagreb (12 beds) and Šibenik, Karlovac, Varaždin, Slavonski Brod, Vinkovci, Sisak (2 beds).

Therapeutic communities for rehabilitation of drug addicts (CSO)

Those addicts who are motivated to completely give up using drugs (drug-free programmes) choose a long-term stay (up to two years) in therapeutic communities. The length of stay and separation from the environment in which the addiction was developed, the order, work rules and specific day schedule over a longer period of time, allow the addicts to reach stable abstinence. Many therapeutic communities set clear selective criteria to ensure that the limited capacities of communities are used by those addicts who are highly motivated for this kind of programme.

In the Republic of Croatia, there are 8 therapeutic communities and 30 therapeutic houses that operate and work as civil society organisations that provide treatment and psychosocial rehabilitation for drug addicts, as religious associations or communities in the framework of humanitarian activities, or are established and registered as social welfare homes for addicts.

First therapeutic communities in the Republic of Croatia were founded in 1992, Susret and Cenccalo, followed by Reto Centar-Prijatelji nade (1993), Papa Ivan XXIII (1998), Mondo Nuovo and Remar Espana (1999), as well as Ne-Ovisnost and Moji dani (2003).

Therapeutic communities that operate as associations and religious communities within humanitarian activities are Remar Espana, association Mondo Nuovo, association Papa Ivan XXIII, association Cenacolo and Reto Centar-Prijatelji nade, while Zejdnica Susret, Home for Addicts Moji dani and Ne-ovisnost, are established and act as social welfare homes for addicts.

11.1.2 Strategies and legal framework

Legal framework for solving the problem of addiction was established after the declaration of independence of the Republic of Croatia and with the rise of sensitivity of political public towards the problem of addiction. At the beginning of 1991, the Ministry of Health established a special expert committee whose task was to develop a programme of combating drugs abuse and to coordinate its implementation. The view that drugs are a general social problem in which the government and its institutions must participate was accepted, and professionals were entrusted with the preparation of a draft strategy. The first National Strategy for drugs control, combating drugs abuse and helping drug addicts in the Republic of Croatia, as a basic document for the implementation of various activities in the field of combating drugs abuse, treatment and care of drug addicts and occasional drug users, was adopted by the Croatian Parliament in 1996.

In order to ensure long-term legal support for the implementation of the national programme based on the National Strategy, in 1996 the Committee launched an initiative for the creation of the Act on Combating (Narcotic) Drugs Abuse, which was passed by the Croatian Parliament on 23 November 2001 (OG No. 107/01), and up till now 5 amendments to the Act on Combating (Narcotic) Drugs Abuse have been passed (OG No. 87/02, 163/03, 141/04, 40/07, 149 / 09, OG No. 84/11). In accordance with the Act on

Combating Psychoactive Drugs Abuse the Croatian Government adopted the Regulation on the establishment of the Office for Combating Psychoactive Drugs Abuse (6 March 2002).

In December 2005, the Croatian Parliament accepted the second *National Strategy on Combating (Narcotic) Drugs Abuse in the Republic of Croatia from 2006 to 2012*, in response to the need for an integrated, balanced and multidisciplinary approach to solving drug problem in society and harmonisation with the acquis of the European Union. This main strategic document has been implemented through two three-year *Action Plans on Combating Drugs Abuse in the Republic of Croatia* (Action Plan for the 2006-2009 and 2009-2012), which was adopted by the Croatian Government.

The institutional system for prevention and treatment of addiction and combating drugs abuse has been established so that the measures taken to combat drugs abuse could be appropriately and effectively harmonised, both among the government bodies and other entities, and state administration and local government bodies, based on the National Strategy and the Act on Combating (Narcotic) Drugs Abuse and other legal and strategic documents.

In June 2009, the the Ordinance on Types and Activities of Social Welfare Homes, Care Outside Original Families, Space Conditions, Equipment and Employees in Social Welfare Homes, Therapeutic Communities, Religious Communities, Associations and Other Legal Entities as well as Centre for In-Home Assistance and Care was adopted (OG No. 64/2009). This Ordinance set out the provision of care in therapeutic communities and social welfare homes for addicts.

11.2 Availability of residential treatment for drug users

The health system

In the Republic of Croatia, residential treatment for drug users is carried out in psychiatric departments in clinical, general or county hospitals. According to the National Strategy on Combating Narcotic Drugs Abuse 2006-2012, the importance of hospital beds for the treatment of addiction is emphasised, and it is also necessary to provide the conditions for detoxification of addicts in clinics or general hospitals in major cities, with an estimated average stay of one month. It is estimated that in the psychiatric services in the Republic of Croatia, in the first phase of the development of the programme network, 50 beds should always be available for detoxification.
It is necessary to open a department for treating the most severe addicts, which would not be oriented towards detoxication, but stabilisation of the condition, where the addicts in critical conditions after attempting suicide or overdose would be treated, and where the pharmacotherapy would be determined.
To be able to monitor those who want the "drug-free" withdrawal procedure, especially those on mandatory treatment ordered by a court decision, to continue the inpatient treatment, following the therapeutic community treatment type, lasting two to three months further 40 - 50 beds should be provided. At least ten of them should be assigned to a specialised residential programme for juvenile drug addicts.
All psychiatric institutions should take a fewer number of addicts, and this will be their special obligation when it comes to emergency cases and those patients who have been diagnosed with some other psychiatric disease or disorder (e.g. psychosis, suicidal tendency).

Therapeutic communities

Welfare programmes for addicts in therapeutic communities are limited by their capacity, selective criteria when entering the therapeutic community, and the length of stay. Regarding the mentioned criteria, 30 houses which implement the therapeutic community programmes in Croatia, can accommodate around 700 people per year.

11.2.1 Treatment programmes

Health system

Addiction treatment after detoxification is usually done through the outpatient system due to limited hospital capacity. After detoxification, the programme aims to maintain abstinence to prevent relapse. Implementation of long-term psychotherapy and family therapy results in changes in the relationship of addicts towards themselves, others, better family relationships and control. With a high-quality treatment programme addicts increase the knowledge about their disease, become aware of the arguments for stopping the substance abuse (cognitive therapy, education). Addicts are supported and encouraged to gradually assume more and more responsibility and to change their immature behaviour by facing the consequences of not fulfilling an agreement, but also by getting praise for the progress made (behavioural approach). It helps them find a new purpose in life. Family therapy helps the addicts to instead of the feelings of frustration and despair gradually start feeling more supported. By re-education, addicts gain more respect for the law and obligations, and are also offered help in resolving the previously accumulated problems, such as unemployment, conflicts with the law, debts, conflicts with the environment (social therapy). Retention of addicts in the programme, abstinence from illicit drugs and improvement of the aspects of socially acceptable behaviour are the best indicators of the quality therapeutic work.

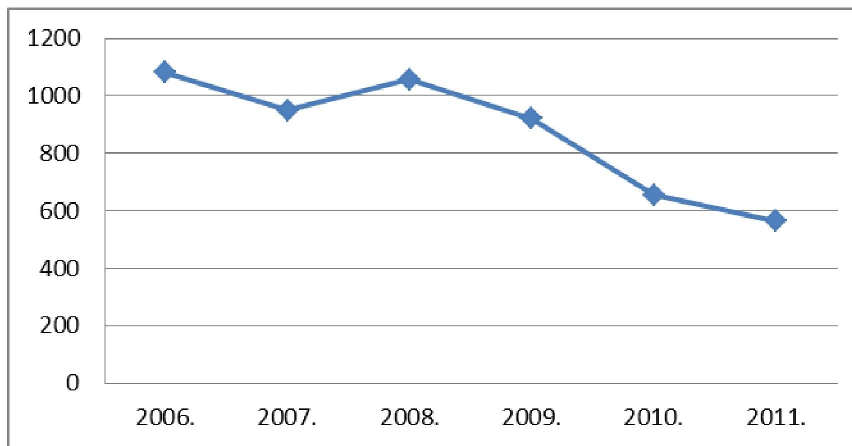
Therapeutic communities

Programmes of therapeutic communities are diverse, yet most of the therapeutic communities are of a religious character, i.e. the treatment is based on strengthening the intensity of faith. The basis of therapeutic community programmes is a well structured occupational therapy, group and individual therapy, and the main goal is psychosocial rehabilitation and inclusion of drug addicts in normal life. Rehabilitation and social reintegration are based on changing lifestyles, empowering social skills in dealing with life's difficulties and problems, and finding solutions. In these programmes, along with religious people, rehabilitated addicts are those who usually coordinate the programmes, while professional staff is less represented.

11.2.2 Trends in inpatient treatment in the health system

According to the data on residential treatment for drug users in the health care system, it is evident that in the period between 2006 and 2011 the number of treated persons dropped. In 2006, 1,081 people underwent residential treatment for addiction to psychoactive drugs, while in 2011, 563 people were treated for the same diagnoses.

Figure 11.1 - Number of persons treated in hospital departments in the Republic of Croatia in the period 2006-2011



Source: Croatian Institute for Public Health 2012

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TURKEY

SECTION 11

RESIDENTIAL TREATMENT FOR DRUG USERS IN EUROPE

No new data.

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NORWAY

Part B: Selected issues

11. Residential treatment for drug users

Astrid Skretting, the Norwegian Institute for Alcohol and Drug Research

11.1 History and policy frameworks

11.1.1The history of residential treatment

As early as 1961, Norway had established one of the first specialist clinics in Europe for problem drug users (the National Clinic for Drug Abusers). Initially, the majority of the patients were so-called 'classic' drug addicts, or adult patients who abused morphine or other opioids. The clinic worked on the basis of a psychiatric/medical model. Based on the new client groups that subsequently emerged as a result of young people's use of illegal drugs, the clinic was reorganised in 1979 into a more social-educational institution with the emphasis on school, work training and rehabilitation.

As a need grew for treatment measures for an increasing number of young people and young adults who had developed problems relating to the use of drugs, it was emphasised that the treatment should not be developed as a separate care service, as had been the tradition in the care for alcoholics. It therefore became a goal early on that the help and treatment services should be developed as part of the ordinary treatment system. In the early 1970s, emphasis was therefore placed on establishing treatment services within the framework of mental health care. The most important reason why the mental health care services were allowed to take responsibility for people who developed drug problems was that the use of drugs was regarded as one of several symptoms of mental health and social problems. Secondly, experience showed that gathering a large number of drug users in the same institution made treatment more difficult. It therefore seemed to be most expedient to treat drug users together with other patient groups (Ministry of Social Affairs, 1976).

Moreover, a separate care service for the treatment of drug users alone would give the impression that this was a very unique and limited illness. The general public would thereby find it more difficult to see the connection between social and economic factors and drug abuse (ibid.).

It became clear relatively quickly, however, that traditional mental health services were not equipped to deal with this new category of patients. Many of the young people who sought treatment for their drug problems needed measures that the psychiatric services could not provide. During this period, political and professional schools also emerged that led to a change in views on how young drug users should be handled. From the early 1980s, more systematic efforts were therefore made to develop special in-patient services for long-term treatment. One important element was that social and mental health problems were not to be treated within the framework of an authoritarian medical-psychiatric understanding. Instead, a psychological, social-educational approach was adopted that focused on equality of status between client and helper and on social network-building. In other words, drug use went from being perceived as a traditional illness to being understood more in social-psychological terms. Based on the recognition that problem drug use among young people is a complex problem that requires untraditional approaches, what are known in the Nordic countries as communal residential and work facilities were established. Other treatment institutions also gradually emerged that were based on different professional approaches, for example what are known as 'greenhouses', which are developed as therapeutic communities. The initiatives largely came from groups or individuals, who established the institutions with the help of public funding.

The HIV/Aids epidemic among injecting drug users in the mid-1980s highlighted the need for greater treatment capacity. Substitution treatment was not regarded as an option at this stage. The most important reason for the opposition to this type of treatment was the idea that heroin users, like everyone else, were capable of changing their behaviour. It was claimed that methadone treatment meant abandoning this fundamental belief in change and society's obligation not to give up, but to try again and again. Treatment

optimism could be said to have predominated on behalf of medication-free treatment of heroin users (Skretting, 1997). The then Ministry of Social Affairs presented a dedicated action plan for the development of in-patient treatment, with the goal of establishing 300–350 new in-patient places for problem drug users (Ministry of Social Welfare, 1988). All the county authorities in Norway were invited to present plans for the development of treatment measures for drug users, and, as a result of financial assistance from the state, around 400 new in-patient places were established.

Overall responsibility transferred to the county authorities

Initially, it was the county authorities that were responsible for treatment institutions for problem drug users, while the state was responsible for corresponding institutions for alcoholics. This was changed by the Act relating to Social Services, which entered into force on 1 January 1993. As a result of the new Act, the county authorities were assigned overall responsibility for the treatment of both patient groups.

The foundations for the organisation of treatment measures for drug and alcohol users by the county authorities were laid in the Act relating to the County Authorities' Responsibility for Institutions for Alcoholics etc. of 1984. The Act relating to Social Services went one step further by assigning overall responsibility for treatment measures for drug and alcohol users to the county authorities. The Act relating to Social Services gave the county authorities responsibility for ensuring that a sufficient number of places in institutions were available to cover the need at all times (responsibility for 'ensuring' this). The emphasis on the municipalities' responsibility for providing help in the local community instead of leaving drug or alcohol users to be treated in institutions was followed up by a funding arrangement whereby stays in county institutions were co-financed by the municipalities and the county authorities. The county authorities could own and run the treatment units themselves, or choose to enter into operating agreements with or buy individual places from private providers. The units were largely regulated by the Act relating to Social Services, but the county authorities could also fulfil their treatment responsibility by using treatment measures regulated by other acts (the Hospitals Act). In practice, this primarily applied to outpatient treatment units originating in the psychiatric services (e.g. the psychiatric youth teams), but also to some in-patient units.

Norway carried out major health policy reforms in the years following the turn of the millennium. As a result of the Regular GP Reform of 2001, all the country's inhabitants were assigned a regular GP. Through the Hospital Reform, which entered into force in 2002, responsibility for and ownership of hospitals and other specialist health services was transferred from the county authorities to the state. Five state-owned regional health authorities were established (reorganised as four from 1 January 2009) that shall ensure that adequate specialist health services are available to the population in the respective health regions.

In 2004, the Hospital Reform was followed up by the Administrative Alcohol and Drugs Treatment Reform. Through this reform, responsibility for treatment for drug and alcohol problems was also transferred from the county authorities to the state represented by the regional health authorities. It thereby became part of the state specialist health service. The reform formed the organisational basis for viewing treatment for drug and alcohol problems in conjunction with the other specialist health services in somatic health care and mental health care. The municipal health and social services still have overall responsibility for covering needs that are not covered by the specialist health service.

Residential treatment for drug users has primarily been organised as long-term treatment periods of one to three years. This is in contrast to institutions that provided treatment for alcohol problems, which have focused to a greater extent on shorter stays in clinics. After treatment for drug and alcohol problems became part of the specialist health service, a gradual shift towards shorter stays in institutions also applies to the treatment of problem drug users. The idea is that treatment will be provided to a greater extent as outpatient treatment, in combination with shorter stays in institutions when this is considered necessary, and in combination with the municipal health services.

11.2 Strategy and policy frameworks for residential treatment

The regional health authorities' new responsibility was defined as 'interdisciplinary specialised treatment for drug or alcohol use', and legislative regulation of relevant treatment units was transferred from the Act relating to Social Services to the Act relating to Specialist Health Services. The Ministry of Health and Care Services has explained in a circular what the amendments entail (Ministry of Health, 2004a). The circular also provides an interpretation of the provisions of the Patients' Rights Act and how they apply to interdisciplinary specialised treatment.

The Patients' Rights Act entitles patients to free choice of hospitals. Correspondingly, drug and alcohol users are entitled to free choice of treatment facility. They can choose between treatment facilities anywhere in Norway that are part of the regional health authorities' services. In other words, the right to free choice is not limited to the health region that the patient 'belongs' to. The right to free choice of treatment facility does not apply to the choice of treatment level, however. For example, a patient who has been granted a right to receive treatment for his/her drug or alcohol use cannot choose residential treatment if he/she has been granted a right to outpatient treatment. Nor can a patient who is deemed to be in need of short-term treatment (up to six months) choose a treatment programme of longer duration. A list of institutions/units that provide interdisciplinary specialised treatment is available at www.frittsykehusvalg.no. The list is divided into detoxification, outpatient treatment, 'short-term in-patient treatment' and 'long-term in-patient treatment'. Most of the institutions included offer both short-term and long-term in-patient treatment.
The Ministry has also prepared a strategy document aimed at the regional health authorities. It outlines national perspectives and strategies for the Administrative Alcohol and Drugs Treatment Reform (Ministry of Health, 2004b).
The goals of this reform are ambitious. It is emphasised that drug and alcohol users with concurrent problems shall receive better services. The treatment shall focus on comprehensive, individually-based approaches, with the emphasis on both a social and health-related perspective (ibid). The reform is intended to ensure that problem drug and alcohol users' patient rights are better promoted and safeguarded, and that they, as patients, receive the specialised health services that are necessary in order to reduce their somatic and mental health complaints, in addition to receiving treatment for their abuse. The need to ensure better services for problem drug and alcohol users with concurrent mental illnesses is emphasised in particular (ibid). The guidelines in circulars and policy documents concern both in-patient and outpatient treatment.
Help and treatment services for problem drug and alcohol users in Norway have traditionally had a large proportion of private service providers, many of which had operating agreements with one or more county authorities. When the Administrative Alcohol and Drugs Treatment Reform was introduced, the regional health authorities took over the county authorities' agreements with private providers of treatment services. It is emphasised that the regional health authorities must give private providers an opportunity to compete on equal terms with public providers of treatment services. At the same time, however, the same quality requirements must apply to private and public treatment services. Now that treatment for problem drug and alcohol use is part of the specialist health service, there is reason to believe that both public and private providers will find that they are subject to more stringent requirements as regards quality and results.
Residential treatment for drug and alcohol problems under the auspices of the state specialist health service is funded by the state and is free of charge for the individual patients. No estimate is currently available of the costs per patient per day.

11.3 Availability and characteristics

National availability and accessibility

Because treatment for problem alcohol and drug use is uniformly organised in Norway, it is difficult to quantify how many in-patient institutions or units only provide treatment for problem drug use. In addition, organisational factors mean that some institutions are big and have several departments, for example units that are part of a hospital department. Based on the list at www.frittsykehusvalg.no, 65 units/institutions state that they provide in-patient treatment for patients with drug problems. Of these, 28 are units affiliated to hospitals, 11 are therapeutic communities/communal residential and work facilities, and 26 are other types of in-patient institutions. While therapeutic communities/communal residential and work facilities primarily provide treatment for drug problems, most of the other units also provide treatment for alcohol problems. The number of in-patient places is estimated to around 1,900 (Statistics Norway). It is not known how many of these places are used to treat patients with drug problems, however. The number will vary from year to year.
As regards the length of different forms of residential treatment, it often varies greatly – from short-term treatment programmes of four to six months to long-term programmes of up to three years. Because the same in-patient institutions in many cases provide both short-term and long-term treatment (in Norway, the

distinction is drawn between ≤ 6 months and >6 months), it is not expedient to provide an overview of the number of units that provide short-term and long-term treatment programmes, respectively.
As long as treatment for problem drug and alcohol use was regulated by the Act relating to Social Services, referrals were made via the municipal social services, and the municipality paid part of the costs for each person undergoing in-patient treatment. When this type of treatment became part of the specialist health service, the right to make referrals was transferred to GPs, as is the practice for the specialist health service in general. However, because many problem drug and alcohol users have little contact with the ordinary health service, the Storting decided that the social services and the GPs shall have equal right to make referrals to interdisciplinary specialised treatment in and outside institutions. The social services' right to make referrals does not include specialised health services in somatic health care and mental health care, however.
Referrals for treatment are considered by an assessment unit that decides whether the referred patient shall be granted a right to treatment in the specialist health service. The assessment units consist of the different outpatient clinics in interdisciplinary specialised treatment and mental health care. A guide has been prepared for the assessment of such referrals (see Chapter 1.3). The guide covers the assessment of referrals to all types of treatment for problem drug and alcohol use. It is the assessment unit that decides whether the referred patient shall be granted a right to treatment and whether the right shall include in-patient treatment (short-term or long-term), outpatient treatment or substitution treatment (Directorate for Health and Social Affairs, 2007). The assessment shall be carried out within 30 working days of receipt of the referral. In cases where a patient is granted a right to treatment, an individual deadline shall be set for when the patient shall receive the necessary treatment at the latest.

11.4 Types and characteristics of residential treatment units

Residential treatment in Norway is diverse and includes different approaches, such as therapeutic communities, family treatment, various psychodynamic methods, communal residential and work facilities, 12-step programmes etc.
There are some big differences between the different residential institutions and between what is included in the treatment programme. For example, it varies whether the treatment institutions themselves carry out detoxification of the patients, or whether patients must have gradually reduced their use of drugs or alcohol or not be under the influence of drugs or alcohol on admission to treatment. It also varies whether education and vocational training are offered as part of the treatment. While residential institutions that provide long-term treatment usually offer such services (communal residential and work facilities and therapeutic communities), this is naturally less common in more short-term treatment programmes. As regards various forms of somatic health care (including testing for HIV, HCV etc.), this is included as an integral part of the treatment programme in residential institutions.
In Norway, substitution treatment is mainly provided as an outpatient service. However, most residential institutions admit patients for different forms of psychosocial treatment as a supplement to the substitution treatment.
As regards various forms of social follow-up/aftercare, this is in principle the municipalities' responsibility. However, such services are sometimes offered by residential institutions as an integral part of long-term treatment.
Although most residential institutions in Norway are not age/group-specific, some units are reserved for young problem users. There are also a few dedicated units for women and families, respectively. There are no special units for ethnic minorities so far.
When a patient who is discharged from residential treatment for drug or alcohol use is assessed as needing help from the municipal social services, the social services will be notified in good time if the patient so wishes. The discharge will then be planned and prepared in cooperation between the social services and the specialist health service.
Drug users in need of long-term, coordinated services are also entitled to an individual plan. The plan is intended to be a tool for cooperation between the patient and various service providers. It shall also contribute to strengthening coordination between the relevant service providers to ensure that the patient gets the help he/she needs. This includes services from the health service, social services, education and employment etc.

11.5 Quality management

Availability of guidelines and service standards for residential treatment

The regional health authorities are responsible for ensuring that there are adequate treatment services for different patient groups. As regards treatment services for patients with drug or alcohol problems, the individual health regions have prepared strategy plans for how to fulfil their responsibilities and what the treatment services shall comprise. The regional plans contain guidelines for which treatment services will be provided. They apply to units operated by the health authorities themselves as well as to treatment services purchased from private service providers. Requirements specifications are prepared in connection with purchases from private service providers, which the relevant providers must comply with.

As of 2012, there are no uniform national guidelines for interdisciplinary specialised treatment over and above what is set out in the above-mentioned circulars and policy documents. This means that there is currently no national standard for staffing and what qualifications staff must have. However, the inclusion of treatment for problem drug and alcohol use in the specialist health service has led to greater focus on health professionals in such treatment than before. Moreover, the Directorate of Health is working on guidelines for the treatment of problem drug and alcohol users that will apply to both residential treatment and outpatient treatment. The following guides/guidelines relating to treatment for drug or alcohol use are also available:

Guide to the assessment of referrals to interdisciplinary specialised treatment for drug or alcohol problems (2007). It applies to both residential treatment and outpatient treatment.

National guidelines for opioid substitution treatment for opioid dependency (2011).

National guidelines for pregnant women in opioid substitution treatment and follow-up until the children reach school age (2011).

Guidelines for the treatment of patients with concurrent drug or alcohol problems and mental illness (2011).

(The guidelines have been discussed in previous national reports to the EMCDDA. See NR 2009–2011).

As regards documentation, interdisciplinary specialised treatment units are required to report patient data to the Norwegian National Patient Register, in line with the rest of the specialist health service. These data form the basis for the annual reporting to the EMCDDA's Treatment Demand Indicator on patients who start treatment. The register of individual-based data was not established until 2009, so the data that are reported are still somewhat inadequate. Work is under way, however, on improving both the quality and the level of coverage. Inadequate reporting has not had any financial consequences for the individual treatment units so far.

11.6 Discussion and outlook

Based on information from the Norwegian National Patient Register, demand for treatment for drug and alcohol problems appears to be increasing. The inclusion in the patient register of patients who seek treatment for drug or alcohol problems is relatively recent, however, which makes it difficult to say for certain how many patients have sought such treatment in recent years compared with the first years of the new millennium.

There is also concern among many treatment providers about the fact that, whereas it used to be possible to offer residential treatment lasting one to three years, the responsible authorities now see shorter admissions as more desirable and want municipalities to take more responsibility for many of the services that were previously included in the treatment. This applies to education, work training, residential follow-up etc.

Since treatment for drug and alcohol problems became part of the state specialist health service, we have also seen increasing concern about the greater emphasis that is placed on the medical part of the treatment through increased use of medication, which may be at the expense of social aspects of treatment. We also note a trend whereby in-patient institutions are being ordered to admit patients in substitution treatment to a greater extent. This is a development that personnel at some in-patient institutions are sceptical about, based on the view that drug users who, for different reasons, are not suited for or do not want substitution medication should be given an opportunity to take part in a treatment programme in which there are no patients receiving such medication.

As mentioned, the trend is towards shorter periods of in-patient treatment, a trend that is also being questioned. While stays of one to three years in institutions were common before, the trend is now for increased use of short-term residential stays and increased emphasis on outpatient treatment. Part of the background to this is that long-term residential treatment has traditionally included social components such as training in living skills, education, employment etc. This is a responsibility that, in principle, rests with the municipalities and other service providers outside the specialist health service. It is therefore a goal that in-patient and outpatient treatment in the specialist health service be seen in conjunction and be combined with different municipal services, such as health-related follow-up, social services in the form of adequate housing, employment etc. Whether such a reorganisation from long-term to short-term residential stays will have the expected results will basically depend on whether the municipalities can actually provide the necessary services for the patient group in question, and whether treatment in the specialist health service is coordinated with the other services.

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SLOVAKIA

Residential (institutional) treatment of drug users in Slovakia (DATA 2011)

In Slovakia, residential health care for patients with drug addictions is provided in psychiatric hospitals and medical institutions, in clinics or departments for drug dependence treatment, but mainly in Specialized Centres for Treatment of Drug Dependencies (CTDD). Outside the health sector, accredited resocialization facilities operate in Slovakia, which fall under the Ministry of Labour, Social Affairs and Family (MLSAF), which provide a concentrated form of psychosocial care provided in the community within a long-term stay of clients pursuant to Article 63 of Act № 305/2005 Coll. on Social and Legal Protection of Children and on Social Legal Guardianship, as amended.

HISTORICAL AND POLITICAL FRAMEWORK

HISTORY OF INSTITUTIONAL TREATMENT

A significant personality in the history of Czechoslovak addictology was psychiatrist Jaroslav Skála, a promoter of psychotherapy and community therapy. In 1948, he founded the first residential (institutional) department for the treatment of alcoholism in Prague. Gradually specialized institutional and residential departments are established in several places in former Czechoslovakia, and thus also in Slovakia. In addition to the issue of dependence on alcohol, which markedly dominated at that time, to a reduced extent also patients with dependence on pills were treated institutionally – opioids (Alnagon, Dinyl) and medicaments with a stimulating effect and containing amphetamine substances (Fermetratin, Dexphenmetrazine) and adolescents with dependence on volatile substances (toluene, acetone).

40 years later, with the opening of the borders after 1989, addictology was increasingly dealing with psychoactive substances, in addition to alcohol, as a result of a marked growth of their use. In Slovakia, Centres for Treatment of Drug Dependencies (CTDD) were established as public allowance organizations established by the Ministry of Health of the SR. The first CTDD was established in Nové Zámky and in 1992 CTDD in Bratislava in the former Alcohol Advisory Centre. It is the largest central specialized health institution in Slovakia, whose main scope of business is prevention, diagnostics, treatment and subsequent after-treatment care for patients with health problems resulting from the use of psychoactive substances. CTDD's structure is formed according to the state-of-the-art principles for health care provision according to the recommendations of the WHO, the European Commission DG SANCO and the National Institute on Drug Abuse in the USA. In 1995, the CTDD was founded in Banská Bystrica. In 2000, the CTDD was founded at the Specialized Psychiatric Clinic - Odborný liečebný ústav psychiatrický (OLÚP) n. o. in Predná Hora. In 2004, the CTDD was founded in Košice and in Žilina. One year later, the CTDD Rieka is founded in Šútov. In the same year, however, two CTDD cease to exist, in Nitra and Humenné. Shortly after, due to the lack of qualified staff - physicians-specialists, also the CTDD in Nové Zámky ceases to exist.

The first resocialization centre in Slovakia, Komunita Ľudovítov n. o., up till now the largest of its type, was founded in 1995 at the initiative of the citizens' association Život bez drog (Life without Drugs) and active support of the Ministry of Labour, Social Affairs and Family. It followed the institutional care of CTDD in Nové Zámky. In 1992, other resocialization centres are gradually founded. Long-term care with a shift to social therapeutic rehabilitation is covered by Sanatórium AT MUDr. Ivana Novotného in Bratislava, which has been operating since 1996. Today the Ministry of Labour, Social Affairs and Family has a record of 19 accredited resocialization centres. At present these therapeutic communities focused on social reintegration of drug abstainers after previous withdrawal medical treatment are predominantly non-profit organizations based on non-governmental organizations, citizens' associations or religious organizations.

Institutional health care of drug users is a medical programme, which consists of medium-term residential treatment, which is carried out for 6 - 12 weeks.

The resocialization programme is conducted usually for at least eight months, in most facilities it is 12 - 24 months, according to client's individual needs.

The key forms of treatment are ambulatory treatment and institutional treatment in healthcare facilities. The institutional form is provided most commonly at initial stages, during and after a short interruption

of drug use. However, in Slovakia still patients prevail who were treated only by ambulatory form according to their own decision.

Strategy and political framework of Residential (institutional) treatment

The Slovak Government, by Resolution № 259/2009 dated 1 April 2009 adopted, inter alia, the National Drug Strategy 2009-2012 (*see NPDS 2009-2012*). Several tasks result from it for the public health sector.

Priorities of the public health within the Action Plan for the National Programme for the Fight against Drugs include also the provision of quality and available health care for drug users.

Medical care related to the treatment of drug addictions in the public health sector is provided free of charge; its availability and accessibility depends on specific contracts of healthcare facilities with Health Insurance Companies (HIC), which publish the relevant facilities. The volumes and amounts of payments to healthcare facilities depend on the policy of particular Health Insurance Companies and vary (roughly €40 and more bed/day/patient paid by HIC). They vary on the basis of contracts on yearly basis and according to the financial status even more often. The users of psychoactive substances with chronic ailments do not belong to attractive insured persons from the point of view of Health Insurance Companies. Even despite that the availability of health care is ensured and an access to treatment for people from the whole socio-economic spectrum. Every citizen is covered by health insurance according to the law and is entitled to the provision of health care of this type. For the groups of the unemployed, children and pensioners, where we can classify a major part of drug users with dependence, the state pays fees to Health Insurance Companies. Other citizens pay insurance on a monthly basis on their own or it is paid by their employer. Beyond the scope of the volume of provided health care or at one's own request a patient can get treatment for direct payment according to the respective pricelist in certain healthcare facilities.

If a patient with drug addiction is employed during residential treatment and has card issued proving the duration of temporary incapacity for work (TIW), they shall be entitled to the payment of income during TIW from their employer for the first 10 calendar days and and to medical benefits from the Social Insurance Agency during the remaining period of TIW. If a patient is voluntarily unemployed, then he/she is not socially insured (has not pension insurance) and payments for him/her for social insurance are not paid by the state (it means that he/she is not entitled to medical benefits). If he/she is involuntarily unemployed, during the treatment he/she can get unemployment benefits (if the right to it was created), and if he/she is not entitled to unemployment benefits, he/she can apply for a social assistance benefit at the Office of Labour, Social Affairs and Family.

Resocialization facilities financially depend on finances from higher territorial units (HTU). A client entering the resocialization programme participates in the payment of stay himself/herself (in certain facilities even with an initial fee of approx €65), at regular monthly intervals (unemployment benefits, social assistance benefits, invalidity pension and others) by a monetary amount ranging approximately from €95 to €225. In some places an agreement is made with the client on the method of financial payment for resocialization stay, or relevant resocialization facility sets client's co-payments according to the relevant provisions of Act № 305/2005 Coll. on Social and Legal Protection of Children and Social Legal Guardianship, i.e. the client pays €3.33/day for boarding (according to the number of meals taken) and €3.48/day for lodging (when social assistance benefits are drawn and a protected allowance, the fee for stay is €87.60 per month and €37.97 pocket money per month).

Each taxpayer in the SR (both physical and legal persons) can donate 2% of taxes to resocialization facilities, if their type is citizens' association or non-profit organization, including healthcare facilities. Various providers can also contribute financially to the development of such facilities (Drugs Fund, Office of Labour, Social Affairs and Family, HTU, entrepreneurs, individuals, etc.)

AVAILABILITY AND CHARACTERISTIC OF RESIDENTIAL TREATMENT

NATIONAL AVAILABILITY AND ACCESSIBILITY

The availability and access to treatment related to residential treatment capacity is fast and further remains on a good quantitative and qualitative level in the Slovak Republic.

Within the whole territory of the SR, in 2011, as much as in 38 healthcare facilities patients were admitted with the diagnosis F 19 (the so-called polyusers), which was followed by the users of psychostimulants (F 15), treated at 27 facilities. The diagnosis F 11 (opiates) was present in 24 facilities and F 12 (cannabinoids) in 20 facilities. At least, hallucinogen users (F 16) and also patients

with diagnosis F 17 (tobacco) were admitted into one facility (*See more in Chap.* ***Error! Reference source not found.***).

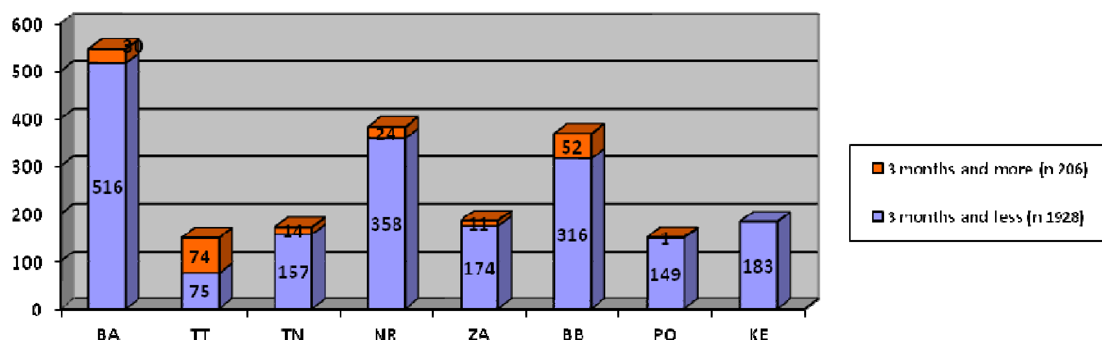
The reporting methodology on drug users treated from dependence focuses on the follow-up of the first demand for treatment in the relevant facility and in the respective year.

In clinical practice after a basic examination in psychiatrist‘s office the physician recommends the form of treatment. For a clear diagnosis of dependence in an active, clinically developed phase with symptoms the patient has an opportunity to choose either ambulatory or institutional form of treatment, but the physician in principle in such cases recommends starting the institutional form of treatment. The final decision is, however, up to the patient and if he/she refuses physician’s proposal of institutional treatment, the ambulatory form of treatment will be provided to him/her. During the treatment the patient has the right to re-assess his/her decision.

The availability of treatment which is fully covered for Slovak citizens from public health insurance is proved also by the fact that among treated patients including institutional treatment are regularly also the homeless.

Neither the access to treatment was and has been a problem for patients. The evidence of this is very short or absent waiting lists for the commencement of institutional treatment due to drug problems. If somewhere a waiting list is created for admission into institutional health care, if the patient wishes to get the treatment promptly, he/she can choose another facility where no waiting is needed as the Slovak healthcare system has a free selection of healthcare provider by patients. However, certain Health Insurance Companies sometimes impose as a precondition for the payment of treatment preliminary approval of the patient’s treatment stay by them. A special situation represents the access to institutional court-ordered drug addiction treatment ordered for performance in a civil healthcare facility. In certain institutional health care facilities, long waiting lists, even with several months waiting time, arise especially for this group of patients. Due to regime and capacity reasons, specialized addictological institutional facilities often admit only a limited and specific number of patients who were sentenced to the treatment by court. The reason is often a low motivation to treatment, frequently occurring personality disorders of antisocial type, which are factors that can disturb and usually disturb the drug regimen of other patients, if there are several such patients in the department. If such a patient gets into a long waiting list, unlike patient who is treated voluntarily, he/she cannot change the medical institution himself/herself, but it is possible only by decision of the court. He/she has no free choice of the provider. However, he/she can theoretically apply just like other patients for the performance of institutional treatment in another place, but if this is without the consent of the court which imposed the treatment on him/her, it is questionable, whether the court accepts a proposal for its completion from a centre other than specified by it. Thus, also in case of court-ordered institutional form of treatment the patient can freely choose an institutional facility for medical reasons.

Figure 0.1: Number of patients admitted in psychiatric healthcare facilities due to problems with drug use (F11 - F19) – comparison of hospitalization length (2011). *Source: Reporting of patient‘s institutional psychiatric care of HF (Ministry of Health of the SR) 1-12*



Within a medical model of diagnosing drug addiction, patients who demand residential treatment are directed to healthcare facilities either without a recommendation, by a clinical psychologist or by a field worker, social worker, general practitioner for children, adolescents and adults, or by an ambulatory psychiatrist or another specialist. These healthcare facilities are subsequently enriched with the activities of organizations providing social assistance (resocialization facilities). Residential treatment can be voluntary according to patient‘s demand who due to problems with drugs has called on himself/herself, or non-voluntary on the basis of court ruling after determining drug addiction by an authorized expert from the public health sector – psychiatrist, with respect to the criminal activity.

Conditions for admission to residential treatment include an age above 18 years (in some places they admit patients younger than 18, however, with the consent of their parents), a voluntary patient’s consent (not applicable to treatment ordered by the court), health insurance (or without health insurance according to a valid pricelist of the relevant facility). In some facilities the condition for treatment can be also direct relation to previous patient’s detoxification. The residential treatment can be repeated several times in the same year for a complicated, chronic, recurrent course of the illness according to the patient’s clinical condition (it also depends on approval by the relevant HIC). Patients can voluntary leave residential treatment at any time at their own request and continue in the ambulatory programme. If they terminate themselves the protected institutional (residential) treatment ordered by the court, the attending physician will report the same to the competent court.

Conditions for the admission of clients to the resocialization programme are in most of such facilities identical. Before admission the client sends an application for admission to resocialization along with curriculum vitae drawn up by him/her. The admission of client usually follows after a previous treatment process (medium-term withdrawal institutional treatment) in a healthcare facility documented by a preliminary discharge report or a resocialization recommendation (note: certain facilities admit clients also without this condition, e.g. on the basis of an interview on the entry). The client’s personal decision and a personal motivational interview, a valid ID card and an insurance card are among the conditions of admission. Another condition is the payment of stay from client’s income (unemployment benefits, social assistance benefits, or another income). Client’s age limited to minimum 16 years (finished compulsory school attendance) or 18 years of age and more. Abstinence is a compulsory condition; the client is obliged to stop the resocialization programme in the event of its breach.

In 2011, 842 clients were in RS (of whom 95 younger than 18) in Slovakia; 153 clients completed the resocialization programme. With 425 beds, the average length of stay in RS was 12 months; the shortest was 4 months (Teen Challenge), and the longest was 28 months (Pahorok) (*See more in Chap. 8*).

TYPES AND CHARACTERISTICS OF INSTITUTIONAL TREATMENT FACILITIES

COMMON APPROACHES

Institutional residential patient care in the public health sector contains comprehensive medical, psychotherapeutic and nursing care comprising diagnostics and the treatment of dependence-related disorders. Medical care covers both the care of somatic and mental health. Patients are provided with medicine against drug addictions through a team of physicians, specialists in the field of psychiatry, medicine for drug addictions. The psychotherapeutic care consists of psychotherapy and psychodiagnostics. (please add other specialists – psychologists, special teachers...) The nursing care focuses on a holistic approach, while maintaining and promoting health, including in prevention. The philosophy of addiction treatment is a stay in a special organized healthcare department where active patient’s participation is required. The basis is a behavioural structured drug regimen applying the elements of the organizational structure of therapeutic community and the principles and techniques of cognitive-behavioural therapy. Stress is laid mainly on group psychotherapy. Medicamentous treatment applying the latest spectrum of pharmacotherapy is no less important part of treatment. The daily regime consists of compulsory and voluntary therapeutic activities. CV writing, rational therapy (didactic therapy), thematic groups (written preparation of assigned topics), individual psychotherapy, assertiveness training, stress handling training, social skills training, series of lectures on craving and recurrences, Programme 12 – steps (NA), anti-smoking, anti-depression and anti-anxiety groups, resocialization group, autogenous training (relaxation training), psychogymnastics, bibliotherapy (reading of specialized literature), ergotherapy, artetherapy, music therapy, field therapy, physiotherapy, abstainer N - club, social and legal advisory, passes belong among them. An important part of treatment is sport and movement activities (fitness centre, tourist trips in the vicinity). Part of the

comprehensive treatment in some facilities is also possible use of an educational stay for patient‘s family members entitled Family therapy.

The resocialization programme in terms of the organization and content is adapted to clients in the form of life in community, which allows their participation in managing and planning the community life. An overwhelming majority of resocialization programmes is based on the principles of classic therapeutic community for addicts. The community is the highest authority and decides on principal issues of its members, such as individual therapeutic procedures up to the highest stages, on rewards and sanctions for the breach of community rules up to exclusion from the therapeutic community. However, the level of community autonomy and self-management and the participation of therapists in the management as rational authorities are not unified in different programmes. A wider community mostly includes also the client’s family members as cooperation with the family and its willingness to participate actively in client’s therapy is the key priority in reaching long-term abstinence. On the one hand, resocialization facilities are located in lonely places where they have conditions for parallel therapeutic and resocialization programme with frequent therapy on a farm, but today they are located also in urban conglomerations (Bratislava, Košice), which facilities their readaptation in the shift into unprotected environment of society. Individual social work?, individual psychotherapy, community work, group psychotherapy, phase groups, sponsorship groups, thematic groups, self-management groups, NA meetings – a 12 Step Programme, bibliotherapy, music therapy, artetherapy, sport therapy, family therapy, group advisory, field family therapy, work therapy, with an exactly set day plan belong among the basic nethods. They ensure also necessary health care for clients in collaboration with specialized healthcare centres. They have conditions for special interest, sport and cultural activity, zoo therapy (canistherapy? where, hippotherapy), gardening or fruit production. Clients are fully involved in self-service activities, they prepare meals themselves, clean the premises themselves, wash laundry, iron, etc. The structure of resocialization plan consists of an adaptation, therapeutic and resocialization period. The clients go through several phases during their stay. The first phase is initial, motivational for newly admitted clients into the facility. It focuses on client’s entry into the community by explaining of its functioning, principles and usually lasts for 6 – 7 weeks. In the second, reference phase the client has a chance to understand himself/herself, understand the reasons for which they started to use addictive drugs. They can meet their close relatives in this phase. The third phase is curative and focuses on an enhancement of client’s self-regulation, on the redevelopment and strengthening of their socially accepted forms of behaviour, moral and ethical norms, performed for instance in the form of passes. The fourth, rehabilitation phase focuses on overall physical and mental renewal of an individual leading to the ability to become independent gradually, searching for a job or going on with the studies. It identifies problematic areas, which can endanger his/her life in abstinence after his/her departure from resocialization. In the last, reintegration phase the client spends more time outside the community, creates conditions for his/her professional fulfilment, housing, change of family relations; he/she searches for forms of meaningful spending of free time, fixes positive habits in a natural environment.

Clients who finish their stay in a resocialization facility can use also the services of protected housing, the so-called “Houses on the halfway,“ which will provide them with year-long housing and supervision to give them assistance in passage of situations immediately after the departure from the resocialization facility.

TYPICAL MIX/INTEGRATION OF SERVICES

In the Slovak conditions, integration of several necessary services for people who have problems with drugs and require a treatment is in principle provided in two ways. Both of them include also institutional form of treatment. On the one hand, it is the integration of services within the network of different specialized independent programmes, providers, which have interlinked collaboration and, on the other hand, various levels of the integration of several services within the same facility up to complex Centres for Treatment of Drug Dependencies (CTDD). But CTDD also must ´out-source´ certain services and depend on collaboration with other institutions.

The complexity and types of integrated services must be understood in different planes. For example, by division of integrated programmes into health care services, including mental and physical health, and social services, including for instance social reintegration (resocialization), but also social assistance, low-threshold programmes. Within institutional care in our facilities, which are included in psychiatry, comprehensive treatment of drug addictions is provided, including often attached other diagnoses and mental disorders, and diagnostics and treatment of concurrent physical diseases. The treatment of double diagnoses, for instance, the combination of affective disorder and addiction, or the treatment of both types of addictions, e.g. dependence on methamphetamines and pathological

gambling. CTDD have standard institutional treatment of later occurring dependence on methamphetamines and continuous substitution treatment, which a patient received in the past due to dependence on opioids. A different view is the integration of subsequently provided different types of services: a low-threshold programme for the replacement of needles and syringes, ambulatory or residential detoxification with the shift to institutional treatment of addiction, which after three months again follows up the ambulatory treatment, but also resocialization in the form of stays in a therapeutic community of non-medical type. It is a recommended line of the curative process, which, however, may not be fully utilized depending on the situation of the user. However, the organizational arrangement and direction of recommendations is important for the client/patient in the integrated care system. Centres for Treatment of Drug Dependencies located in towns provide in most cases the replacement of sterile needles and syringes, ambulatory treatment, substitution treatment, institutional detoxification and institutional addiction treatment, ambulatory after-treatment and resocialization in clubs for long-term abstainers, within one facility. Although AT sanatórium I. Novotného does not have low-threshold programmes, unlike the others it has also institutional form of resocialization in the form of a residential-type therapeutic community. Testing for infectious diseases: HIV, hepatitis, syphilis, etc. and, if necessary, cooperation in the treatment with the relevant physicians-specialists also belong to the range of integrated services. For services, which are not provided by the institutional facility, within the network of cooperating institutions it has agreements on cooperation with other specific facilities where the patient/client can be sent. In healthcare facilities intended for residential care of patients having problems with drugs, the integration of medicamentous treatment is typical, as well as of cognitive-behavioural individual and group psychotherapy, and social therapy.

Residential detoxification treatment belongs among programmes provided by facilities for the treatment of drug dependencies. It usually takes 1-2 weeks, or can be performed also in ambulatory form. This does not belong here!

A hepatitis B vaccination programme, a testing programme for blood-borne infectious diseases (HIV/AIDS, hepatitis B, C, syphilis), a programme for the provision of sterile needles and syringes, medical education among the users of psychoactive substances, toxicological examinations of the urine for all addictive drugs, the issue of curative tools, e.g. in the form of the journal "Nezávislosť" ("Independence"), or an Internet service for the public in the field of addictions belong among programmes, which are predominantly carried out by specialized Centres for Treatment of Drug Dependencies.

When performing the diagnostics and treatment of patients with mental disorders related to the use of psychoactive substances, the medical staff follows the latest criteria of the World Health Organization and consistently respect the International Classification of Diseases – its 10th revision (MKCH-10, Chapter V.), following the medical concept of the medicine of drug addictions of the MH SR.

Within a long-term after-treatment process, special healthcare facilities provide supporting and refresher stays lasting 1-2 weeks, with possible use ¼, 1/2 and ¾ per year depending on approval by the HIC for patients, who have already passed the basic institutional treatment and abstain. Their purpose is the prevention of the occurrence of possible recurrence through the strengthening of motivation to maintain abstinence, continuous solving of problems, which occur in the patient's life.

Professionally patient's overdosage falls within the competence of urgent medicine, for the purpose of the monitoring of vital functions and application of symptomatic treatment. In practice, however, it looks completely different and an overdosed drug user or his team does not seek for such assistance and tries do handle the overdosage without professional assistance. In Slovakia, for instance, also for this reason several Internet portals have been developed for drug users, dealing with "overdosage management".

The Public Health Authority (PHA) of the SR participates in activities in the area of drug prevention. Primary prevention of the abuse of illegal addictive drugs is implemented within the National Health Support Programme and the National Programme for the Fight against Drugs, which are implemented by the Health Support Departments and Health Consulting Centres at the regional PHA in the SR. Activities are focused mainly on children and young people and are performed in the form of advisory, lectures, meetings, film projections and peer activities.

According to a study of the International Organization for Migration, migrants who belong to the main population group vulnerable to social exclusion, asylum seekers in Slovakia in certain asylum centres have problems with the provision of specialized health care, mainly as regards the issue of drug abuse and mental disorders.

SUBSTITUTION TREATMENT OF OPIOID DRUG USERS IN THE CONDITIONS OF INSTITUTIONAL - RESIDENTIAL TREATMENT

In Slovakia, substitution treatment for patients with dependence on opioids is carried out either in the form of methadone substitution therapy or by administering buprenorphine with naloxone. Roughly 500 – 600 patients currently receive substitution treatment in Slovakia.

Since induction and the whole treatment in principle is performed in ambulatory conditions, stays for such patients in the environment of institutional treatment are not frequent. They are, however, more frequent in CTDD where substitution programmes and also residential departments exist. The indications of substituted patients for institutional form of treatment are several, for instance, it is the treatment of another dependence, which is not manageable in ambulatory form, first of all on methamphetamines, sometimes on alcohol, sedatives, etc., along with the substitution of opiates. Another reason is the need to treat the stabilization of toxic psychosis or affective disorder.

A gap is in the absence of possible provision of substitution treatment in resocialization facilities and in institutions for the service of a term of imprisonment (in prisons) where for organizational and technical reasons they do not accept substitution therapy during the stay for clients in any of such facilities. A methodological guideline of the MH SR, however, does not exclude its provision in prisons and in therapeutic communities.

TYPICAL LEVELS AND DEVELOPMENT OF COOPERATION in terms of the organizational standards for health care amend and highlight the basic cooperation axis of residential facilities with ambulatory services of a general psychiatrist or addictologist and with a general practitioner, before and after discharge from residential treatment.

(*Level 1*) The client receives information on voluntary institutional treatment of drug addictions usually in the psychiatrist’s office, which is the first contact place, or in the general practitioner’s office. He/she can become aware of the treatment also from family members, friends or relatives, independently from the Internet or leaflets or booklets with a detailed description of services provided, which are issued and distributed by the relevant specialized facilities. He/she can select a specific specialized facility on the national level, there are regional limits.

Over the course of institutional treatment the client becomes aware of possible after-treatment in a resocialization facility, and in case of interest through a psychologist who leads the resocialization group, he/she will select a specific facility within the whole territory of the SR, according to information provided.

(*Level 2*) Specialized facilities for treatment cooperate with all psychiatric subspecializations such as gerontopsychiatry, pedopsychiatry or sexuology. One of the basic and necessarily cooperating branches in diagnostics and treatment of drug addicts is clinical psychology and subsequent after-treatment (sociotherapeutic clubs, resocialization facilities). Meetings on the local, regional, national and international level are organized on a regular basis for the purpose of cooperation, exchange of experience or solving topical problems of clients in the form of case seminars and workshops. Cooperation with other medical branches such as internal medicine, pediatry, urgent medicine, surgery, neurology, and also gynecology, dermatovenerology or infectology is necessary, as well as consulting cooperation with the departments of laboratories and clinical biochemistry, mainly in dealing with serious somatic damage and complications. It is also performed from the local up to the (inter)national level.

(*Level 3-4*) If it is necessary to deal with psychical or somatic complications, there is close cooperation among particular branches, including the provision of patient‘s medical documentation.

A permanent task of the medicine of drug addictions in reducing the social consequences of drugs is the participation of experts from the branch (who work in specialized facilities) in the commissions of state administration for antidrug policy, specialized advisory activity for the bodies of executive powers, and participation in legislative boards and commissions of legislative power. Workers of the field in the interest of and in favour of patients collaborate actively with all paramedical organizations and institutions of the company, including mass media, for compliance with legislative norms related to civil laws and ethics in carrying out the profession.

MANAGEMENT OF RESIDENTIAL TREATMENT FROM QUALITATIVE ASPECT

AVAILABILITY OF GUIDELINES AND STANDARDS FOR RESIDENTIAL TREATMENT SERVICES

In Slovakia, residential treatment for people who have problems with drugs is governed by statutory rules, decrees regulating public bodies in this area, mainly of the Ministry of Health of the SR and the Ministry of Labour, Social Affairs and Family of the SR, as well as by methodological instructions, specialized directives issued by the WHO, for instance for medically assisted treatments, as well as by the Ministry of Health and the main specialist for drug addiction medicine at the Ministry of Health of the SR. An integral part of the management of residential treatment is also control mechanisms and drawing conclusions.

The quality control system of health care provided in the residential form of treatment is similar to other forms of curative care in the public health (see also Chap. 7). The supervision of correct medical procedures, performance of standards for staff and material provision falls within the competence of the Ministry of Health of the SR, and in some cases of higher territorial units, of the Healthcare Surveillance Authority. Inspection is conducted also by health insurance companies as the contractors of institutional facilities. Also for institutional facilities the quality guarantee is continuous performance of ISO 9001:2000 quality standards certification.

Diagnostic and therapeutic processes are managed according to basic healthcare laws, in particular by Act № 576/2004 Coll. on healthcare providers and by others. In Slovakia, the diagnostics of mental disorders resulting from the use of psychoactive substances is performed according to Annex № 1, which is the 10th Revision of International Classification of Mental Disorders of the World Health Organization (MKCH-10/SZO).

The system of drug addiction treatments is based on science-based approaches. It is concentrated in the field drug addiction medicine, which is a superstructure field of psychiatry and methodologically is managed by the main specialist for drug addiction medicine at the Ministry of Health of the SR.

The Ministry of Health of the SR, pursuant to Article 74 par. 1 c) of Act of the National Council of the SR № 277/1994 Coll. on Healthcare, as amended, issued a Specialized Guideline regarding Standards for Diagnostics and Treatment in the field of drug addictions, with effect from 1 June 2003. The subject of the Specialized Guideline is a proposal of diagnostic standards, treatment and preventive activities for patients dependent on psychoactive substances from the aspect of organizational and competence procedures (*See: Article IV - Treatment, Patient Resocialization*).

Just like it has been stated above, quality is ensured by external audit for certification according to ISO 9001:2000. Moreover, healthcare facilities have an approved internal inspection system, which relates to inspection procedures for quality assurance, availability, specialized medical care, as well as the organization management. Here belong, for instance, the recording and method of handling complaints, cost efficiency, etc. The implementation of an internal inspection system is under the supervision of the promoter of organization; for most CTDD it is the Ministry of Health of the SR. Slovakia has set standards for minimum staffing in residential departments within healthcare facilities, reflecting the standard in the provision of institutional care in the medical sector. Specification of the structure and required number of jobs is left to the competences of the director of the relevant healthcare facility. The staffing of CTDD (set for 20 beds) is developed by the physician with specialization in psychiatry or by a physician with specialization in drug addiction medicine, quantity 1, a nurse or a nurse with specialization in nursing care in psychiatry or a nurse with a certificate for the care of drug addicts, quantity 2, other healthcare specialists with university education with specialization in clinical psychology, quantity 1, another healthcare specialist with university education in the field therapeutic teacher, quantity 1.

In the past, on the basis of results from an inspection of the MH SR, due to the non-performance of standards for minimum staffing of residential facilities, CTDD in Humenné and Nové Zámky were closed.

The professional provision of resocialization facilities must have ambulatory form of psychiatric care secured under contract. It should have psychologists - certified therapists, social workers, therapeutic teachers, nurses and labour therapists. In 2011, in accredited RS, 12 psychiatrists worked (8 RS does not have them), 27 psychologists in 18 RS, they had maximum social workers - 58, 19 teachers and 17 other medical staff.

The MH SR in collaboration with HIC, specialized companies and the Healthcare Surveillance Authority (HSA) prepares indicators for the assessment of health care availability, efficiency of the use

of sources, efficiency and adequacy of health care and its results. All institutional facilities in the sphere of authority of the MH SR, where most of CTDD belong, are evaluated, for instance, also according to the bed capacity occupancy indicator. Also Health Insurance Companies attempt to evaluate them, and they apply several criteria such as patient satisfaction, length of admission, etc. Their evaluative criteria and also the results, however, are not single and are often inconsistent. Two out of three facilities operating in Slovakia are private joint-stock companies doing business for profit, and they stress economic criteria in the evaluation, and for residential treatments they tend to shorten the stay.

An internal efficiency assessment of treatment is in place almost in every specialized facility, however, in particular in CTDD Bratislava along with IDZ and OLÚP n. o. Predná Hora, through repeated collection of data (e.g. after a year, two, three years, etc.). The assessment relates not only to the stay of patient in institutional care, but to the entire system of services provided, whereas abstinence is an important but not inevitable and the only indicator.

Thanks to balanced management, several CTDD did not need financial resources for payments to creditors from the public sector. According to a budgetary guideline of the Ministry of Finance of the SR, on the basis of application of the Government Office of the SR, CTDD in Bratislava had approved financial resources, which were designated for the implementation of research services in the field of drug addictions for the needs of the monitoring of drug situation in the Slovak Republic according to the requirements of the European Union.

The Ministry of Labour, Social Affairs and Family of the SR manages and controls non-medical institutional facilities for clients having problems with drugs, which in the Slovak conditions include resocialization facilities in the form of therapeutic communities. The basic specialized norms are contained for them in Act № 305/2004 on Social Care and Guardianship of Children.

DISCUSSION AND CONCLUSION

ATTITUDES, OPINIONS

The availability and access to institutional, medical and resocialization care is relatively good. Treatment in healthcare facilities is free, and except court-ordered institutional treatments also waiting lists are short and often do not exist. In most facilities, the institutional form of treatment during the patient‘s stay provides several services within the organization, or ensures services externally by integration with other providers. Institutional treatment is not an alternative of ambulatory treatment, but usually forms its part. In most cases it is integrated in it, and the patient comes for institutional treatment from a doctor’s office and usually returns to ambulatory treatment. Despite physician’s – psychiatrist‘s recommendation (“matching“), institutional treatment is an alternative on the part of patient who can refuse it and choose ambulatory form of treatment. It is true, for instance, for detoxification. In such a modern participative process of treatment, institutional treatment is not in opposition to ambulatory treatment. In our conditions, for instance, the option of institutional treatments in indicated cases is used along with substitution treatment, which is predominantly ambulatory for patients with opioid dependence. Another example of the integration of both forms of treatment for one patient is short-term institutional stays, the so-called refreshing stays of long abstainers in ambulatory treatment. Both forms supplement one another, and therefore have a synergic effect in the therapeutic process.

In social discussions we can sometimes find an opinion that the institutional treatment of addictions is expensive in comparison with ambulatory treatment, and therefore should be reduced to the minimum, or it should be paid by patients from their own resources. Our assessment studies of treatment efficiency indicate that institutional form of treatment has an unsubstitutable position in the therapeutic process for a major part of patients. Imposition of a fee on it or partial imposition of a fee would generally make the availability of addiction treatment harder in the population. Attempts to reduce institutional treatment to one episode paid to the patient from solidary national health service contravene the findings of medicine based on evidence, which refer to that heavy addiction is a chronic recurrent ailment and repeated decompensation of the condition after a time limited stabilization period is just like for other chronic ailments a reason for intensive treatment, and not for its rejection. The medical model of addiction as a chronic ailment is often a strong professional counterargument.

Among old, authoritative approaches applied in psychiatric practice in the past, but also among social stereotypes in a part of medical staff, a moralistic, condemning attitude to patients dependent on drugs

and alcohol appears even today. Typically the staff of specialized institutional addictological facilities least frequently stigmatizes its patients. A moral stigma is, however, for many people for social reasons an internal barrier for the start of residential treatment of drug addiction. This issue will need yet long systematic education focused mainly outwards to the general population, also in Slovakia.

The current economic and financial crisis is a threat for a relatively well set system of residential treatment of patients with addictions in Slovakia. In the past due to the lack of finances for qualified medical staff that migrated to other places, certain residential addictological centres stopped their activity. Also for this reason consistent evaluation of treatment is necessary, including the highlighting of not only its medical effects, but also its related economic benefits for society. Efficient treatment needs also good social marketing.

BACK TO TOP

PORTUGAL

12. Residential treatment for drug users in Europe

History and policy frameworks

The Therapeutic Communities (TC's) here understood as units that provide care to patients drug addicts and patients with polydrug use requiring prolonged hospitalization with psychotherapeutic and socio-therapeutic support, under psychiatric supervision in order to a better rehabilitation and reintegration of the patient and to prevent relapses, to allow the development of responsible and accountable life projects. TC's are structures with specific programs open to internment and treatment of patients' dependent of psychoactive substances with different programs and models that vary among themselves in philosophy, therapeutic structure, with different concepts in the responsibility and self esteem of patients, valuing different methods and values.

TC's appeared before there was any coordinated and comprehensive public policy of intervention in the phenomenon. Therapeutic communities grew, multiplied and occupied spaces, once didn't existe at that time programs, projects and public legislation that offered alternatives to dependent people who wanted to treat themselves.

The history of residential treatment in Portugal reports to the 70s closely linked to other vectors of intervention such as prevention and reintegration and appeared as an answer to the abuse of substances nationally.

Due to the expansion and complexity of the problem, governments that followed the 25th of April 1974 sought to find answers to this phenomenon and contribute to all citizens have access to adequate responses to the needs expressed and identified.

Thus in 1975 were created in the Presidency of the Council of Ministers: - The Youth Study Center (Centro de Estudos da Juventude), whith mandate to "study problems related to drug use, particularly the social medical treatment of the drug addict, anti-drug prevention, as well as, in general, the youth drug use related problems " and – The Judiciary Drug Research Centre (Centro de Investigação Judiciário da Droga), for "the prosecution of the research, fiscalisation, supervision and criminal prosecution activities in this area".

In the sequence of the work done by these Centers was created in 1976 the Coordinating Cabinet for the Fight Against Drugs and structured the Center Study and Prophylaxis of Drugs (CEPD).

CEPD organization assumed a national and regional ambit to facilitate the elaboration of policies and the speed up of responses to the target population, so in 1977, were created three Regional Delegations Porto, Coimbra and Lisbon.

It was in the framework of Regional Delegations that appear the first Therapeutic Community as a residential project intervention for drug addicts. Besides these aspects the hurry to train future experts, the individual and family care were contemplated in the assisting caring policy.

To the spread of drug addiction phenomena occurred in the 80s, the politic answer tried to find integrated responses at treatment level and others that allow dealing with the phenomena and with the sanitary and social problematic related with it. The history and evolution of this initiative since that age till present is reflected in different aspects: on one hand, there was a multiplication of responses regarding intervention on phenomenon (in terms of quantity and diversity of approaches), an effort that convoke public entities as well as social civil society forces and, on the other hand, it was possible to frame it in the scope of public policies coordinated by governmental institutions.

In 1982, CEPD moved to the Ministry of Justice maintaining the national and regional structures.

In 1987, within the Council of Ministries and interministerial dependence, was created "Projecto Vida", an integrated plan to fight drugs, contemplating actions in the fight against traffic and in the vectors of prevention, treatment and reintegration of drug addicts.

For treatment was intended:

- National coverage with adequate services and a articulate and efficient response;
- The creation of a hospital emergency unit for drug addicts encompassing a detoxification service;
- And in outpatient an attending center.

And so arises, in Lisbon, in the framework of the Ministry of Health, the Taipas Center in 1987 (made 25 years in October this year).

In 1990, was created the Drug Addiction Prevention and Treatment Service (SPTT) in the framework of the Ministry of Health and all the existing services were integrated into it.

In the '90s, with many TC, linked to Private Social Solidarity Institutions and Non-Governmental organizations (IPSS/NGO) and complexity of consumption of substances, occurred the developing of residential treatment, with the appearance of the CT, with the service opting by conventions instead of their own units.

Subsequently, the national network of outpatient of the SPTT has been renamed to Specialised Outpatient Drug Abuse Treatment Centres (CAT). Simultaneously, appears "Projecto Vida" service tutored by the Presidency of the Council of Ministers, which becomes par excellence, the dynamic body for interventions of preventive nature and with the publication of Decree-Law n. º 90/2001, 18th May, has established itself as the Portuguese Institute of Drugs and Drug Addiction (IPDT), service endowed with administrative, technical and financial autonomy.

The finding that the existence of two different organisms linked to the same problematic would not be sustainable in terms of rational management of public resources has led to the fusion of both, as stipulated in Law n. º16-A/2002, 31st May, looking up, to achieve not only the services complementarities and the need for effective coordination of goals to proceed in the framework of the fight against drugs, how to use more efficiently the existing resources.

The fusion process is concluded with the publication of the Decree-Law n. º 269-A/2002, of 29th of November that creates the Institute on Drugs and Drug Addiction (IDT, I.P.) as the organism resulting from the merger of SPTT with IPDT. IDT was a service tutored by the Ministry of Health that only had administrative and technical autonomy, being the body responsible for all the intervention areas in the fight against drugs and drug addiction.

As body dependent of the Ministry of Health with the mission to be the entity of the public administration with specific responsibilities in the reduction of licit and illicit drug use and decrease of addictions, and with the vision to be the national reference entity with international recognition, to intervene in addiction behaviors, established the aegis under which the coordination, articulation and implementation of drug addiction policy would fall.

With regard to treatment, one of the consequences of this design and evolution of public policies related to drug addiction, focused primarily in the articulation of the different therapeutic modalities in a comprehensive and integrated care framework that allows finding specific and appropriate answers to the needs of each user.

In organizational terms, this initiative of articulation of responses involved not only the public treatment structures but also congregate the private institutions operating in this area. The vast majority of these structures were therapeutic communities. The needs determined by that articulation led to become indispensable the definition of forms and procedures to allow the clear passage of patients between treatment structures, offering differentiated and specific therapeutic answers, as also become evident the need to define criteria and indicators that could ensure the minimum and necessary conditions for the therapeutic intervention.

Finally in 2007 with the publication of the Decree-Law n. º 221/2007, 29th May, appears the IDT, I.P., body that resulted from the merger between the extinct Regional Centers of Alcohol (North, Center and South) and the IDT, basing, based on this option on the understanding that the phenomenon of drugs and drug addiction, attentive to its transversal nature should pay particular care and attention not only to the consumption of narcotic and psychotropic substances, illegal by definition, as well as the consumption of licit substances such as alcohol and medicinal substances.

In the passage of the century, the growing offer of opiates substitution programs was diversified both in number and in exigency in a perspective to reach more clients with different levels of exigency that was translated into a less demand of responses, as the residential treatment.

In that sense, since the beginning of the 90s the public agencies to which was entrusted the responsibility of treating drug addiction seek, by law, imposition to implement a set of norms and criteria's related to the licensing, fiscalisation and functioning of these units. On the other hand were created units with competence for the prosecution of these actions. The evolution of the public administrative device for the area of drug addiction and which culminated in the creation of IDT, I.P. didn't do more than stabilize and reinforce the importance of this area. Within IDT, I.P. was created a Licensing and Fiscalisation Unit inserted in the Treatment and Reintegration Department, which oversees all the activities in this domain.

In 2012, for issues related to the financial crisis that crosses the country was extinguished by fusion IDT, I.P. A new body was created, SICAD (General-Directorate for Intervention on Addictive Behaviours and Dependencies), with attributions in planning and monitoring programs to reduce the consumption of psychoactive substances, in preventing addictive behavior and decrease of dependents, being the operacionalization of interventions concentrated in the framework of the Regional Administration of Health (ARS).

11.1. History of residential treatment

History of residential treatment for drug users (since 1980s if possible): origins, main actors, factors that have influenced development; - changes in use of residential and outpatient treatment over time

TC's appeared historically in response to the inneficiency of Psychiatric Institution to meet the needs of persons with mental health problems (Maxwell Jones model) and severe problems of drug abuse (Day Top model). TC revealed well structured and an efficient instrument for the reform of Mental Health – known by his deinstitutionalization – that WHO in the 50s didn't had doubts to suggest its adoption. However it has been under drug addiction treatment that it has developed its potential and show her efficiency.

It's known that in the area of intervention of drug addiction and alcoholism several organisations have emerged that do not require the action of experts such as Alcoholics Anonymous (AA). The evolution of this type of organizations that choose the US as their priveliged area of development, influenced scientif practices in this area.

Europe was confronted later on with drug addiction problema. Of course the idea of TC wasn't strange in the old continent. Maxwell Jones was the founder of a democratic model. But the application of this model of TC was done to other populations, such as war wounded in hospital setting (Kooyman, 2001; Jones, 1969).

The first TC's free of drugs followed, between us, the principles of democratic models. The experience did not prove fruitful and demanded a reformulation. Since the beginning of the 70s, however, the practice used has been approaching certain principles of the American tradition.

In Portugal, the first TC for dependents was created in June 1978 in Coimbra. Over 28 years of functioning the TC Arco-íris suffered some changes, maintaining however the fundaments inspired by Maxwell Jones, Daytop and Eric Erikson. Lately, this institutional triad saw the need to add the concept of fuzzy identity of Otto Kernberg.

In Portugal institutions such as PATRIARCHE, REMAR, RETO or BETEL are institutions close to the Synanon model approach, although doesn't have as many means or powers as that American organization has come to possess. However also here is seen the cult's founder, a certain institution's closing in on itself and a consequent disdain by the outside.

REMAR (Rehabilitation of marginals) owns farms that serve the first stages of monitoring. The idea of the residents being displaced from the geographical area where they inhabit, is other of the principles followed. Reinsertion is done within the institution: residents can participate in collections or work in the sales. However the dogmatism of its functioning is evident through the cultivation of a religious idea strongly anti-Catholic. Ideally, the reinsertion is done in the militancy of REMAR. The ideal evolution of the organisation would be exponential, since the criteria for success passes by a blind and permanent adhesion to daily values of institutional experience. Internally play an important role the religious ceremonies that occur in a special environment.

These practices are not confrontive as in Syanon or Daytop. However, the public confession of sins (similar to what happened in the first Christian communities) strengthens the feeling of belonging to the group, as well as can have auto-disciplinary effects.

In the early days the TC's were concentrated in the North of Europe. The Southern countries have not had this type of institutions. This is understandable: Portugal and Spain only knew the first waves of heroin addicts with the entry of the eighties (Romani, 1991).

In 1978, Don Mario Picchi in Rome is the empeller of Project Homem that later would internationalize. In Portugal, Project Homem has for example intervention centers in Braga, where it proposes a phased staggered intervention: day center, join TC in a full inpatient regime and finnaly reintegration programmes in protected apartments. TC it's integrated in a program which constitutes only one of its phases.

A modern TC must be able to coordinate the confrontation groups at the same time that applies other group technics. The technic team must incentivate the hierarchy and the observation of essential rules. The experts however are not above the residents and can be called to the confrontations. On other hand, the hierarchies can be reformulated, leaders replaced or there may be a specific leader for each task. A modern TC must establish a dynamic balance between the confrontation groups and the traditional psichoterapeutic groups must combine the teachings of the hierarchy model with the democratic model (although the hierarchy remains the matrix, from which you can perform these combinations).

These are the nets of an unstable balance that is a renewed challenge to the technical teams working in the area. Psychologists and other experts must be able to coordinate their knowledge and technical capacities with specific knowledge that emerged through long decades of tradition, of the several self-help movements.

Changes in use of residential and outpatient treatment over time

One of the consequences that have been verified in the patients' population and clinic realities was the need to fit one of the central aspects of therapeutic programs, namely the determination of time permanence in TC. The period of 6 to 12 months initially determined for treatment – Therapeutic Community type of illicit psychoactive substance-dependent user, also was passed to admit and consagrate average times of treatment of 3 months for patients with problems related to alcohol use. However, depending on the evolution of the patient, these deadlines initially determined may be extended.

As a result of the evolution of the phenomenon over the last few decades, TC's had to adapt to new realities. The target population – of these units (persons with problems of addiction to psychoactive substances) reflected this evolution, whether in relation to new patterns of abuse/dependence of substances, whether in the biopsychosocial problems associated with drug addiction. These amendments, which originated new subgroups of people with problems related to the abuse/dependence of psychoactive substances, added to the already known subpopulations, which due to the natural phenomenon of progression through the stages of the life cycle, began also to highlight new intervention needs.

As result, the interventions dispositives had to accommodate to new realities by changing and adapting its responses. TC's tried to give answers to the new specifities, adjusting the therapeutic programs to specific populations such as:

- Users and/or polyusers of illicit psychoactive substances /alcohol, medecines and tobacco);
- patients with comorbility (ies) somatic and/or mental;
- Ageing of drug addiction population;
- Pregnants;
- Parents with small children[179];
- Couples;
- Teenagers with consumptions;

[179] All children and youth with less than 18 years old that goes to TC, either by its own need or accompanied by family members, since they are not sent by the Court, must be identified by the Commission of protection of Children and youth (CPCJ).

- Young/Adults with long and very serious judicial pathways and eventually with judicial measures restricting their own freedom.

Each TC should consider the capacity of response that efectively have, to answer to each one of these problems. In the definition of your profile answers must be taken into account, among others, the following.

- The therapeutic program implemented;
- Physical conditions;
- Technical team (number of technicians, time allocation);
- Geographical localisation (accesses and accessibilities);
- Interinstitutional colaborations established.

Of the various changes that the evolution of the phenomenon came to produce in terms of target populations – for treatment in a TC, deserve particular emphasis the issues related to minors. Thus, and in respect of its legislative framework-normative, according to the Joint Order No. 18683/08 admissions for specific programmes dedicated to young people and teenagers, in TC's beds with conventions lack of an appointment in treatment team of the Centre of integrated Responses in the area of residence of the patient. If it has not been possible to date of admission to the TC, this appointment can be provided by the treatment team of the geographical area where is located the TC. Must be justified by the treatment team technicians accompanying the minor the benefit of going to a TC for the family in general and for the minor in particular. Whenever possible, intervention near the family of origin, should take place in order to involve her as an active part in the process of change.

11.1.2. Strategy and policy frameworks for residential treatment

Current policy frameworks for provision of residential treatment

The legal diplomas that specifically regulate this activity, are Decree-Law 16/99, 25th January and Joint Order of the Ministry of Finances and Ministry of Public Administration and Health n.º 18683/2008, apart from others, that can embrace relevant juridical approaches as those regarding foreign residents in Portugal and legislation on minors.

Prior to their opening, all private TC's must obtain a license from IDT, I.P., and are subject to regular inspections. Therefore, these units must comply with the requirements expressed in the Decree – Law Nº 16/99, issued January 25th, 1999, in order to obtain the official approval of their license demand, which can be revoked in case of non compliance with legal requirements, also contains requirements concerning Clinical Direction and staff.

All patients that wishes to undertake treatment in a TC with convention (with financial benefits from the Government) should do it accordingly to the Joint Order n.º 18683/08 that states the mandatory requisites of the established conventions, through the IDT, and the private health units, with or without profit means, with the aim of treating drug addicts and alcoholics.

Foreign citizens, living in Portugal, can access medical internment, when caring the Portuguese National Card of the National Service Health. Without this Card, medical treatment is only accessible when presenting a more than 90 days proof of residence (stated by the local Parish Council) as stated in Decree-Law n. 135/99, 25th April, article 34.

Objectives regarding residential treatment listed in documents

In the Portuguese Strategy and National Action Plans there are no direct references to residential treatments or TCs. They are mentioned in the Treatment Axe and the Guidelines for the Treatment and Rehabilitation in Therapeutic Communities objectives are described.

The approval by the Government of the "National Drug Strategy 1999" was a clear sign of maturity in the political intervention regarding the complex problem of drugs and drug addiction.

The principles, objectives and strategic options that guided the action for those years were accurately defined. This document was a historic turning point in the structuring of a global policy faced with the problem of drugs and drug addiction on different fronts: from prevention to the fight against drugs and money laundering, from treatment to the social reintegration of drug addicts, from harm reduction to training and research.

For that purpose, we gathered together the best of our scientific knowledge, we listened to our most renowned specialists and practitioners in this field, we reread the experiences of the last twenty years, we promoted intense public debate and, finally, we made options, which are intended to be clear and coherent, on a par with the challenges that we face and Portugal's international responsibilities in this domain.

In the first Portuguese Drug Strategy (1999) several references are made to the objectives, role, criteria admission, quality requirements of Therapeutic Communities:

"54 – The strategic importance of the treatment of drug addicts

The guarantee of access to treatment for all drug addicts who seek treatment is an absolute priority of this national drug strategy.

The humanistic principle on which the national strategy is based, the awareness that drug addiction is an illness and respect for the State's responsibility to satisfy all citizens constitutional right to health, justify this fundamental strategic option and the consequent mobilisation of resources to comply with this right.

56 – The diversity of treatment methods and the principle of holding qualified Specialists responsible

Although progress has been noted in recent years, the treatment of drug addicts is difficult and does not permit sectarian orthodoxy or absolute certainties. There is a great diversity of models of intervention, especially in therapeutic communities, but also in other support structures. From physical withdrawal, as outpatients or inpatients, to psychotherapies of various types, whether for individuals or groups, to family therapy, to long-term confinement in therapeutic communities, as well as the use of antagonist medicines (naltrexone) or agonists (methadone and LAAM), many are the possible combinations.

The diversity of treatment methods is rewarding and, therefore, to be maintained, and it is necessary to encourage dialogue between the different models.

It should also be remembered that the establishment of admission criteria based on the ideological or religious positions of drug addicts can make their maturation and individualisation more difficult, when it does not, in certain cases, result in a outrageous exploitation of the particularly vulnerable state in which drug addicts are to be found.

Faced with the inevitable diversity of treatment models, what is important, in general terms, is to ensure that the services provided satisfy minimum requirements of quality, namely by holding the qualified specialists responsible.

This type of requirement has been reinforced in the new legal regulations for the licensing, operation and supervision of the activities of private units acting in the field of drug addiction (Decree-Law 16/99 of 25th January), which should now be controlled by the relevant licensing and supervisory authorities, in order to prevent the provision of services by entities that do not satisfy a series of basic quality requirements.

On the other hand, it also is important to promote the evaluation of the results of the different treatment programs.

58– Guaranteeing access to treatment

The guarantee of access to treatment for all drug addicts who seek treatment implies the development of a global policy, in a variety of areas.

The guarantee of treatment resources also includes, as we can see, an increase in provision through private units, especially for long-term internment in therapeutic communities. Naturally, it will only be possible to talk of true accessibility for drug addicts when this supply is covered by conventions, so as to ensure partial funding of the cost of the services provided by the State.

From this point of view, special significance can be attributed to the new system of support for the treatment and social reintegration of drug addicts, guided by the purpose of promoting conditions for accessibility, the attention that was previously focused on extending the infrastructure now turned towards the equity and response efficiency of the system (Decree- -Law, 72/99 or 15th March).

The problem of the persistent waiting lists at some CATs is even more important today, especially in more densely populated regions and where the drug problem is felt more intensely. The elimination of waiting lists at CATs is an imperative for this national drug strategy. For this purpose, a more rational

management of available resources must be ensured, more human and material resources must be made available to the SPTT, and obstacles in attracting practitioners to this field must be overcome.

It is also necessary to increase, through conventions, the number of places available in therapeutic communities, especially in the North and, in particular, for minors, pregnant women, mothers with young children and cases of double diagnosis.

It is also important to involve the whole health system – and not just the SPTT – in the treatment of drug addicts.

60 – Caring for high-risk groups

“One of the concerns that should guide improvements to the system of provision of health care to drug addicts is the guarantee of programmes especially designed for specific or high-risk groups.

Particular groups of patients also have extreme difficulty in finding appropriate responses for their cases. For example, there are very few specific treatment programmes for drug addicts with AIDS or for pregnant drug addicts, which only exist in Lisbon, Porto and Coimbra. The problem is even more serious when there is a need to use therapeutic communities. The need for more places in therapeutic communities for minors, pregnant women, mothers with young children and cases of double diagnosis, namely drug addicts with an associated mental pathology, have already been noted.

69 – Treatment of imprisoned drug addicts

“Available indicators on the judicial system and, in particular, on the prison system show the existence of a high number of imprisoned drug addicts, with the additional problems of high rates of contagious diseases, especially hepatitis, AIDS and tuberculosis.

In this respect, significant progress has been made over recent years in the area of health care provision in prison establishments, through both the installation, or rather improvement, in infrastructures and equipment, and recruitment of health staff.

It was also in response to this concern that the Ministry for Justice extended and diversified drug addiction treatment structures and programmes in prison establishments.

“G Wing” (a therapeutic community) at the Lisbon Prison, created in 1992, was doubled in size, as was the *Casa de Saúde das Caldas da Rainha* (Health House of Caldas da Rainha).

It is considered a priority to use prison terms to promote treatment, with the possibility of access to any therapeutic form that is considered appropriate. It is therefore important to guarantee the continuity and extension of prison programmes, namely withdrawal with psychopharmacological support, treatment with antagonists, substitution therapeutics and socio-therapeutic programmes.

But it is also important to implement mechanisms to enable inmates to have recourse to forms of treatment that do affect the prison regime, namely commitment to therapeutic communities and admission to residential reintegration units”.

In the Action Plan Horizon 2004, several references are made to the objectives or role of Therapeutic Communities

TREATMENT

Bearing in mind the strategic aim of ensuring access to treatment for all drug addicts seeking it, the National Plan for Combating Drugs – Horizon 2004 proposes that existing schemes be stepped up and innovative responses piloted in order to achieve the general objectives detailed below.

Overall aims and guidelines

1. By the end of 2002, complete the national CAT network, increase the number of drug addicts receiving treatment by 50% and substantially increase the number of drug addicts being treated successfully;

2. By 2002, increase the capacity of detoxification services by 50%, making this sufficient to meet demand;

3. Increase by 100% the public capacity for low threshold substitution treatment;

4. Increase by close to 100% the number of health centres working with the SPTT in providing substitution treatment and increase by 300% the number of health centres and hospital services joining addict screening and treatment schemes.

***Areas of intervention and action*:**

a) create, by the end of 2002, intervention programmes for treatment (outpatient support and in-patient units), which should be providing operational services by the end of 2004, aimed at specific groups or populations with risk behaviour,

namely:

- under-age consumers or addicts;

- pregnant addicts or mothers with small children;

- addicts with related mental pathologies (double diagnosis cases);

- addicts with related organic pathologies (AIDS, hepatitis, tuberculosis), in order to extend screening and medical supervision;

- non-addicted user workers or addicts taking part in the Aid Programme for Employees at Work (specialist unit for intervention at work) run by the Ministry of Defence;

b) design therapy circuits which increase the involvement of the whole Health System in the treatment of drug addicts, through greater coordination between the relevant public and privates services in this area, namely the Directorate-General of Health, the Mental Health Services, the Alcohol Abuse Centres and private health care organizations providing care on a contract basis;

c) promote access for drug addicts to new forms of treatment;

d) develop, adapt and implement therapeutic strategies to respond to the consumption of new drugs and new patterns of consumption;

e) extend psycho-therapeutic support programmes to the children of drug addicts;

f) extent intervention strategies for drug addicts not seeking the available treatment services;

g) develop and gauge methods of assessing the results achieved by different treatment programmes;

h) involve the whole Prison Health Service in the treatment of addicted inmates. By the end of 2002 the pluri-disciplinary health worker teams at all prisons should be structured or increased;

i) build and equip new drug-free units at prisons, by the end of 2004;

j) continue with treatment programmes when entering and leaving the prison system, extending and improving cooperation with the organizations providing services in this field.

k) use all the possibilities allowed by law and any new procedures, which may be created in order to guide addicts convicted of drug-related offences towards treatment.

l) Step up supervision of the private units, operating on a contract or other basis, providing services to drug addicts undergoing detoxification or treatment.

ACTION PLAN AGAINST DRUGS AND DRUG ADDICTIONS HORIZON 2008

The Action Plan Against Drugs and Drug Addictions - Horizon 2008 is structured according to Cross - Cutting Areas (Coordination, International Cooperation, Information, Research, Training and Evaluation, Legal Framework Review) and Mission Areas. Demand Reduction (Prevention, Dissuasion, Risk and Harm Reduction, Treatment and Reintegration) and Supply Reduction.

It has been designed not as a static list of objectives, but as a dynamic and adjustable policy instrument. Under each axis and each vector the results to be achieved are identified, the objectives and actions are time-scheduled, and the parties responsible for implementation, as well as their main partners, are indicated. Assessment tools and indicators for each action are also proposed, with a view to the structural qualification, constant improvement and regular evaluation of the different programmes and interventions.

It is also envisaged to strengthen the active involvement of civil society, namely private and social care institutions, viewed as fundamental to complement the public treatment network and to ensure responses in the areas of prevention, risk and harm reduction and reintegration.

Objective 63. "Improve the provision of treatment programmes to the drug-using population based on ethical criteria and scientific evidence.

Action 63.1. "Define guidelines for outpatient and inpatient (residential and short-stay) treatment programmes, as well as pharmacological (with opiate agonists, opiate antagonists and psychopharmacs), psychotherapeutic, social and public health/risk and harm reduction (vaccination, referral) treatment programmes

Objective 68. Ensure the adequate training of professionals in the treatment area, both internally (IDT) and externally.

Action 68.1. Training action addressed to professionals according to a biunivocal cascade model, including prison staff".

ACTION PLAN AGAINST DRUGS AND DRUG ADDICTIONS 2009-2012

Objective 51. Promote measures to facilitate access to the different treatment programs, managing waiting times according to ethical and scientific criteria, local realities and international recommendations.

Action 51.1. Monitoring waiting times for first appointments and admissions to treatment programs.

Action 51.2. Definition of models for admission/transfer of users to services or programs (street teams, Therapeutic Communities, Day Centers, Detoxification Units, Alcohol Units and Therapeutic Program with Opiates Agonists).

Action 51.3. Definition of admission criteria for the different programs.

2. Availability and characteristics

Historically, in Portugal, TC's were always in the frontline in what concerns responding to drug abuse. Since the mid – 70's, when a first public response to emerging drug problems was implemented, two TC's were created (in Lisbon and Coimbra), as a part of a set of treatment modalities to drug abusers. The next decade saw the appearance of private TC's, mainly inspired by the "Le Patriarche" movement, who stood aside of the public treatment services. Later, with the development and integration of public responses to drug related problems in one single structure – IDT, IP, a new framework for TC's licensing and operation was devised, in which preservation and enhancement of ethical, legal, and scientific - based criteria were the main concern. Since then, a wide network of professional units covered the countries' needs in what concerns residential treatment.

2.1 National (overall) availability

In 2011, there were 68 therapeutic communities (3 public and 65 private units) operating in mainland Portugal.

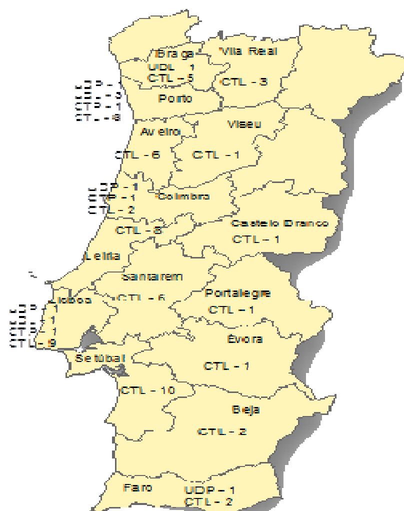


Figure 2 – Distribution of Therapeutic Communities within the Country (IDT, I.P. 2012)

Therapeutic Communities (TCs) are specialised units that provide care to drug users who require prolonged hospitalization and psychotherapeutic and socio-therapeutic support with the purpose to promote their rehabilitation and treatment.

A residential internment usually has duration of 3 to 12 months, usually without need for medication. IDT, I.P. has three units of this type: Porto, Coimbra, Lisbon, 65 private Therapeutic Communities are accredited by IDT, I.P.

Prior to their opening, all private units underwent a licensing process and are subject to regular inspections. 61 of these 65 private units also established a convention with IDT, I.P., by which some or all of their places can be occupied by patients coming from the public network of outpatient treatment services managed by IDT, I.P. This means that IDT, I.P. pays or supports a number of beds.

Of these 68 TC's, 3 are public, with a total of 55 beds, 134 patients were treated in 2011 in these units, a total of 15 929 days of hospitalization, which corresponds to an occupancy rate of 79,3%, -7% decrease in comparison to last year.

	N.º of clients					N.º of days of hospitalization					Occupancy rate (%)				
	2008	2009	2010	2011	TX.CR %	2008	2009	2010	2011	TX.CR %	2008	2009	2010	2011	TX.CR %
North	56	54	55	56	+1,8	6.683	6.818	6.975	6.326	-9,3	83,0	84,9	86,9	78,8	-9,3
Center	25	29	30	28	-6,7	3.775	3.981	4.217	4.272	+1,3	86,0	90,9	96,3	97,5	+1,2
Lisbon	50	44	39	50	+28,2	6.569	5.606	5.935	5.331	-10,2	85,5	73,1	77,4	69,5	-10,2
Total	**131**	**127**	**124**	**134**	**+8,1**	**17.027**	**16.405**	**17.127**	**15.929**	**-7,0**	**84,6**	**81,7**	**85,3**	**79,3**	**-7,0**

Table 6 – Public Therapeutic Communities (IDT, I.P. 2012)

The other 65 TC's are private, with a total of 2 112 places – in 2011, a total amount of 3 996 patients were treated in these services representing a decrease in relation to last year of 379 clients.

From the 65 private therapeutic communities, 61 have conventions with the IDT, i.P. in 2011 supported 1 530 beds, more 14 than last year in the same date.

	N.º of Units	N.º of Beds 31 December	N.º of Clients	N.º de dias de Internamento	Occupancy Rate (%)
Licenciadas	65	2.112	3.996	-	-
Convencionadas	61	1.530	3.008	421.368	78,8%

Table 7 – Private accredited and convention Therapeutic Communities (IDT, I.P. 2012)

Concerning patients admitted to beds with convention, was registered a variation rate of 14.1% in comparison to last year; equally this variation was negative regarding the number of internment days, -6% than in 2010.

N.º of Convencionadas beds				N.º of clients					N.º de dias de Internamento				
2008	2009	2010	2011	2008	2009	2010	2011	TX.CR	2008	2009	2010	2011	TX.CR
1.516	1.516	1.516	1.530	3.254	3.474	3.502	3.008	-14,1%	416.191	453.102	448.864	421.368	-6,1%

Table 8 – Private TC's and with Convention (IDT, I.P. 2012)

In 2011, the total number of places under convention with IDT, I.P. was 1 530. Under the terms of this convention, IDT, I.P. will pay for an important part of treatment of each individual patient (80% of the total cost), during the actual period of his/her stay in TC. Thus, no direct or automatic public funding is awarded to private TC's, on any other basis than "receiving for treatment services actually rendered".

Among the 65 private licensed TC's, 53 provide specific programs, in order to meet patient's special needs. Places available within the scope of specific programs add up to 400, being their distribution as follows:

- 29 TC's provide specific programs for patients with psychiatric co-morbidity, with a total capacity of 219 places;
- 17 TC's provide specific programs for adolescents, with a total capacity of 148 places;
- 7 TC's provide specific programs for adolescents, with a total capacity of 33 places.

In what concerns public TC's in 2011, of the total number of 134 patients treated, 37 had psychiatric co-morbidity. No records of pregnant women or adolescents admittances were obtained.

To be admitted in a TC, the patient prior therapist has to evaluate his knowledge and motivation to undertake this type of intervention as well as its individual adequacy to this therapeutical tool.

All patients that wish to undertake medical treatment in a TC with convention must do it according to the Joint Order n. º 18683/08. Admission criteria are several: voluntary internment; signing up of the Informed Consent Form (patient and family, if possible); Clinical history, Analysis and other recent medical exams; In case of disease or cronical infeccion, a specific medical report must be sent together.

The Expulsion criteria: (mandatory) are the following: risk behaviours for the patient and/or others; possession and/or use of abuse substances; serious failure on accepting TC rules of procedure.

2.2. Types and characteristics of residential treatment units

The health care system of IDT, I.P. is composed of various types of specialized units, in relation to residential treatment, have been created, streamlined or celebrated to the rhythm of the needs expressed by the target population and the budgetary possibilities, as well as the design of policies intervention that enable more integrated responses, citizen-centered and advocating a easy accessibility.

Thus we have:

- public units, those units within the network of the service.

Private units are all the units providing health care in the drug addiction area, which were assigned by IDT, I.P. operating licences allowing them to accept drug addicts in treatment, under Decree-Law n º 16/99 of January 25th and Decree - Law 13/93 of 15th January.

Private units with conventions are those ones where the service reserves some beds in order to increase the number of beds available for the treatment of drug addicts who have clinically indicated to do so.

Each region has a number of conventioned beds which can be occupied through a internment proposal elaborated by the therapist of the patient with the collaboration of other intervenients and with favour order of the responsible regional clinical.

TC is an integrated resource and a specialised unit that provides care to drug addicts needing prolonged internment with psychotherapeutic and sociotherapeutic support with the aim to promote treatment and (re) socialization. A residential treatment usually has the duration of 3 to 12 months.

Aiming to create a space for reflection: promoting the change negative behavioral patterns; promote autonomy and responsibility; develop relational ability; (re) discover social competences and forseen social inclusion.

The most important approach element of the TC is the Community. The community is both the context and the method in the change process. It is the element of community that distinguishes TC from all other approaches to treatment and rehabilitation of substance abuse and related disorders, is the use of the community as a method that differs from other TC community modalities.

Each TC should choose the target population that want to reach taking into account among other questions the following:

- The therapeutic program implemented;
- Physical conditions;
- Thechnical team (number of technicians, time allocation);
- Geographical localisation (accesses and acessibilities);
- Interinstitutional colaborations established.

In the therapeutic program of the TC there are elements which structure the diary organization, daily work agenda, therapeutic groups, stahes, and recreational time while others as treatment goals, program structure flexibility, the intensity of interactions are adaptable. Works based on scientific evidence favoring the strength of TC as a method.

Thus, IDT, I.P. has at national level three public CT's, in a total of 55 beds.

The importance of its existence is being reference units with a key role in training technicians intervening in the area and because they provide different responses to the drug addict population.

TC Ponte da Pedra – Leça do Balio, Porto is the first certified TC according the norm ISSO 9001:2008 and the the intervention is based in a bio-psycho perspective – social understanding of drug addiction, has the duration of 9 to 12 months divided into different phases.

TC Arco-íris: the therapeutic program is based in planning individual treatment dimensions in medical/psychiatric, psychotherapeutic, sociotherapeutic, social, family and relapse prevention has duration of 6 to 12 months, divided into different phases.

TC do Restelo: the therapeutic program is based in a comunitary model hierarchical organized and offers a systemic treatment modality, whose general assumptions fit the perspective of De Leon, and are based on fundamental aspects that intertwine and guide the therapeutic process: drug addiction, the person, the healthy lifestyle and recovery, has a minimum duration of 12 months and is divided into 5 phases.

As a result of its history as specific modalities of intervention in drug addiction, exists several “models” or programs exists (hierarchical, democratic, religious inspiration – Catholic, Protestan or other, Minnesota, 12 steps, Portage and others), accepted as valid methods for treatment.

In what concerns models of intervention, only in the 90’s, within the framework provided by public policies and institutions encompassing all the intervention on drug addiction, integrating private and state institutions, that professional TC’s and scientific – based methods of treatment could flourish, and “take the ground”. Binded to the respect of minimal standards and quality criteria depicted in the law, the spread of professional TC’s occurring in the last two decades entailed a diversification of scientific – controlled intervention models and conceptual frameworks. Thus, from the initial two public TC’s until nowadays, new forms of intervention on residential treatment were implemented – an overall assessment of the scope of the conceptual and treatment frameworks put to practice by TC’s in 2011 shows:

- Minnesota / 12 steps: 9
- Bio-psycho -social : 9
- “Projeto Homem” (Daytop Village inspired) : 7
- Hierarchic : 5
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- Systemic : 2
- *Portage Programme for drugs* : 2
- Cognitive-behavioural: 2
- Intensive Psychoterapy: 2
- Client centered; Democratic ; Bonding Therapy : 1

Along with their increase in number, in the last two decades TC’s had to adapt to new problems arisen by the ever-changing phenomenon of drug abuse and addiction, and its health and social consequences. This effort of constant adaptation led to a diversification of treatment and rehabilitation interventions provided by TC’s, concerning these three areas: an enlargement of the scope of services provided to patients, admittance of OST – medicated patients, and a stronger effort put on building a network with other institutions working in the field of drug addiction, and/or related areas. The following examples are clear in illustrating the results of these efforts:

- An overview of integration of services typically provided by Portuguese TC’s include:

- For the most part of TC’s: OST; case management; HIV/AIDS, HCV, and STI screening, testing/diagnosis, treatment, and monitoring; group therapy; institutional therapy; recreational therapy; educational; employment; peer-group support;

- For some TC’s (in accumulation with mentioned above): Detoxification; housing; motivational and /or relapse prevention therapy; individual therapy; vocational training; life skills; training; aftercare; professional training.

2.2.3. Integration of OST in residential treatment

From the enlargement of the scope of services provided to patients, , admitting OST patients was probably one of the most clear example of the effort put forth by TC’s to adapt to new reality and needs of people suffering from addiction to opiates (TC’s were classically seen as a non – medicaliazed form of treatment). Nevertheless, since the final of the 90’s, progressively more TC’s

admitted patients under OST, with discontinuation during residential treatment being seldom envisaged as an initial objective for these patients, and later evolving to a more flexible approach to the complementarity of treatments required for dealing with such a complex problem as drug addiction. Actually, in Portugal, programme characteristics in what concerns patients under OST shows that from the 65 licensed TC's, 59 admit patients under OST; in most cases, patients are already on OST prior to admittance. Methadone and High Doses Buprenorphine can be used.

Programme characteristics:

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Portugal has two Guidelines in this area – "Normas Orientadoras dos Programas Terapêuticos com Agonistas Opiáceos em Portugal" and "Manual de orientações técnicas para a implementação de programas de substituição opiácea de baixo limiar de exigência". The first, aims to establish itself as a support to harmonise procedures, methodologies and terminologies, but also a clarifying and oriented instrument for the intervention itself in Therapeutic Programs with Opiate Agonists, under treatment and risk and harm reduction and consequently, to promote greater consistency of intervention.

2.2.4 Typical levels of collaboration and networking

- Systemic links of residential treatment to other units and services: descriptively, to what extent each level of networking is being used (please use the categories provided in the Appendix 1);

- If available, please give examples of established collaborations with external partners and organisations, indicating the particular area of collaboration (e.g. referral process; management of co-morbidity; programme exit, aftercare, management of drop out);

A stronger effort put on building a network with other institutions working in the field of drug addiction, and/or related areas was another consequence of the evolution of TC's in Portugal. The evolution of TC's in Portugal brought about a multidisciplinary approach to the problem, that fitted its complexity. As seen above, this movement entailed a diversification in the response on what concerned treatment modalities; subsequently, a parallel evolution was also observed in the field of networking. Thus, from its early stages where TC's were designed as closed environments without perspectives of real recovery from drug addiction, the evolution towards more scientific and humanistic approaches led to the recognition of the importance of establishing links to and from the community. Networking became one of the major building blocks for the intervention of TC's, which grants them the statute of treatment units.

An overall assessment of the typical levels of networking by TC's in Portugal can be put forth:

- Level 1: Employment Centers, Judicial matters;

- Level 2: Physical co morbidity, and general health issues;

- Level 3: Aftercare, halfway houses, transferral, social matters (family, children, protected employment), psychiatric co morbidity, severe/urgent physical co morbidity, OST, drop out management;

-Level 4: Treatment admittance, treatment discharge and continuation of treatment in outpatient services.

This is merely an example: levels of networking can differ from one TC to another; and also, accordingly with his / her evolution in treatment, patients can be proposed to play a greater role in managing relevant networking for his / her specific situation (more Level 1 networking).

3 Quality management

As previously mentioned, the integration and coordination of policies and interventions regarding drugs and drug related problems in one single public structure – first SPTT (created in 1990) which dealt mainly with treatment issues, evolving subsequently to IDT, (2002), which detained a broader scope of competencies in this field, opened ways to attend to important dimensions in what concerns

TC treatment. Thus, the compliance with minimal criteria for licensing and functioning by these unites (covering all the main areas, from building features, accessibility, staff, clinical records, assessment and reporting, and so on…) could be determined and universally imposed by law (Decree – Law Nº 16/99, issued January 25th, 1999). Furthermore, improvement of quality of care in both public and private units can be easily managed. The framework for TC's approval, functioning and accountability to IDT, IP thus created opened a way for a better and more fluid collaboration between the national authority on drugs and drug abuse, and private TC's. As a result, conventions between IDT, I.P. and private units could be established, by which patients coming from the public outpatient treatment services can be referred to these private units, with a substantial part of the costs of their treatment to be assumed by IDT, .IP. (80%).

Several therapeutic communities implemented a Quality Management System ISO 9001.2000, which is an international reference for the Certification of Quality Management Systems.

Certification according to ISO 9001 recognizes the effort of the organization to ensure compliance of its products/services, customer satisfaction and continuous improvement.

The use of this system corresponds to the following objectives:

- Develop your activity in accordance with the satisfaction of clients;
- Strengthen the effectiveness and efficiency of the process;
- Build trust based on a standardized and transparent management;
- Increase social legitimacy and promote continuous improvement of its services aimed at expanding its social intervention.

This Quality System Certificate allows for clear benefits for clients-users, the organization and the community:

- Systematic evaluation of the dynamics of global activity at the TC, stimulating continuous improvement trough an increase of transfer of know-how and motivation,
- Increased satisfaction of users.
- Increased social legitimacy, strengthening integration in local networks and welfare and the community, ultimately benefiting the families, the networks and the society.

In 2011, the public TC's having quality certification was: Ponte da Pedra 2009 and the private TC's having quality certification were Dianova and "Entre Pontes". It was the first private TC to obtain the certification ISO 9000:2008. Issued on 2010-09-30, validity date 2013-09-29.

3.1 Availability of guidelines and service standards for residential treatment

National and/or local guidelines

In Portugal national guidelines for treatment and rehabilitation in Therapeutic Communities are available – (Linhas Orientadoras para o Tratamento e Reabilitação em Comunidades Terapêuticas"2011). These guidelines has as objective to systematize and clarify the procedures and criteria that support the relationship between public institutions that regulate the activity in the field of drug treatment and the private TC's.

The guidelines are a working tool for all partners involved in this relationship, based on one hand a summary of the provisions scattered trough the different legal instruments that govern this activity and on the other hand, the results of the initiatives undertaken by IDT, I.P. concerning quality on these type of units. A practical reference guide was elaborated, that intends to be a support for experts and professionals working in this field and for those who intend to intervene in it.

Service standards: staffing levels, minimum requirements for staff qualification

It is the task of the State to ensure the guarantee of a minimum level of quality of health services provided, not only in what refers to requirements of infrastructure and operating standards, but

specially on human resources, in order to ensure the necessary technical monitoring and necessary medical accountability on the supervision of the treatment provided.

The objective is not, and it wouldn't be possible, to guarantee from the start the success of treatment or even to restrict the diversity of treatment methods available in the market. But rather to set basic quality requirements, that private units must have in order to provide this type of services. The regulation of these mechanisms, respecting the singularity of the centres, follows closely the standard rule for licensing and supervising private health units, without prejudice to the specific reality that addiction requires.

Prior to their opening, all private TC's must obtain a license from IDT, I.P., and are subject to regular inspections. Therefore, these units must comply with the requirements expressed in the Decree – Law Nº 16/99, (issued January 25th, 1999), in order to obtain the official approval of their license demand, which can be revoked in case of non compliance with legal requirements. These legal requirements cover all the relevant areas:

- Definition of a TC unit;
- Physical requirements
- Facilities
- Construction characteristics
- Technical installations and equipment
- Clinical Direction
- Staff
- Rules and treatment programme
- Clinical records
- Insurance
- Price
- Complaints book.

The Decree – Law 16/99 also contains requirements concerning Clinical Direction and staff:

- Clinical Director should be a college graduate with adequate training in the area of addiction
- Supervision by psychiatrist is mandatory;
- Patient physical health follow up, treatment initiation/continuation and referral are to be guaranteed by a medical doctor;
- Staff with an adequate training in the field of addictions, and in what TC treatment is concerned, properly deployed in a work schedule that guarantees a permanent attention to patients.

Also, a detailed list of facility requirements is depicted in the Decree – Law 16/99, concerning:

- Construction;
- Accessibility;
- Building features: areas for rooms, common areas, service areas;
- Circulation of persons and goods;
- Electrical systems;
- Residues disposal;
- Food and nourishment;
- Laundry equipments;
- Refrigeration equipment;
- Water supply, and waste water disposal;
- Security systems: fire and intrusion.

For specific programes:

As previously stated, the evolution of the phenomenon determined the neeed to create specific intervention programs, in order to fit subsets of users with problems that require adapted interventions - minors/teenagers, pregnant women, drug addicts with severe mental illness concomitant. In this sense, the licensing of TC's that in its therapeutic program explicitly address the inclusion of users carrying these specific characteristics, will be dependent on the mandatory following requisits:

a) Treatment of pregnants in TC's:

- Assure the conditions in the pregnants room taking into account the space occupied by the crib or bed and coordination with the kindergarden
- Existence of therapeutic programme specifically developed for pregnants

- Ensure follow-up of pregnant in obstetrics/gynecology as well as the need for pediatric monitoring of the newborn

Comunicate to CPCJ and Social Security child's birth, for evaluation and monitoring, namely in the search of nurseries, kindergarten and respective payment.

b) Treatment in TC of minors/teenagers

- Existence of treatment program specificaly developed to minors/teenagers
- Provide diferentiated pedagogical support, for mandatory school
- Promote carefuly monitoring of the legal aspects related to minors/teenagers

c) Treatment in TC's for double diagnosis (Concomitant mental health)

- Therapeutic program specificaly developed for drug addicts and alcoholics carriers of serious concomitant mental disease;
- Assure the monitoring whenever necessary of the medecine therapeutic administration;
- Assure that the number of drug addicts and alcoholics carriers of serious concomitant mental disease do not exceed 10 patients simultaneously;
- Include in the technical team a psychiatrist with weekly presence, a general practioner with bi-weekly effective presence (both easy to contact in the remaining time); a psychologist with daily presence and on-call on weekends and a qualified social educator/education social/monitor daily.

To guarantee the fulfillment of the norms fixed, it is organised a System of inspections and supervision in charge of IDT, I.P.

In 2011 there were 40 inspective actions and/or fiscalisation to private entities with intervention in the field of drug addiction. The actions were distributed, ones for licensing and others for the follow-up, which sought to contribute to the reduction of inadequacies, veryfing almost complete correction of non-conformities detected.

These actions focused in parameters such as:

- quality of the care provided to drug addicts and the health gains;
- the technical conditions of the premises where the care is taking place
- the technical teams of the Institutions.

For each patient admitted, TC's under convention are liable to send to IDT, I.P.

- An Admittance questionnaire;
- A Discharge questionnaire;
- A Follow up questionnaire, after discharge;
- A Three – year follow up questionnaire, after discharge.

Some TC's also report their yearly activities to IDT, I.P.

Links between funding and reporting

In Portugal, TC's under convention with IDT, I.P. receive their funding on a "treatment service rendered" basis, i. e., per patient in treatment. Thus, they must report monthly the number of patients that were effectively treated during the previous month.

Through the Joint Order n. º 18683/2008, 14th of July 2008, the Ministries of Finances and Health fixed the values:

- TC – 900€ month/patient
- TC with specific program and expressly dedicated to minors/pregnants or drug addicts with serious concomitante mental disease – 1000€/month/patient.

4. Discussion and Outlook

The next decade saw the appearance of private TC's, mainly inspired by the "Le Patriarche" movement, who stood aside of the public treatment services. Later, with the development and integration of public responses to drug related problems in one single structure – IDT, IP, a new framework for TC's licensing and operation was devised, in which preservation and enhancement of ethical, legal, and scientific - based criteria were the main concern. Since then, a wide network of professional units covered the country' needs in what concerns residential treatment.

As a result of its history as specific modalities of intervention in drug addiction, exists several “models” or programs exists (hierarchical, democratic, religious inspiration – Catholic, Protestan or other, Minnesota, 12 steps, Portage and others), accepted as valid methods for treatment.

In what concerns models of intervention, only in the 90’s, within the framework provided by public policies and institutions encompassing all the intervention on drug addiction, integrating private and state institutions, that professional TC’s and scientific – based methods of treatment could flourish, and “take the ground”. Binded to the respect of minimal standards and quality criteria depicted in the law, the spread of professional TC’s occurring in the last two decades entailed a diversification of scientific – controlled intervention models and conceptual frameworks. Thus, from the initial two public TC’s until nowadays, new forms of intervention on residential treatment were implemented – an overall assessment of the scope of the conceptual and treatment frameworks put to practice by TC’s in 2011 shows:

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A stronger effort put on building a network with other institutions working in the field of drug addiction, and/or related areas was another consequence of the evolution of TC’s in Portugal. The evolution of TC’s in Portugal brought a multidisciplinary approach to the problem, that fitted its complexity. As seen above, this movement entailed a diversification in the response on what concerns treatment modalities; subsequently, a parallel evolution was also observed in the field of networking. Thus, from its early stages where TC’s were designed as closed environments without perspectives of real recovery from drug addiction, the evolution towards more scientific and humanistic approaches led to the recognition of the importance of establishing links to and from the community. Networking became one of the major building blocks for the intervention of TC’s, which grants them the statute of treatment units.

In 2011, there were 68 therapeutic communities (3 public and 65 private units) in mainland Portugal. The number of clients in therapeutic communities increase 13% in comparison to last year (3 601 in 2009, 3 385 in 2008 and 3 167 in 2007), consolidating the grown of last years.

Concerning average waiting time for entry into treatment programs the public therapeutic communities present 9 days of waiting, all TC’s presented values below the 22 days referred as acceptable

Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Therapeutic Communities	**67**	**75**	**79**	**75**	**73**	**72**	**73**	**76**	**70**	**70**	**69**	**68**
Public Network	2	2	2	2	2	2	3	3	3	3	3	3
Accredited Network	65	73	77	73	71	70	70	73	67 [a)]	67	66	65
With Convention	54	63	64	63	61	62	64	60	62	62	62	62
Without Convention	11	10	13	10	10	8	6	13	5	5	4	3
Patients in Therapeutic Communities	**4032**	**4527**	**4189**	**4138**	**4254**	**4161**	**4228**	**4557**	**4698**	**4578**	**4499**	**4130**
Public Network	*67*	*72*	*66*	*57*	*75*	*68*	*110*	*134*	*131*	*127*	*124*	*134*
Accredited Network	*3 965*	*4 455*	*4 123*	*4 081*	*4 179*	*4 093*	*4 118*	*4 423*	*4 567*	*4 451*	*4 375*	*3 996* [b)]
With Convention	2 519	2 825	2 877	2 891	2 900	2 944	3 036	3 033	3 254	3 474	3 502	3 008
Without Convention	1 446	1 630	1 246	1 190	1 279	1 149	1 082	1 390	1 313	977	873	988

Table 9 – Number of Therapeutic Communities and Patients from 2000 to 2011 (IDT, I.P. 2012)

a) The change in the number of structures in relation to last year is due to adjustments made in some Private Units, not reflecting a real reduction in supply in this context since was a increase in the number of beds available
b) Information received at IDT, P.P. until 31/12/2012, data will suffer update next year, with the inclusion of information received between 31/12/2012 to 31/12/2013.

Challenges

Patients that undertake residential care are an older population with a significant number of years of addiction, presenting a severe psychiatric and physical co-morbility and a long path in different help and care structures and services leading to an overall feeling of frustration and helplessness, creating a group of "veterans" with great difficulty on building up a healthy and adequate life style.

One challenge related with this is the need to adjust the therapeutic programs to these situations and at the same time fidelity to the program, in order to increase the program efficiency.

Other challenges that TC's will have to face in the near future are the following:

- Financial issues (it should not decrease the minimum limit for treatment);
- New drugs, new addictions and new ways of use;
- Lack of professional skills, economical crisis and high unemployment rates endanger patients' professional reintegration;
- The search for a place to live, asylum or hostel instead of a therapeutic project;
- Work together with Universities to supply scientific-based studies that might support the increase of residential treatments efficiency.

Regarding the dependencies without substance, like gambling, internet, and shopping, it is urgent to validate the use of TC's. There are already some experiences in the United States and China, with inpatient programs in TC, which is a surprising answer, since common sense tends to consider these dependencies without substance, as a minor problem and a minor concern.

In time of crisis, it is not expected to reduce the number and urgency of cases we face. If this answer (TC's) significantly weaken or disappear, people untreated will return to society, frustrated and angry, with predictable consequences in terms of public and social order. Back to the past, to repression, prison incarceration, where costs per individual and to the State will be higher than the recovery in TC.

Specific added value of residential treatment

National Institute on Drugs Abuse (NIDA, 2005) investigations showed that patients in CT present better results in all physical and mental health indicators than any other treatment strategy.

Besides that, TCs have capacity to respond to the treatment of some substances that have been trivialized, such as hashish and marijuana. Some substances have increased their prevalence, has it is the case of cocaine, a product for which there is no substitute or antagonist, i.e. medicinal weapon's that are used for opioids. In the current situation the TC's are basic instruments that work in network with multiple society structures, authentic foundations in response to the referred increase in the prevelences reffered.

Studies also showed that after leaving a TC, 55% of the individuals had never relapse and 43% had relapse, from these last ones 31% after relapse stopped, being abstinent for several years. The percentage of relapses in subjects with medical release is four times less than the percentage of individuals without medical release. Therefore, stay in the program until the end is a predictor of success. If the vast majority at the entry date to TC reported to have committed delinquent acts (theft, robbery, drug possession and trafficking, forgery, among many others) after leaving the TC the vast majority had not committed any of the offenses mentioned. Also in relation to employment, results are positive, since the vast majority of individuals who left TC were employed, and those who are unemployed are those who are consuming.

These are some facts that demonstrate the need and clear fundament for the existence of TC's. One can think in a logical of immediate savings, which can be expendable. But if this happens, you lose a key resource in order to give hope and efficiency in the help to problems that afflict and martyr Portuguese families. We also referenced the various models and the history of TC's in Portugal for the last 20 years, which ceased to be an experience to become a reality and gave a decisive contribution to the international recognition of the Portuguese approach to the drug problem.

BACK TO TOP

NETHERLANDS

11 Residential treatment for drug users in Europe

11.1 History and policy frameworks

11.1.1 History of residential treatment

To a large extend, this paragraph is based on the study of Gemma Blok (2011), entitled "Sick or weak: History of the addiction care in the Netherlands" (*Ziek of zwak: Geschiedenis van de verslavingszorg in Nederland*).

Medicalization
In the Netherlands, from 1881 onwards, people who were picked up drunk three times were sent to the *National work facilities* (Rijkswerkinrichtingen). Life was harsh in these labor detention centers, and the results of a stay in these facilities were poor. In response to this hardship the *People Federation against alcohol abuse* and other organisations looked for a more human solution. Partly for this reason the first addiction clinic in the Netherlands was founded in 1891: *Hoog Hullen,* a non-religious asylum for "needy drinkers". This development was in line with the medicalization of alcohol abuse which took place in Europe and the USA in the nineteenth century. The treatment now consisted of first detoxification and after that offering the patients "powerful" food, purifying drinking water, healthy work, hydrotherapy, and sport.

About twenty years later, the first outpatient facility was established: the *Medical health center for alcoholism* (Medisch Consultatiebureau voor Alcoholisme) in Amsterdam. After that several inpatient mental healthcare hospitals opened special wards for people with alcohol problems. The main reason for special wards was stigma driven. Alcoholics wanted not to be associated with "crazy" people.

The fight against alcoholism and alcohol abuse was not initiated by the government but by different enlightened persons, whether or not religious driven, like doctors, teachers, vicars, professors and factory owners.

Although opiates were used (especially) by the wealthy bourgeois women and morphinism was diagnosed as a disease (around 1900), there were no special clinics for problem opiates users. These women were admitted to sanatoria. Around the same time certain laborers in the industrial centers and farm workers used opiates to release the hardship of their life. At that time opiates were easily accessible medication. It took a time before it was found out that this medication was addictive. Thus, until the sixties of the twentieth century, the addition care mainly focused on alcoholism and alcohol abuse.

Paradigm shifts
During the last century, various paradigm shifts have occurred in the perception of addiction. At the end of the nineteenth century alcohol addicts were seen as "sick" instead of "weak" persons. In the first addiction clinic it was tried to help them by curing their disease. About two decades later, damage control was added to the treatment goal in the form of preventing social and financial decay. After that a pendulum movement became visible. Initially, the goal of addiction treatment shifted from total abstinence to damage control. Next, the goals of addiction treatment shifted back from the acceptance of addiction as a chronic disease and applying harm reduction to efforts to reach total abstinence.

After 1950, a new perspective became prevalent, namely the psychological approach to addiction. According to this new approach, the root of addiction problems was to be found in the addict's childhood. This perspective brought along new therapeutic treatment options. In the same period new medication became available which further broadened the treatment options, like Librium (1960), a benzodiazepine that made craving less severe.

In 1960, the Jellinek clinic was founded, a "Therapeutic community" in the city of Amsterdam especially for alcohol addicts. In the sixties more of these clinics were opened like the Boumanhuis in 1962 in the city of Rotterdam. Many of these clinics originated from a former *Medical health center for alcoholism* (Medisch Consultatiebureau voor Alcoholisme).

New young drug users

After 1960 a new client population came up: the young drug users. But it was not until 1968 that special care was organized for this group in the form of a consultation hour in the centre of Amsterdam where young drug users could get help and advice. In 1969 the *Medical health center for alcoholism* (Medisch Consultatiebureau voor Alcoholisme), in response to the new drug problem, became the *Medical health center for alcohol and drugs*.

Also in 1969 the first methadone treatment started in the Jellinek clinic. Problem drug users were given methadone according to a schedule by which the dose was reduced in six weeks. After 1972 heroin use became epidemic. It started in the capital city of Amsterdam, and although it was also used in the outside areas, Amsterdam remained the centre of heroin use.

The main group of drug users consisted of people who were frustrated about their position in the Dutch society, like youngsters who did not finish school or only finished low skilled education. They were jobless or only did unskilled work. A disproportionate large number of immigrants from Surinam were addicted. This group had a double disadvantage. On the one hand they already belonged to the weaker groups in Surinam, and on the other hand they emigrated to the Netherlands during an economic recession. Their housing situation was poor and there were not enough jobs available for the newcomers.

The prevailing view in addiction care was that parents are to blame for the addiction of their child. This resulted in the vision that addicted patients must loosen the bonds with their family. This vision collided with the (culturally driven) need of strong family ties and the wish to restore the family relations among the immigrants from Surinam. This collision of values was one of the reasons that an alternative treatment was realized for this group. An example of such an alternative treatment facility was "Wan Pimpel". The Surinam caregivers at this facility were less detox-minded compared to the Jellinek clinic. They helped the addicts with practical issues and gained their trust, and this way they could make the drug use a subject of discussion.

In 1979 the public health services (GGDs) started a "methadone bus" in the major cities in the Netherlands. On fixed times drug users (mostly vagrants) could come to pick up a dose of methadone at certain areas in the city that were visited by the methadone bus. There was no control on the use of other drugs and there were no therapeutic obligations. In the beginning a major part of the methadone clients was of Surinam origin.

Residential care

Meanwhile, the addiction care facilities only reached a small fraction of the drug users. There was a threshold to receive addiction care. The patients had to be motivated and had to submit themselves to certain rules to be admitted to a therapeutic program. The government supported this approach. The Health Council reported in 1976 that the only meaningful treatment of addiction aims at total abstinence. Every other approach was supposed to stimulate an addicted person to persist in his lifestyle. At that time the addiction care was rather optimistic about the therapeutic possibilities. The Drug-free Therapeutic Communities (DTCs) came up, and the Jellinek opened the DTC "Parkweg". The average stay in this kind of clinic was eight months to one and a half year. In due time, the caregivers noticed that a too liberal and too noncommittal approach led to improper use of the DTC by the patients. Therefore, the caregivers were looking for other approaches.

In the USA a new treatment method came up in the form of the Hierarchically Structured Drug-free Therapeutic Community (HSDTC). This form of treatment was based on the mutual contact between the addiction patients and self help. In 1972 the "Emiliehoeve" was founded in The Hague, it was the first HSDTC in the Netherlands. The treatment program at the Emiliehoeve consisted of therapy, sport, housecleaning, and other tasks. The residents had to work hard and were not allowed

to use any addictive substance which was tested by means of urine tests. After this initiative, a few other clinics were founded which applied the same treatment method. By the start of the eighties, a total of 120 treatment units (beds) were available in the HSDTCs in the Netherlands.

In the "Delta Psychiatric Hospital" (Delta Psychiatrisch Ziekenhuis) in Rotterdam an "eclectic" program was developed. It consisted of working hard and sporting, based on the idea that as long as someone is busy he has no time to think about drugs.

Next to this there were various Christian rehabilitation centers and residential communities for drug users. In these institutes daily life was filled with working hard and engagement with faith.

Unfortunately there was a group of extreme problematic drug users that were not reached by the existing care. Many of them were imprisoned on a regular base. Some prisons created special wards for this group, like "Demersluis" (1979) in Amsterdam, where caregivers from the Jellinek clinic assisted these detained patients.

As already mentioned above, the inpatient addiction care treated just a part of the drug users. The outpatient and outreaching care offered by a "Medical health center for alcohol and drugs" and a "Public Health Service (GGD)" reached more people. The Public Health Service (GGD) of the main cities played (and still plays) an important role in supporting the problematic drug users. The methadone distribution in Amsterdam and Rotterdam, for instance, was taken care of by the Public Health Service in cooperation with the addiction clinics.

Alternative treatment

Around 1980 a movement against the traditional addiction care came up. According to this movement the traditional treatment was humiliating, arrogant, and pedantic. Drug addicts should be helped to build up a human life. The basic idea now was that if the addicts can obtain drugs from their general practitioner, and if they have their own house, they can live an independent life. In 1980 the first "Junky Union" (Junkiebond) was set up in Rotterdam and many followed. A vicar became familiar with the drug scene and he opened his church the "Pauluskerk" for the drug users and accepted that they were using drugs. According to the vicar, "Society has to face reality, there are people who need drugs and they buy and sell it".

The discussion now started about heroin on prescription. A small experiment in Amsterdam started with morphine provision, and later an experiment was conducted with methadone that could be injected. These experiments were not successful yet, partly because the drug addicts were not interested.

In the beginning of the eighties, the Dutch government started to change its drug policy. The former treatment goal of "abstinence" was now partly replaced by a plea for easily accessible methadone. Acceptance of drug use and harm reduction now became the leading principles.

Measures against nuisance

Notwithstanding the attention that was given to drug users, the public nuisance caused by hard drug users remained. Therefore, in 1993, the government issued the "Policy Document Nuisance" (Nota Overlast). A total of 212 million Dutch guilders (96.2 million Euros) were reserved for care innovations to attack public nuisance. As a result, the "Inpatient Motivation Centers (IMCs)" were set up. The IMCs targeted criminal hard drug users, and put them under judicial constraint to motivate them for treatment. Moreover, the treatment options during imprisonment were extended. The drug users were not forced into treatment, but they were stimulated by rewards and sanctions to make a choice for treatment.

In 1997, there started an experiment with a new stringent measure, the "Judicial Placement of Addicts" (Strafrechtelijke Opvang Verslaafden). This measure was meant for addicted prolific offenders. They had to undergo a long-term forced placement (1.5 – 2 years). The program focused on five areas: work/education, relationships, meaningful leisure activities, housing, and debt settlement. They could still choose to be treated or not. In case they refused treatment, it would lead to imprisonment for two years without privileges.

Collaboration with mental health care

In the nineties, the collaboration between the addiction care and the mental health care improved. More attention was now paid to patients having dual diagnoses (DD). In 1995 the first outpatient projects started, and later on the first clinics were established. An inventory from 2006 shows that there were at least 20 DD clinics and 19 outpatient treatment programs. These programs were meanly running in the mental health care clinics. The addiction care delivered a third of the total treatment services.[180]

These developments can be traced back to another paradigm shift. Addiction was no longer seen as a superficial behavioral characteristic, but was now seen as a result of abnormal brain processes. For a long time addiction was perceived as an isolated disease which was treated outside the mental health care. In the nineties this view started to change. Addiction care clinics now frequently merged with institutions for mental health care. Nonetheless, the addiction care is still hosted in special wards, circuits, and care programs (Van der Stel, 2010).

11.1.2 Strategy and policy frameworks for residential treatment

Agreement among stakeholders

On the 18th of June 2012, the Minister of Health, Welfare, and Sport (VWS) and the different stakeholders signed a broad agreement for the future of mental health care. The Minister and representatives of caregivers, professional associations, health insurers, and patient- and family organisations agreed about different shifts in the mental health care. Agreement was found about shifting from inpatient to outpatient care, from secondary to primary care, from primary care to the general practitioner (GP), and from the GP to self management. As a result of the agreement, the health insurers and care providers have planned to reduce the number of inpatient beds with a third compared to the capacity of 2008. The parties approved to strongly stimulate prevention, self management, and the recovery-oriented care. The secondary care will now be financed by "performance funding" instead of "budget financing" (Government Information Service, RVD, 2012-06-18*).* Although the incentive of the reduction of inpatient beds has a financial origin, all parties agree that it will be an advantage for patients to stay in their own social environment to be treated there.

This agreement pursues the reduction of beds which already started some years ago. In 2007 the mental health care in Belgium and The Netherlands proportionally had the largest inpatient capacity in Europe (Van Hoof et al. 2010). Knowing this, the health insurers issued that therewith a reduction in inpatient beds had become necessary. Since then this has become an issue in the policy of the insurers when contracting mental health care. Since January 2012, the health insurers have significantly decreased the available funding for the inpatient treatment and have increased the funding for outpatient treatment.

Historically, the addiction care has focused more on outpatient treatment facilities. Nevertheless, the addiction care also has its inpatient clinics, and many addiction care clinics have now planned to reduce their beds. The institute for addiction care Iriszorg, for instance, has planned to terminate 40 clinical beds before July 2012. The resulting supernumerary staff has been offered an appointment in a new intensive outpatient team aimed at preventing and reducing clinical admissions.

Own contribution

Another major change in the mental health care and the addiction care is the own contribution which the patients have to pay since the beginning of 2012. Patients who are treated ambulatory have to pay 100 euro a year, and patients who receive a clinical treatment have to pay 145 euro a month. There are a few exceptions. The own contribution is not charged for patients who are 17 years or younger, patients who are placed compulsory, patients on a crisis admission (maximum 28 days), patients who receive interferential care, and patients with a judicial status.

The own contribution has had implications. Since the beginning of 2012, many patients decided not to be treated or to finish their treatment because of the own contribution. In March 2012,

[180] http://www.ledd.nl/index.php?option=com_content&view=article&id=7&Itemid=8.

the National Branch Organisation for Mental Health Care and Addiction Services (GGZ Nederland) conducted a quick scan among its 96 member institutes by sending them a questionnaire. A total of 54 member institutes participated in the quick scan, 24 integrated hospitals and 7 clinics for addiction care. Almost 60 percent of the respondents indicated that there were patients who had finished their treatment or had received less treatment, all because of the own contribution.

At the insistence of its "Board of clients" (Cliëntenraad), the institute for addiction care Bouman GGZ decided that in 2012 the institute itself would pay their patients "own contribution". A condition was that the patients should complete their treatment. Reimbursing the patients' own contribution, according to Bouman GGZ, prevents major health damage and social damage among its (potential) patients. It also prevents a long-term increase in the healthcare costs.

During the first months of 2012, the institute for addiction care in Amsterdam, the Jellinek, had 25 percent less new admissions. This was one of the reasons that the town council of Amsterdam decided to pay the own contribution for the mental health care patients having a minimum income. The council expected that public unrest would occur when patients with mental problems and addiction problems would remain untreated. Some officials from justice and the police predicted the same, and many of these stakeholders expressed their concerns through the nationwide media.

Amsterdam is not the only municipality that has decided to pay the patients' own contribution. In June 2012, the municipality of Langerdijk made the same decision. This municipality also reimburses the own contribution for people with a low income. More clinics and municipalities took similar measures.

By the end of October 2012, a new government agreement was reached. As part of the agreement it was decided to skip the controversial own contribution. Until now it is not clear yet what will happen to the contributions which were already paid in 2012.

Funding of the addiction care

In the Netherlands, the care sector is funded under three laws:

1. The Community Support Act (Wet Maatschappelijke Ondersteuning, WMO);
2. The Health Insurance Act (Zorgverzekeringswet, Zvw);
3. The Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten, AWBZ).

Ad 1: The Community Support Act

Since 1994, giving shelter to the homeless and setting up programs for social reintegration have become a responsibility of the municipality. In 2007, the Community Support Act became effective, and since then the responsibilities of the municipalities have increased. It is probable that in 2013 the *support function* will also have to be funded by the municipality and this will also include the facilities for supported living for patients with chronic addiction problems.

The municipality has the task to fund outpatient care which targets addiction problems and the prevention of addiction problems. Another task of the municipality is to target the nuisance caused by addiction.

The facilities on a local level are funded by the government by means of 43 centre municipalities (centrumgemeenten). These centre municipalities are usually the largest municipality in a region. They make arrangements for the care provision in each community. The care provision on that level is given by the *public health service* (GGD). A public health service is funded at the municipal level, and at the moment there are 28 such public health services, each located in a GGD region. The municipality decides which tasks a public health service will have to execute.

Ad 2: The Health Insurance Act

The health insurance companies finance that part of the addiction care that targets the curing of the addiction. The inpatient treatment in the addiction care facilities is financed under the Health Insurance Act as long as the treatment duration is less than a year. In the Netherlands everyone is compulsorily insured.

Ad 3: The Exceptional Medical Expenses Act

Addiction care with a duration of one year or longer is funded under the Exceptional Medical Expenses Act (AWBZ). This form of addiction care includes residence in an inpatient clinical setting as well as supported living in a shelter or a hostel. Almost everyone who lives or works in the Netherlands is automatically AWBZ insured and pays a AWBZ-contribution.

The Ministry of Security and Justice (VenJ) is responsible for specific parts of the addiction care. Especially the forensic addiction care and the probation care for addicts are a responsibility of this Ministry.

On the 29th of October 2012, far-reaching measures were announced in the new Government Agreement. It was announced that the health care insurers will become financially responsible for the total mental health care, which will probably include the addiction care. The major change will be that the long-term mental health care and addiction care will be transferred to the Health Insurance Act (Zvw). The plan is that the current inpatient care will be transferred from the Exceptional Medical Expenses Act (AWBZ) to the Health Insurance Act (Zvw) by 2015. A decision still has to be taken whether the facilities for social support will be "hosted" at the municipalities or at the health insurers. For the period from 2015 up to including 2017, an outline agreement will be settled with the insurers and the care providers. As a part of the plan, the health insurance companies will have to be completely risk-bearing by 2017.

11.2 Availability and characteristics

This paragraph will give an overview of the existing treatment facilities in the Netherlands for problematic drug users. First, a description will be given of the addiction care facilities in general, and next three special facilities will be described: addiction care for the youth, the judicial addiction care facilities, and the special care provision.

11.2.1 National (overall) availability and accessibility

It has already been mentioned above (see § 8.3) that, in the Netherlands, all care institutions are legally obliged to prepare a "social report" (maatschappelijk jaarverslag) each year. Among other topics, these social reports give some information about the inpatient capacity of the addiction clinics. This information is reviewed in table 11.2.1. In the former years, many clinics for addiction care merged with clinics for mental health care. These integrated clinics reported the accumulated figures in their social report, including the capacity for addiction care as well as mental health care. Therefore, the figures for only the addiction care facilities were obtained from additional sources (see the footnotes to table 11.2.1).

Currently, there are thirteen established addiction care facilities in the Netherlands which offer a clinical stay (see table 11.2.1). In addition to these established facilities, there are more acknowledged addiction care clinics, but these are not taken into account in this paragraph. The care which these (private) clinics offer, is not accessible for everybody, especially because of a larger own contribution one has to pay. In paragraph 1.4 above, some information was given about private clinics like Castle Craig, CrisCare, RoderSana, SolutionS Center, and U-center. The majority of the established addiction care facilities have now become a department of a larger integrated hospital for mental health care. Here, "integrated" includes different forms of care that can be outreaching care, outpatient care, or inpatient care. From the thirteen established clinics, only five are now left that only offer addiction care.

Table 11.2.1 shows that, in 2011, there were 2,101 beds for inpatient addiction care on the treatment wards. In addition to these beds, there were 862 "other" beds including, for instance, sheltered living facilities. The number of "treatment" beds in an established institute ranged from 16 to 306, sometimes including the beds for detoxification. In total there were 80 clinical units, ranging from

2 to 12 units per institute. There were differences between the units due to different treatment methods and different target groups. The units included, for instance, youth clinics, specialized facilities like therapeutic communities, and units applying self-help like Jellinek Minnesota or the Tactus 12-Step treatment program.

Accessibility
In different cities or regions in the Netherlands the addiction care is organized in a different way. The specific way of cooperation between an addiction care clinic, a public health service, or a medical health center for alcohol and drugs (in some regions) differs per region. The regional cooperation depends on many factors like the policymaking process on the local level and the presence of certain addiction care facilities in the region. Above, it was already mentioned that in the Netherlands the care sector is funded under three laws. This makes the situation even more complicated. Roughly speaking, it has resulted in the following triple situation:

1. The social support facilities that are organized at the municipal level are covered by the Community Support Act (WMO). For the clients, there is a WMO-counter which organizes the individual access to municipal facilities. However, the funding of the addiction care is based on agreements at a higher level between a municipality and an institute for addiction care, for instance an agreement about the funding of outreaching care.
2. Outpatient addiction care with a duration of less than a year is covered by the Health Insurance Act (Zvw). The general practitioner (GP) is the gatekeeper for the Zvw. A prospective addiction client needs a referral by the GP for being admitted to the addiction care.
3. The inpatient addiction care with a duration of less than a year is also covered by the Health Insurance Act (Zvw), but the care with a duration of a year or longer is covered by the Exceptional Medical Expenses Act (AWBZ). An AWBZ indication for an addiction care clinic is performed by a "Care Indication Centre" (Centrum indicatiestelling zorg, CIZ) or a Bureau for Youth Care (Bureau jeugdzorg). Many integrated clinics now have a central admittance facility, but the addiction care in general has also remained accessible through an own ‘entrance’.

able 11.2.1: Capacity of beds and number of clinical units at the inpatient addiction care facilities in the 13 established institutes in 2011

Institute, Place of business	Domain of care	Capacity of beds addiction care 'treatment'	Capacity of beds addiction care 'other'	Clinical units[181]
1. Stichting Arkin, incl. Jellinek, Amsterdam	Addiction & mental health	134 (incl. 10 DD*-beds)[182]		5
2. Lievegoed zorggroep Arta verslavingszorg, Bilthoven	Addiction, mental retardation & mental health	59	38 SL*	4
3. Stichting Bouman GGZ, Rotterdam[183]	Addiction* & mental health	287	184 SSH*	6
4. Parnassia Bavo Groep B.V., incl. Brijder Verslavingszorg B.V., The Hague	Addiction & mental health	281	60 SSH*	12
5. Stichting Centrum Maliebaan, Utrecht	Addiction	152		5
6. Stichting Verslavingszorg Noord Nederland, Groningen	Addiction	214	48 SL*	9
7. Stichting Tactus Verslavingszorg, Deventer	Addiction	201 (incl. 48 FC* and 24 DD*-beds)	134 SSH*	8
8. Stichting IrisZorg, Arnhem	Addiction & social relief	201 (incl. 24 DD* and 34 FC*)	66 SL* 332 HWT*	5
9. Stichting Emergis Centrum voor GGZ, Goes	Addiction & mental health	16[184]		2
10. Stichting De Hoop, Dordrecht	Addiction & mental health	110		7
11. Stichting Novadic-Kentron, Vught	Addiction	306		12
12. Vincent van Gogh voor GGZ, Venray	Addiction & mental health	44		2
13.Stichting Mondriaan, Heerlen	Addiction & mental health	96 (incl. 28 DD)[185]		3
Total		**2,101**	**862**	**80**

*DD = dual-diagnosis bed, FC = forensic care, SL = sheltered living, SSH = small-scale living, HWT = housing without treatment. "Units" include youth facilities, judicial addiction care, long-stay facilities, and DD-clinics.

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[181] Based on information from the websites of the care providers.
[182] According to Care Institutions Accreditation Act (WTZi), acceptance of Arkin July 2011, https://zoek.officielebekendmakingen.nl/stcrt-2010-11519.html.
[183] Since 01-07-2012 Bouman GGZ merged with Delta GGZ: new name Antes.
[184] Merging research report Emergis, http://www.centraleclientenraademergis.com/uploads/5/9/2/7/5927248/onderzoeksrapportage_fusie__boer_en_croon.pdf.
[185] According to Corporate Social Responsibility Report 2010 Mondriaan, http://www.mondriaanzorggroep.nl/upload/1/300/305/MJD%202010%20ZH%20definitief.pdf.

Therapeutic communities
It has already been mentioned above that, in different units of the inpatient addiction care, different treatment methods are applied. As an example of an important treatment method this paragraph focuses on the *therapeutic community.* Table 11.2.2 gives an overview of the therapeutic communities in the Netherlands, their capacity, and the average stay in these communities.

Table 11.2.2: Capacity and average stay for the therapeutic communities in the Netherlands

Therapeutic community (umbrella institute)	Capacity in beds	Average / Maximum stay
De Witte Hull (Lievegoed zorggroep)	20	Average 10 months
Aanzet (Lievegoed zorggroep)	12	Average 8 months
Emiliehoeve (Brijder verslavingszorg)	32	Maximum 1 year
Horeb (Stichting De Hoop)	70	Average 1 – 1.5 year
Total	**134**	

In the eighties the therapeutic community was a common treatment method. Currently, there are only four therapeutic communities in the Netherlands operated by three institutes for addiction care. The *Emiliehoeve* was the first therapeutic community in the Netherlands, and is still in operation. The other therapeutic communities are part of an anthroposophicly inspired institute (Lievegoed zorggroep) or an evangelically inspired institute (Stichting De Hoop).

The total capacity of all four therapeutic communities in the Netherlands comes down to 134 beds. On average, the clients stay in a therapeutic community for a period between 8 months and 1.5 years. This is a longer stay than the average stay of a regular clinical admission. The target group of a therapeutic community consists of patients with addiction problems who need more structure than outpatient treatment can offer. A therapeutic community focuses on abstinence and is directed towards psychological recovery, behavioral change, learning to take responsibility, social rehabilitation, and social reintegration. It is also directed towards improving the relationship of the patient with his or her environment and towards changing the lifestyle of the patient.

Data from the National Alcohol and Drugs Information System (LADIS)
For the Netherlands, the data for the Treatment Demand Indicator (TDI) are delivered from the National Alcohol and Drugs Information System, the LADIS (see Chapter 5 above). Apart from delivering the data for the TDI, the LADIS also contains a separate database about the inpatient episodes related to the admissions for an addiction problem. During 2011, the LADIS registered a total of 38,275 inpatient episodes that had resulted from 11,675 admissions (IVZ, personal communication 30-05-2012). After correcting for double counting, it turned out that behind these 11,675 admissions there were 11,413 unique persons.

To distinguish true residential treatment from merely inpatient detoxification, it was decided to leave out the addiction patients not having had a continued inpatient episode of at least three weeks during 2011. It was assumed that a detoxification would not last longer than three weeks. It was found that from the 11,413 unique addiction clients a total of 5,351 clients had indeed been residentially treated for at least three weeks. From these 5,351 clients, 2,583 clients had been admitted for a primary problem with alcohol, 865 clients for cocaine, 779 clients for opiates, 649 clients for cannabis, 183 clients for amphetamines or ecstasy, 119 clients for GHB, 71 clients for medicines, and 102 clients for other addictions. All in all, during 2011, a total of 2,666 clients had received residential treatment for a primary problem with a drug (including medicines). Table 11.2.3 shows the proportion of the drug clients having received residential treatment.

Table 11.2.3: Number of primary drug clients and number and proportion having received residential treatment during 2011

Primary drug	Total number of outpatient and residential clients	Number of clients in residential treatment	Proportion of residential treatment
Cocaine	7,517	865	11.5%
Opiates	11,315	779	6.9%
Cannabis	10,632	649	6.1%
Amphetamines/ecstasy	1,645	183	11.1%
GHB	659	119	18.1%
Medicines	810	71	8.8%
Total	**32,578**	**2,666**	**8.2%**

Source: LADIS, IVZ (Wisselink et al. 2012).

Table 11.2.3 shows that the group of cocaine clients was the largest group in the residential addiction care, followed by the clients for opiates and cannabis. This order of ranking differed from the total population of the addiction care. In 2011 the largest group in the total population was given by the opiates clients (11,315 persons), followed by the cannabis clients (10,632 persons), and the cocaine clients (7,517 persons). Opiates, cannabis, and cocaine were the three leading substances in residential treatment as well as in the total treatment group, but the order of ranking differed.

For the different drugs, table 11.2.4 shows the distribution of the residential clients over the age categories and gives the percentage of male clients.

Table 11.2.4: Distribution of residential clients over age categories and percentage male in 2011

Primary drug	Number of residential clients	10 -20 years	20 -30 years	30 -40 years	40 -50 years	50 -60 years	60 -70 years	% male
Cocaine	865	1.0%	23.8%	36.1%	29.5%	9.1%	0.5%	78.3%
Opiates	779	0.1%	6.3%	24.9%	46.0%	20.9%	1.8%	80.2%
Cannabis	649	16.0%	44.8%	26.2%	10.0%	2.9%		81.7%
Amphetamines /ecstasy	183	8.2%	54.1%	27.9%	6.0%	3.8%		77.1%
GHB	119	2.5%	66.4%	26.9%	4.2%			70.6%
Medicines	71		11.3%	25.4%	33.8%	22.5%	7.0%	53.5%

Source: LADIS, IVZ (Wisselink et al. 2012).

Clients who primarily demanded treatment for opiates use, most often belonged to the older age categories. Clients who had a primary problem with Cannabis, Amphetamines/ecstasy, and GHB on the contrary belonged to the younger age groups.

A majority of the residential addiction clients was male. Roughly speaking, about 80 percent of the primary residential drug clients were male. An exception is given by the groups of GHB clients and medicines clients. In these groups, the percentage of male clients was lower.

Youth addiction clinics

Before 2005, there were only three specialized youth addiction clinics in the Netherlands, namely the *Mistral* (part of Brijder), and the *Bauhuus* and the *Breegweestee* (part of Verslavingszorg Noord Nederland). In 2006, the Minister of Health, Welfare, and Sport (VWS) designated special funding to

tackle the lack of sufficient clinical treatment places in the youth addiction care. Since then, nine extra youth clinics have been founded. The Minister targeted at 300 places. Currently, about 180 extra places have been realized in addition to the places already existing before 2005. Two clinics have planned to realize eight and ten beds extra, but one clinic expects a reduction of three beds before the end of 2012. By then, two third of the targeted places will have been realized.

For the different youth addiction clinics, table 11.2.5 gives their starting year, the number of beds for detoxification and treatment, and the duration of detoxification and treatment. The information in this table has been obtained by personal communication (e-mail and telephone) with professionals from the youth clinics.

Table 11.2.5: Starting year, number of beds for detox and treatment, and duration of detox and treatment for the youth addiction clinics in the Netherlands in 2011

Youth clinic (Umbrella institute)	Starting year	Beds detox (& diagnosis)	Beds treatment	Detox duration (weeks)	Treatment duration (months)
Youz (Bouman GGZ)	2011		28	max. 3	3 – 4
Mistral/ Mistral Detox (Brijder/Parnassia)	2000/ 2007	16 + 1 crisisbed	17	24 hrs to 8	4
DD jeugd kliniek (Dimence)	2009	8 detox	8	4 - 5	4 -6
Jeugdkliniek Paschalis (GGZNML)	2008	16	10**	1 - 4	3 – 4
De Kajuit (De Hoop)	2009		16		4,5*
Jeugdkliniek (IrisZorg)	2010	9	27	1 - 2	0,5 - 3,5
Herten (Mondriaan)	2010		15*	4 - 6	3 – 6 *
Kentra24 (Novadic-Kentron)	2011	Some	22***	2	3
Jeugdkliniek (Tactus)	2010	No detox	16****	No detox	3 - 4
Bauhuus (VNN)	2004	9 (flexible)	7 (max. 8)	4	6
Breegweestee (VNN)	1979	No detox[186]	25	No detox	5-7
Total		**About 68**	**About 192**		

Source: personal communication with professionals from the youth addiction clinics. *including detox, **end 2012 – 3 beds, ***end 2012 + 10 beds, ****end 2012 + 8 beds.

From the eleven youth addiction clinics, only one clinic has no youth detoxification facility. The duration of the detoxification ranges from 24 hours to 8 weeks. Often during the phase of detoxification the diagnosis takes place as well, which probably explains the differences in the duration of the detoxification. The treatment duration ranges from 2 weeks to 7 months. In two clinics this duration includes the detox phase.

[186] < 23 years: Bauhuus, > 23 years: adult care.

Judicial Facilities

In the Netherlands there are a few forensic addiction clinics (FACs). Especially in 2012, some of these clinics were founded (see table 11.2.6). One of the reasons for founding FACS was the declining number of patients disposed to be involuntarily admitted to a forensic psychiatric hospital on behalf of the state (TBS-measure). In 2006, the number of 'new' TBS-patients was still 188, which decreased to only 94 'new' TBS-patients in 2010 (DJI 2011).

The decline in the number of these TBS-patients was mainly due to an increase in the number of suspects refusing a forensic psychiatric examination, prior to the judicial process. Without such a psychiatric examination, the TBS-measure cannot be taken. The duration of the TBS-measure is on the rise and now accounts for almost ten years. The duration of the TBS-measure seems to have reached a tipping point. Individuals who have committed offenses worthy TBS, would be more quickly released again after a custodial sentence than after a forensic treatment. Therefore, lawyers advise their clients not to cooperate, also because the duration of a hospital treatment is not always proportional to the original offense. When having only a prison sentence and not the TBS-measure, a convict will be set free sooner, but without having received treatment.

Given the decline in TBS-patients, the TBS-clinics are now looking for alternative care provisions to utilize their capacity and therewith to maintain their capacity. In two cases, the new forensic addiction clinics (FACs) were developed in cooperation between an addiction care clinic and a forensic clinic. In the FACs there was a total of 178 beds.

Table 11.2.6: Forensic addiction clinics(FACs), participating institutes, founding year, and capacity in beds

FAC	**Participating institutes**	**Founding year**	**Capacity (beds)**
Basalt	Centrum Maliebaan and Oostvaarders-kliniek	April 2012	24
Piet Roordakliniek	Tactus	Before 2005	60[187]
FVK De Smaragd	De Kijvelanden and Bouman GGZ	February 2012	24
Triple-X	Palier (Centre for forensic and intensive care)	Before 2007	50[188]
FPA Roosenburg	Altrecht	± 1990	20
Total			178

11.2.2. Types and characteristics of residential treatment units

The clinical addiction care offers a wide variety of treatment methods. Especially in the large institutes many programs are available for different target groups. All the institutes mentioned in table 11.2.7 offer treatment and support to addiction clients in general. Some of these institutes also offer treatment and support to special groups of clients. Examples of such special groups are young people, patients who prefer a maximum of privacy, and patients who can afford a treatment in a private facility.

[187] Closed setting and open social-reintegration setting.
[188] In the program (clinic and rehabilitation facilities).

In this paragraph, the common treatment methods are reviewed first, and next more detailed information will be given about the treatment methods for specific target groups like young people and clients undergoing judicial measures. The information has been mainly gathered on the websites of the institutes, but some of the websites are not that clear about the treatment that is offered. Therefore, the information reviewed below is not expected to be complete. No attention will be paid to the clinical detoxification facilities and the treatment methods applied for detoxification are assumed to be known.

In the Netherlands, a majority of the institutes for addiction care offers the common evidence-based psychosocial treatments, like cognitive behavioral therapy, community reinforcement approach, motivational interview techniques, 12-Step approach, and partner and family therapy. In table 11.2.7 the treatments offered by the addiction clinics are listed in alphabetic order. It is remarkable that the established institutes more and more offer the 12-Step approach (Minnesota Model) which has originated in self-help groups like Alcoholics Anonymous.

Table 11.2.7: Treatment methods offered in the addiction clinics of the institutes for addiction care

Institute for addiction care, Place of business	Treatment method offered in the addiction clinic of the institute for addiction care
Stichting Arkin, incl. Jellinek, Amsterdam	ART, CBT, CRAFT, LST, MIT, MM, PE, SST
Lievegoed zorggroep Arta verslavingszorg, Bilthoven	MT , RT, TC
Stichting Bouman GGZ, Rotterdam[189]	CRA, PE, RM, SST
Parnassia Bavo Groep B.V., incl. Brijder Verslavingszorg B.V., The Hague	CBT, CRA, LST, MM, TC, MDFT, MIT, RM, RT
Stichting Centrum Maliebaan, Utrecht	FT, CBT, LST, PT
Stichting Verslavingszorg Noord Nederland, Groningen	MDFT
Stichting Tactus Verslavingszorg, Deventer	CT, LST, MDFT, PRT, PT, RM, SST
Stichting IrisZorg, Arnhem	CRA, CT, DT, SST
Stichting Emergis Centrum voor GGZ, Goes	LST
Stichting De Hoop, Dordrecht	MM
Stichting Novadic-Kentron, Vught	CRA, DT, FT, LST, MT, PT, RM, SST, ST,
Vincent van Gogh voor GGZ, Venray	FT
Stichting Mondriaan, Heerlen	CT, LST, PT, RM, RT, SST

See Box 1 for an explanation of the abbreviations.

[189]Since 01-07-2012 Bouman GGZ merged with Delta GGZ: new name Antes.

Box1: Treatment Methods (abbreviations)

(A)CRA: (Adolescent) Community Reinforcement Approach ART: Aggression regulation training AT: Assertiveness training BG: Budget group CBT: Cognitive behavioral therapy CRAFT: Community Reinforcement Approach and Family Training CT: Creative therapy DT: Drama therapy EBPC: Experiential body-centered psychotherapy (Pessotherapy) EMDR: Eye Movement Desensitization and Reprocessing ERT: Emotion regulation training ET: Expressive therapy IDDT: Integrated Dual Disorder Treatment LST: Life-style training LM: Liberman modules (MD)FT: (Multidimensional) family therapy MIT: Motivational interview techniques/therapy	MM: Minnesota model (12-Step) MT: Musical therapy MP: Medical psychiatric therapy OC: Orthopedagogic components PE: Psycho education PG: Parental guidance PM: Psychomotorial therapy PRT: Partner relation therapy PT: Pharmacotherapy RM: Relapse management RT: Running Therapy SCM: Social competence model SDM: Shared decision making SH: Self Help SocT: Socio therapy SOT: Solution oriented treatment SSI: Supporting and structuring interview SST: Social skills training ST: Systemic therapy TASU: Training aggression and substance use TC: Therapeutic Community

Many clinics do not specifically mention creative therapy or physically oriented therapies like psychomotorial therapy, although such therapies are usually part of the regular treatment provision. Therefore, it may be assumed that these kinds of therapies will be available in most of the clinics.

Youth addiction clinics

Paragraph 11.2.1 above already reviewed the youth addiction clinics in the Netherlands. In this paragraph more specific information will be given about these youth clinics. Table 11.2.8 reviews the respective age groups, the target groups, and the treatment methods. The information in this table has been obtained from personal communication (by e-mail and telephone) with professionals from the clinics.

When excluding the addiction clinic for young adults (Breegweestee from VNN), there are ten youth addiction clinics. In eight of these ten clinics, children from the age of twelve to thirteen years who have an addiction problem are already welcome. In two clinics, sixteen years is the threshold for being admitted. In seven clinics, the maximum age is 23 to 24 years. Two clinics apply 20 to 21 years as the maximum age. In one clinic (Bauhuus from VNN) the maximum age is eighteen years, but young adults from 18 to 30 years are welcome in another clinic at the same institute (Breegweestee from VNN).

Only three clinics present themselves explicitly as a dual-diagnosis clinic (DD-clinic). Nonetheless, almost all clinics indicate that many of their clients suffer from (underlying) comorbid disorders (see table 11.2.8). These clinics usually diagnose the comorbid disorders as AD(H)D and ASD. In addition, depression, anxiety, and ODD are mentioned a few times.

The youth clinics offer a wide variety of treatment methods. In general, a clinic does not favour a specific treatment method, but at one clinic (Kajuit from De Hoop) the 12-Step program counts as the leading treatment method. However, within the approach of this clinic other treatment methods are offered as well.

In general, there are three leading therapeutic methods given by client-centered psychotherapy (e.g. MIT), system therapy (e.g. (MD)FT, ST), and behavioral therapy (e.g. SCM, (A)CRA and CBT). In addition to these leading therapies there are some alternative therapies, but these are hard to categorize. Alternative therapies are, for example, EMDR, IDDT, LST, and SOT. Another leading method, psychodynamic therapy (psycho analysis), is not applied in the (youth) addiction care.

Table 11.2.8 further shows that, by means of different therapies (ST, (MD)FT), a majority of the youth addiction clinics explicitly involves into treatment the system around the young client. The system around the client is given by the family and the parents. The involvement of the young client's system is not surprising. The clients are young people who still need (some) parental guidance. One clinic emphasizes that no clinical treatment is offered at all without the cooperation of the system, that is the parents. Almost all clinics offer some form of behavioral therapy (CBT, (A)CRA). About a third of the clinics offer elements from the client-centered approach in the form of Motivational therapy. It is remarkable that there is only one youth clinic (Kajuit from De Hoop) that offers the 12-Step treatment. De Hoop's 12-Step program is based on its Christian identity. Contrary to the youth addiction care, the established addiction care for adults has now adopted the 12-Step program as a regular treatment method.

Table 11.2.8: Youth addiction clinics, age groups, target groups, and treatment methods **Youth addiction clinic (Umbrella institute)**	**Age in years**	**Target group: addiction and other disorders**	**Treatment method**
Youz (Bouman GGZ)	16 - 24	DD & TC[190], Contra indication low IQ	CRA, MIT and SOT. Group- and individual oriented, aimed at various areas of life (incl. LST), addiction- and CMD - oriented: FT/ST, MIT, CBT, RM, EMDR, PT
Mistral/ Mistral Detox (Brijder/Parnassia)	12 - 20	DD	SCM, ST and basic attitude of MIT
DD jeugd kliniek (Dimence)	12 - 23	DD, CMD[191] (AD(H)D[192], ASS[193], ODD[194], CD[195], depression, anxiety, bipolar disorder, bonding problems, threatened personality development, traumatization, and disturbed mourning process)	ST, IDDT, MIT, CBT, PE, PG, MDFT, PM, CT, MT, ET, SST, ART, ERT, AT. Group- and individual oriented
Jeugdkliniek Paschalis (GGZNML)	16 - 24	CD (ADHD, ASD, affective disorders) as long as someone can function in the group	RM, MIT, CBT, SDM, SR, CT, PMT, EMDR, CRA, PT, MDFT, SocT, OC
De Kajuit (De Hoop)	12 - 23	CMD secondary to the addiction problem and treatable in group (ADHD, minor ASD & ODD)	12-Step treatment, within this program SST, CBT
Jeugdkliniek (IrisZorg)	12 - 23	CMD (depression, anxiety, ADHD and ASD). Some come with a judicial status	A-CRA, ST
Herten (Mondriaan)	12 - 21	CD (ADHD and ASD), some come with a judicial status, parent-child problems	SOT, CGT, ST/PG, LST, DT, MT en PM, RT, SST. Group oriented, on indication individual (e.g. CBT)
Kentra24 (Novadic-Kentron)	12 - 23	Attention is paid tot underlying problems. Severe psychiatric problems in cooperation with care circuit.	A-CRA, SCM & ST
Jeugdkliniek (Tactus)	13 - 23	Mild CMD (AD(H)D and ASD)	SOT and structuring and encouraging to go to school and prepare for work
Bauhuus (1) Breegweestee (2) (VNN)	12 – 18 18 – 30	(1) CD (PDD NOS (ASS), ADHD, borderline and other) (2) Young adults, less CD possible because one works according to principles of SH and TC	(1) 3 approaches: ST, SOT, CBT, next to this SST, LB, CT, (2) Principles of TC/SH, next to this, SOT, scheme therapy, group oriented, no 'leading school', RM

[190]DD: Dual diagnosis (mental problems), TC: Triple cripple (mild mental retardation).
[191]CMD: Comorbid disorders.
[192]AD(H)D: Attention Deficit (Hyperactivity) Disorder.
[193]ASD: Autism spectrum disorders.
[194]ODD: Oppositional Defiant Disorder.
[195]CD: Conduct Disorders.

Judicial Facilities
In paragraph 11.2.1 above, it was already reviewed that, in the Netherlands, there are a five forensic addiction clinics (FACs). Table 11.2.9 gives some more information about the target groups of these FACs and the treatment methods which they offer.

Table 11.2.9: Forensic addiction clinics (FACs), target groups, and treatment methods

FAC	Target group	Treatment method
Basalt	(Young) adults with psychiatric problems and criminal behavior	CBT, LST, MIT, PRT, SSI, TASU, ST, ADHD coaching/treatment, scheme therapy
Piet Roordakliniek	Males with psychiatric problems and (frequent) criminal behavior	RM, integrated treatment, emphasis on early detection of signals
FVK De Smaragd	Males (>18 years) with (frequent) criminal behavior	CBT, SocT, DT, CT, MT
Triple-X	Adults (>18 yrs) with (frequent) criminal behavior and long-term problems on various life areas	Group therapy, BG, ST, SST, ART, LST, EBCP
FPA Roosenburg	Adults (>18 yrs) with criminal behavior and DD-problems. Mainly psychotic disorders, behavioural problems and severe social problems	CBT, MP and ST, RM, RP, ST, PT, ART, PE, SST, LM, MT, PM

All five forensic addiction clinics (FACs) explicitly offer care to patients who suffer from addiction problems and have shown criminal behavior. In two of the five clinics, only males are admitted. All five clinics treat multi-problem patients. In addition to having shown criminal behavior and suffering from addiction problems, the majority of the FAC-patients also has psychiatric and social problems.

The forensic clinics offer a wide variety of treatment methods. All clinics offer a combination of therapies and in none of them one specific treatment method counts as a leading approach. In all clinics group sessions are part of the program. A majority of the clinics offers cognitive behavioural therapy and system therapy. All clinics try to improve the social situation of their patients. Triple Ex explicitly tries to involve patients in a work program, whereas in some other clinics "doing work" is a regular component of the week program.

Special care provision
This paragraph will present some examples of special care provisions for target groups like the elderly, addicted parents, clients with a mild mental retardation, highly vulnerable clients, employed clients, female clients, and young clients (in a private setting).

Elderly
Each year, the Foundation for the Provision of Care Information (IVZ) reports figures from the National Alcohol and Drugs Information System (LADIS, see also chapter 5). In 2011, 16% of the 69,312 general addiction clients aged 55 years or above (about 11,100 clients), and from the additional 17,453 addiction clients in the probation care 5% aged 55 years or above (about 900 clients). Among these older clients in the general addiction care, aging 55 years or above, 74% were primarily addicted to alcohol and 15% were primarily addicted to opiates. Therewith the addiction care has invested substantially in the elderly with alcohol problems. Most of the treatment is given in the form of outpatient treatment.

During the beginning of the seventies, the use of opiates became epidemic in the Netherlands. Many of the opiates users lived a harsh life. Because of their unhealthy lifestyle, many of these chronic drug users have aged more rapidly. Since 2009, a special facility for this group of users has been established in the form of *Woodstock* located in The Hague and operated by the institute for addiction care Brijder, part of Parnassia. Woodstock can house 33 clients who are homeless; are 45 years or older; have psychiatric problems; are chronic addicts; suffer from an addiction which has been shown to be untreatable; have problems in various fields such as financial management, administration, contact with family, leisure, and (volunteer) work; and who are able to make agreements about their own behavior.

Woodstock assists its clients with managing their finances and administration, restoring the contact with their family, personal hygiene, cooking, and so forth. The residents are also assisted in finding a hobby and (volunteer) work. They are allowed to smoke, drink, and use drugs in their own room. Woodstock is explicitly meant for older chronic addicts. In the area of social services there are more facilities for elderly homeless, and the target groups partly overlap.

Addicted parents
The institute for addiction care Verslavingszorg Noord Nederland (VNN) maintains a special addiction care facility for addicted parents having children ageing 0 to 12 years. This special facility is called *De Lage Kamp.* This clinic has a capacity for twelve families. There are facilities for four pregnant women. The clinical treatment program takes about twelve months, and after the clinical admission the family can obtain an aftercare program. There are individual therapeutic sessions as well as group sessions. De Lage Kamp is accessible for families from all over the Netherlands.

Clients with a mild mental retardation
In 2009, the institute for addiction care Novadic-Kentron opened a special clinic targeting clients of 18 years and older who suffer from an addiction problem in combination with a mild mental retardation (MMR). Although the treatment in this special clinic mainly targets the individual client, therapies are offered in a group of six persons at maximum. The therapy is characterized by often repeating the information that is given to the client. It is a practical form of therapy and it applies a visual approach. The communication in this form of practical therapy is supported by cards with pictograms which help the clients to find words for emotions. Such a card is called a *Sociopicto*.

The aim of the treatment for addicts with a mild mental retardation (MMR) is total abstinence. The treatment therefore pays attention to relapse prevention, increasing the motivation for abstinence, and reducing substance use. Next to this the treatment focuses on increasing the self-reliance of the clients by means of practical support. Extra attention is given, for example, to housing skills and personal hygiene. The treatment program is further adapted to people with mild mental retardation (MMR) by offering only one intensive therapy component a day. The rest of the day is focused on activities and less on giving information.

Highly vulnerable clients
In 2009, in the town Veenhuizen in the north of the Netherlands, the institute for mental health care GGZ Drenthe opened a clinic called the *Beter leven kliniek* (Better life clinic). This clinic has a capacity for 30 clients, mainly young adults, having a mild mental retardation (MMR) in combination with psychiatric, social, emotional, behavioral, and addiction problems. In this clinic in the north of the country, those clients from the cities of Amsterdam and Rotterdam are admitted who were already treated in a variety of treatment settings, but without success.

At the *Beter leven kliniek* (Better life clinic) the patients are admitted on a judicial basis for two or three years. The clinic functions within a closed setting, and is built on the grounds of a former penitentiary. During their stay at the clinic the patients learn to socialize; to cope with their problems; to accept help and support; and they learn to live within a daily structure with work, activities, and relaxation. All in all, the treatment aims at learning to live in a sheltered community. During the stay in the clinic, the team of social workers around the patient assesses how much freedom a patient can already handle, conversely how much structure he or she still needs. During the first period of their treatment, the patients will have to stay in the clinic. During the second period, in a programmatic way, the patients are given more and more freedom outside the clinic.

Employed clients
At the end of 2011, the Jellinek clinic in the city of Amsterdam started a new treatment program targeting clients with medium or severe addiction problems who are employed during the day. This new treatment program is to be followed during the evening hours. This way, the employed clients do not have to interrupt their occupation and they can still profit from the daily structure it gives.

If necessary, the clients first receive a regular clinical detoxification of one week. After that they are admitted for six weeks to the evening program. In this period they also spend the night in the clinic. After working hours, the clients go to the clinic, have a meal in the group, and at seven o'clock PM the group sessions start. The treatment program applies diverse therapeutic methods and components, like cognitive behavioral therapy and relapse prevention. The clients increase their motivation to stop using the substance to which they are addicted and learn how to cope with risk situations.

Female clients
Some clinics offer a special program for female clients and other clinics have separate wards for male and female clients. As an example, the institute for addiction care De Hoop in September 2011 started the program *Challenge Vrouwen* (Challenge Women). This program starts with a clinical period that takes 20 weeks, followed by a part-time daycare period taking 12 weeks. There are facilities for mothers to stay in the clinic together with their children. The leading treatment method is the Minnesota model.

The Jellinek Minnesota also offers a special program for female clients. There is a capacity of twelve beds, and the female clients are admitted for eight weeks. After that period, those patients who have not yet found a suitable living environment, can be referred to the *Safehouse* where daycare is offered. Again, the Minnesota model counts as the leading treatment method, in the clinic as well as in the *Safehouse*.

Young clients
In the Netherlands, there a various private clinics. In 2010, the established institute for addiction care the Jellinek opened a new private clinic on Curaçao, one of the islands of the Netherlands Antilles. This new private clinic is called the *Jellinek Retreat*. Usually, clients aging between 30 and 50 years visited this clinic. However, in the summer of 2011, the clinic started a special program for young people aging between 16 and 23 years. The program is offered during the (school) summer holiday. It targets young people who excessively use party drugs, cannabis, or alcohol (binge drinking). It also targets young people

who excessively visit the internet, for example to play games. In addition, young adults are also welcome at the Jellinek Retreat if they have to cope with other problems like obesity, ADHD, depression, feeling sad, and apathy.

The leading treatment method at the Jellinek Retreat is given by cognitive behavioral therapy. There are individual as well as group sessions. Next to the therapeutic program the clients can participate in a lot of activities like sporting (boating, snorkeling, hiking, swimming, and mountain biking), sightseeing, and relaxation therapy. The treatment program takes four to six weeks, and the Jellinek institute on its home base in the Netherlands offers the aftercare.

11.3 Quality management

During the past years, the mental health care and the addiction care have given priority to being transparent and benchmarking the quality of their services. In recent years different instruments have been developed and implemented for quality measurement.

Consumer Quality Index

The *Consumer Quality Index (CQ-I)* is a standardized instrument to measure, analyze, and report the experiences of clients in the health care. For the mental health care four versions of the CQ-I are available for different populations, including the Consumer Quality Index clinical mental healthcare and addiction care. By means of the CQ-I, patients are questioned about their experiences with, for instance, the information they received about the treatment, the attitude of the caregivers, the treatment options that were available, and to what extent they are satisfied with their treatment.

In 2012, the institutes for mental health care and addiction care will be obliged to interview a sample of their clients by means of the CQ-I. The results from these interviews will be used for benchmarking on the level of teams, departments, and institutes. The benchmarking will take place within the framework of the national performance indicators. Different stakeholders, like the health insurers and the Health Care Inspectorate (IGZ) will be able to compare the experiences of the clients. Some addiction clinics publish results from benchmark research on their website in order to provide information about the quality of their services to their (potential) clients and their family.

Youth thermometer

Institutes for mental health care that provide care to young people aging 12 to 18 years can apply the *Youth thermometer* each year. This instrument assesses the satisfaction with the received care of the young clients as well as their parents. The Youth thermometer measures the appreciation of the information that was received about the treatment programs, the involvement of the clients in taking decisions, the satisfaction with the care worker, and the appreciation of the results of the treatment. The results from the Youth thermometer are applied in the same way as the results of the Consumer Quality Index (CQ-I) as described in the paragraph above.

Routine Outcome Monitoring

Benchmarking will also be done by means of *Routine Outcome Monitoring* (ROM, see also previous National Report 2011, § 5.3.1). ROM is a method to clarify, evaluate, and improve a treatment program. The input for the ROM method comes from different sources. A first source of information for the ROM is given by the agreements between patients and professionals about the treatment targets. A second source of information is given by measurements of the problems of the patient, at least at baseline and at the end of treatment. Sometimes there are also measurements available from one or more follow-ups.

The purpose is that the information collected by ROM can be applied at the individual level, at team level, at the level of a whole institute, and at the level of a nationwide benchmark. All in all, the ROM method will have to serve four functions: 1) giving information about the treatment and support programs that are actually followed; 2) learning about how to improve the quality of treatment; 3) conducting research; and 4) giving account about the treatment that has been given. In the future, the data from the ROM can possibly be used in the context of the national performance indicators, for example to measure the outcomes of treatment at a national level.

The data for the ROM are collected at a national level by the *Foundation Benchmark Mental Health Care* (Stichting Benchmark GGZ, SBG). This national data collection by the SBG started in the beginning of 2011. The implementation of ROM is work in process. In 2012, the institutes for mental health care and addiction care will have to deliver their data to the SBG. Consequently, the SBG intends to perform a benchmark on the ROM data during the course of 2012. The insurers intend to use the ROM data for contracting mental health care and addiction care.

In the beginning of 2012, a sharp dispute arose about the ROM. On the one side of the debate position was taken by eleven professors of psychiatry, senior university lecturers, and board members of institutes for mental health care. On the other side of the debate position was taken by the insurers and the SBG. The insurers were putting pressure on the institutes to deliver their treatment outcomes to the ROM data base held by the SBG. If the institutes would not deliver their data, the insurers would cut down their budgets. During the debate, the professors, lecturers, and board members of the institutes complained that the "insurers held hostage of care workers by means of expensive and nonscientific bureaucracy". They argued that the insurers lacked the instruments to compare institutes in an objective manner. These instruments must be developed, but it can still take years[196].

Patient security

Funded by the Ministry of Health, Welfare, and Sport (VWS), the Netherlands Association for Mental Health Care (GGZ Nederland) conducts since 2008 the patient security program *Safe care, everyone's concern*. The program is based on the *Security Management System* (Veiligheidsmanagementsysteem, VMS) and the *Safely Reporting of Incidents* (Veilig Incidenten Melden, VIM). The program targets five main themes given by somatic comorbidity, suicide prevention, medication security, fire safety, and reducing coercion and restraint. These are issues about which it is known that there are security risks for the patients.

By means of the patient security program, GGZ Nederland encourages the institutes for mental health care and addiction care to be aware of the risks involved for patients, and to take measures to reduce those risks as much as possible. The program develops standards and tools that support institutes to work towards patient security.

The patient security program *Safe care, everyone's concern* is in line with similar programs for the medical hospitals in the Netherlands, the care for the disabled, the nursing homes, the home care, and the primary care.

In this line GGZ Nederland and the Foundation Harmonization of Quality in Healthcare (Stichting HKZ) have made agreements on the assessment of the security management system for the period from 2012 to 2014[197]. The themes of the security program are part of the Certification schemes for the HKZ. By the end of 2014, all institutes for mental health care and addiction care will have to be certified on the security norms. In the period 2012-2014 the institutes will receive security visitations from an external audit team. The results will be presented to the Health Care inspectorate (IGZ). On the website

[196]http://www.psy.nl/meer-nieuws/nieuwsbericht/article/zorgverzekeraar-straft-ggz-instelling-die-geen-data-aanlevert/?no_cache=1&cHash=1a72f16af92b9d36f4fe80c590614660.
[197]http://www.veiligezorgiederszorg.nl/meerjarenafspraken-hkz-igz-ggznl.pdf.

www.veiligezorgiederszorg.nl (safe care everyone's concern) all information about the patient security program is collected.

Audits

In their annual accountability reports, the institutes for mental health care and addiction care report which audit system they employ (see table 11.3.1). All addiction care facilities apply internal audits and the audits are in line with the HKZ. Three institutes also apply the independent audits from the Center Certification ACT and FACT (CCAF) and the European Foundation for Quality Management (INK-Model/ EFQM).

Table 11.3.1: Types of quality audits in the thirteen regular institutes for addiction care

Institute, Place of business	Internal quality audits	HKZ[198]- certificate and audits annually	Independent audit CCAF[199]	INK-Model/ EFQM[200]
1. Stichting Arkin, incl. Jellinek, Amsterdam	X	X		Since 2009 EFQM/INK recognition for excellence, 3 stars
2. Lievegoed zorggroep Arta verslavingszorg	X	X		
3. Stichting Bouman GGZ, Rotterdam	X	X	Certification FACT	
4. Parnassia Bavo Groep B.V., incl. Brijder Verslavingszorg B.V., The Hague	X	X		
5. Stichting Centrum Maliebaan, Utrecht	X	X		
6. Stichting Verslavingszorg Noord Nederland, Groningen	X	X		
7. Stichting Tactus Verslavingszorg, Deventer	X	X		
8. Stichting IrisZorg, Arnhem	X	X		
9. Stichting Emergis Centrum voor GGZ, Goes	X	X		
10. Stichting De Hoop, Dordrecht	X	X		
11. Stichting Novadic-Kentron, Vught	X	X		
12. Vincent van Gogh voor GGZ, Venray	X	X	Certification FACT	
13. Stichting Mondriaan, Heerlen	X	X		

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[198]HKZ: Harmonization Quality in Healthcare.
[199]CCAF: Center Certification ACT and FACT.
[200]EFQM: European Foundation for Quality Management.

POLAND

Part B: Selected Issue

11. Residential treatment for drug users in Poland

11.1. History and policy frameworks

11.1.1. History of residential treatment *(Piotr Jablonski, Katarzyna Pulawska – Popielarz, Jolanta Koczurowska)*[201]

In the 1960s and 1970s drug-dependent individuals, if they found medical care, were treated under the existing health care system. Drug treatment offered only 90 beds across the country and it was provided almost exclusively by psychiatrists. One of the first and leading drug treatment centres was Polydrug Treatment Ward by Provincial Specialist Psychiatric Hospital in Lubiaz near Wroclaw (1971-1976). In the health care community, drug treatment was considered very difficult, and the outcome of treatment and post-rehabilitation in Poland and the world were not encouraging and optimistic enough (Andrzejewska, 1974). The success of drug therapy was aided by the experience of Garwolin Sanatorium for Children and Adolescents, which was promising for the drug-dependent population and innovative across the public health care. At that time the facility was headed by dr Ewa Andrzejewska. In 1972, the sanatorium started admitting adult patients dependent on drugs. Here, the professional career of many drug practitioners and researchers began with Marek Kotanski topping the list. Drug therapy models offered to drug-dependent patients at psychiatric care facilities failed to generate satisfactory outcome. Treating both alcohol and drug abusers in a single ward mostly was completely disruptive for the whole unit and discouraged both service providers and patients from further work (Swiatkiewicz, Moskalewicz & Sieroslawski, 1988). The awareness of the inadequacy of the proposed solutions was becoming universal and prevented drug therapy efforts. Consequently, for example, in Pruszkow Hospital drug treatment at alcohol abuse wards was found unnecessary and ineffective (Leczycka and Steffen-Kusz, 1986). A revolutionary change in drug treatment approach was initiated by Marek Kotanski in 1978. Behind the change was not only willingness to provide care for substance abusers but also disappointment with previous therapy models and their results: “We all deluded ourselves into thinking that they are recovering and we are helping them to do so” (Kotanski, 1984). Together with some patients and staff of Garwolin Sanatorium he established in Gloskow the first therapeutic community-based drug rehabilitation centre (for approx. 30 patients) called MONAR. Basis principles of this variety of therapeutic community combine the

[201] The history of treatment was published in: red. Jabłoński, P., Bukowska, B., Czabała, J. Cz. (2012) Uzależnienie od narkotyków. Podręcznik dla terapeutów. Krajowe Biuro ds. Przeciwdziałania Narkomanii.

American and European experience and the Polish specificity. The rules included charismatic leadership, equality of community members, total abstinence, limited influence of outside role models, developing one's norms (Siczek, 1994).

In 1981, a Catholic therapeutic community 'Betania' was set up. For several years it operated without the awareness and consent of the authorities. In 1981, the first Polish after-war anti-drug non-governmental organization was registered – MONAR Youth Association. It was the aforementioned Gloskow centre that became a first step towards the establishment of the association with Marek Kotanski as its creator and a spiritual leader. The same year MONAR entered into a historic memorandum of agreement with the Ministry of Health regarding principles of conducting and financing drug prevention and treatment programmes. In 1981-1983 MONAR opened 11 therapeutic communities, including a pioneer Matarnia house for children and adolescents in Gdansk, upon initiative of Jolanta Koczurowska. Between 1982 and 1990, 20 MONAR centres were established across Poland. In 1987, the Catholic Anti-Drug Movement KARAN was founded. Soon a centre for youth at risk of drug addiction was opened. The Drug Prevention Society established a facility for children and adolescents under 18 in Wolka Przybojewska near Warsaw. In the south, upon initiative of father Czeslaw Cekiera, professor at Lublin Catholic University, the Catholic Youth Education and Post-Rehabilitation Centre was established while in Grzmiaca near Warsaw - a first public substance abuse treatment facility (Koczurowska, 2008).

Residential drug rehabilitation facilities were mainly established by NGOs, which like MONAR, started sprouting up across Poland. The drug-free therapeutic community model was followed with minimum or even none pharmaceutical support. Rapid spread of HIV among drug users dramatically changed the public perception of the phenomenon, affected health of Polish drugs users and 'forced' society to find new ways of addressing the problem. A first infection of HIV was identified in 1985 and a first AIDS case in 1986 (HIV i AIDS w Polsce, 2008). In April 1993, out of 2 548 registered HIV-positive people, over 70% were drug users. Facing substantial public anxiety and the lack of services for HIV-positive people, Marek Kotanski opened a MONAR community for HIV-positive drug addicts in Zbick near Opole in 1984. Soon it became clear that this HIV-determined community was too homogenous, which hampered therapy. As a result of this experience, in 1988, all MONAR centre and the majority of other centres started admitting any users regardless of their health status. It was a step that increased drug therapy success rates among HIV-positive users in communities of mixed member composition, which prevented them from being stigmatised. In the face of HIV epidemic among drug users, atmosphere of the related social intolerance and aggression, the Ministry of Health and Social Care made an important decision. Under the auspices of the Ministry, father Arkadiusz Nowak established first two centres in Konstancin and Piastow (1991) and then another one in Anielin (1998) for individuals with HIV/AIDS.

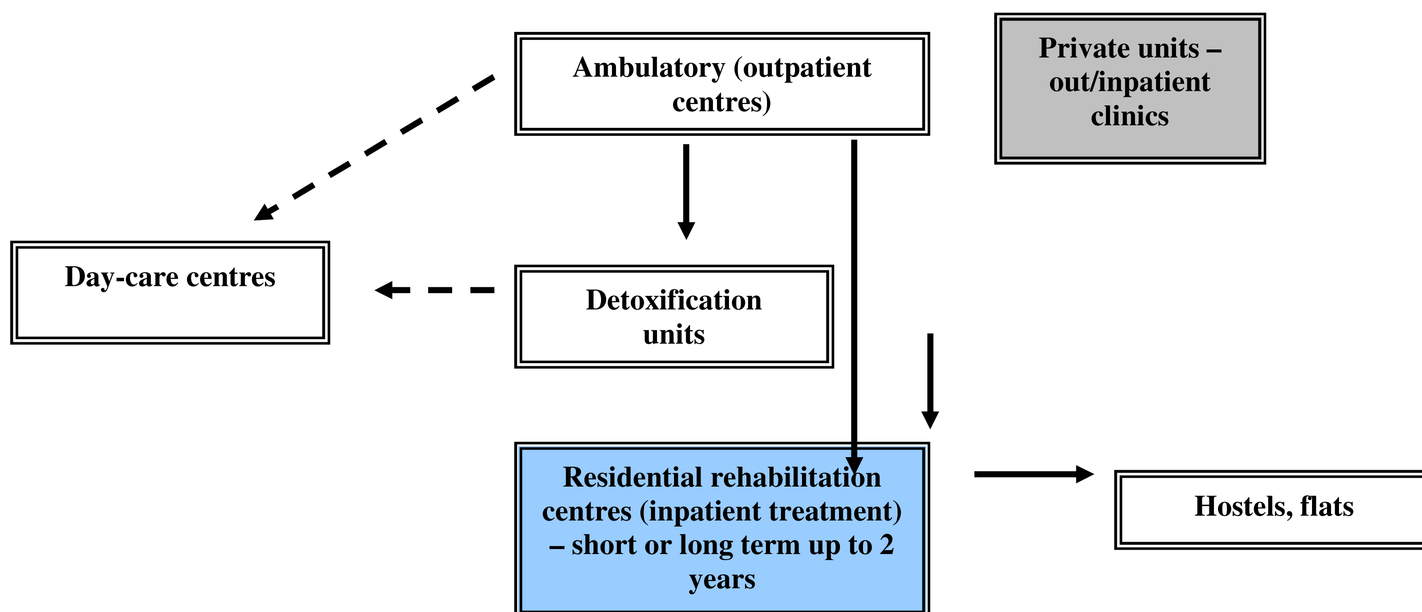
Growing mental disorders among drug addicts necessitated the development of a new adequate drug treatment model. The response was Faimilia centre in Gliwice for patients with dual diagnosis. The centre founder, dr Andrzej Maj-Majewski, and his team enriched the therapeutic model with their psychiatric treatment experience.

The contemporary Polish drug therapy model has been based on the dominating role of long-term secure residential treatment with therapeutic community as a primary type of intervention.

11.1.2. Strategy and policy frameworks for residential treatment

The system of specialised help for people addicted to psychoactive substances is part of a healthcare system aimed at people with mental disorders. In Polish drug treatment and rehabilitation system, apart from outpatient consultation centres, drug prevention and therapy ambulatory clinics, ambulatory substitution programmes, detoxification wards, day-care centres, hostels and flats there is a broad range of residential treatment services. This form is the oldest and most developed part of Polish drug treatment system.

Figure 11.1.2.1. Structure of treatment facilities for drug users



Source: Jablonski, P. National Bureau for Drug Prevention.

Pursuant to the Act on counteracting drug addiction residential treatment centres must be health care units which within the meaning of the Act provide rehabilitation and reintegration of drug dependent individuals free of charge, regardless of the patient's place of residence or therapy duration. A drug treatment unit (residential treatment clinic) is defined as a facility which admits problem drug users for voluntary treatment to live and fulfil all obligations such as school or court orders (if necessary). Drug rehabilitation is defined as a process in which a person with a drug-related mental disorder reaches an optimum health status, social and mental functioning. Treatment and rehabilitation or social reintegration

by the drug dependent individual is voluntary excluding, inter alia, individuals younger than 18 years of age and incapacitated individuals. In those cases, the treatment may be enforced by means of a court order.

A broadly understood therapy and all accompanying services under confinement are financed from public sources (National Health Fund – NFZ). The NFZ also provides minimum service quotas guaranteed at these sites.

The drug treatment is available both for insured and uninsured patients. In case of uninsured patients the treatment is funded by the Ministry of Health.

The organization and range of services at residential drug treatment clinics are regulated by the Act on counteracting drug addiction, Act on patients' rights and patient ombudsman, Act on public benefit and charity work, Act on mental health protection, Regulation of Minister of Health on types and scope of medical documentation and manners of processing thereof, Regulation of Minister of Health on specific conduct in substitution treatment and specific conditions to be met by a health care unit providing substitution treatment, Regulation of Minister of Health in specific conditions and conduct in treatment or rehabilitation of drug-dependent individuals sentenced for committing crimes related to the use of narcotic drugs or psychotropic substances, Regulation of Minister of Health on professional and sanitary requirements for rooms and equipment at health care units, Regulation of Minister of Health on drug treatment training.

11.2. Availability and profile. Residential treatment availability assessment. Basic features of services provided. *(Katarzyna Sollich)*

11.2.1. National availability and accessibility

Residential treatment units are mostly located outside urban areas, which is intended to provide patients with 'natural' separation from active drug users and those who supply drugs. The latest information brochure (2011) published by the National Bureau for Drug Prevention shows that 79 clinics providing residential drug treatment (excluding alcohol) offer programmes ranging from 6 weeks to 24 months, which are divided into three types of treatment varying in terms of duration: short-term (6-12 weeks), mid-term (3-12 months) and long-term (12 to 24 months). In 2 out of 79 clinics patients as young as 7 years old are admitted. The remaining clinics are divided into two types: those for patients 13 or 16 and older (they also offer programmes for adolescents) and those for patients 18 or 21 and older, the so-called clinics for adults.

The National Health Fund as the sponsor specifies the residential treatment admission criteria in contracting regulations. They provide that residential treatment fall within the hospital benefits pool and just as other hospital patients drug treatment patients must be referred by the health insurance physician, private doctor or court of law. For many years the most popular practice in Polish conditions has been the referral given by a psychiatrist or a counsellor in an ambulatory drug treatment unit.

In residential treatment the service provider is mandated to offer free and necessary diagnostic testing, medication and some medical products. A patient with mental disorders caused by psychoactive substance use is admitted upon his or her written consent while the admission of a minor or an incapacitated individual is done based on the legal guardian's consent. An important fact is that regarding residential treatment clinics as hospitalization, results in a situation that the funding procedure takes the form of the so-called 'persondays', whereupon the patients hospitalization is financed on a 24-hour basis regardless of the type of action taken. According to the information brochure on drug services, in 2011 in Poland, there were 79 residential drug treatment units and they offered around 2600 beds. The number of units per province ranged from 1 to 13. Under the framework of the National Mental Health Protection Strategy 2011-2015 (Regulation of Council of Ministers of 28 December 2010), a minimum residential substance abuse treatment availability rate should stand at 0.7 per 10 000 population. Based on the 2011 drug services brochure data, the substance abuse treatment in Poland complies with the Strategy requirements[202].

Residential drug treatment data, including data on residential treatment facilities, are systematically collected by the Institute of Psychiatry and Neurology. The latest available data go back to 2009. They show that in 2009, the clinics offered a total of 2 599 beds while the number of stays stood at 7 819 with a total of persondays of 786 054.

11.2.2. Types and characteristics of residential treatment units

Residential rehabilitation is performed by rehabilitation or rehabilitation and reintegration centres under public health care and NGOs. Despite structural and formal variations, virtually all clinics decided to adopt a therapeutic community model as the leading model of intervention. Out of 79 units (according to the national information brochure on drug services) this form of assistance was provided by 70 clinics, out of which 59 used it exclusively, 5 combined it with the Minnesota model, 8 combined it with other forms of intervention such as social therapy, motivational interviewing or problem-solving oriented therapy.

The foundation of the Polish variety of therapeutic community in terms of theoretical framework and training basically do not differ from the widely accepted international standards. It contrasts with traditional hospitalization where a patient most often felt isolated and deprived of the ability to actively participate in the recovery process (Koczurowska, 2001). Daily meetings of patients and staff are the source of feedback and are useful in decision-making at all levels, co-leading the meetings and social learning by social 'here and now' interaction. Moreover, in every correctly functioning therapeutic community democracy principles are imposed, which means that every member has equal rights and obligations in management and decision-making. The principles of consensus is also observed, which means that decisions are made based on joint and universal agreement regarding any action. The following principles are also present: the principle of permissiveness which promotes acceptance,

[202] The National Mental Health Protection Strategy. Regulation of 28 December 2010 of Council of Ministers.

understanding and tolerance, the principle of participation and community which means that all matters of members become shared matters in a community and the principle of realism which says that the community members must be exposed to direct experience of confronting the newly mastered skills with the reality (Koczurowska, 2012).

In 2011, the Minnesota model was reported as the core model in 7 residential drug treatment units in Poland (based on the information brochure on drug services). It is used as one of the models in alcohol and drug treatment facilities. Minnesota model facilities base their strategy on: task force groups which are intended to help patients solve personal problems and make decisions related to addiction; partner groups initiated by patients without therapist participation and educational lectures on symptoms of addiction, behaviour of the dependent individual, biological and social factors for addiction and assistance techniques to be used in behavioural change (Rachowska, 2012).

Internship centres which provide training for addiction therapy specialists and instructors also report combining the following intervention models:

- bio-psycho-social model explaining the etiology of addiction and other mental disorders, theory of psychosocial development according to E.H. Erikson, cognitive therapy according to A.T. Beck, systemic family therapy, psychopathology of children and adolescents,
- concept of therapeutic community, intensive addiction therapy, 12-Step Programme, coping skills training according to Peter Monti, cognitive and behavioural theory, motivational psychology,
- cognitive-behavioural model, Gestalt therapy, insight therapy, role playing, psychological mechanisms of addiction, therapeutic community model,
- addiction psychotherapy based on democratic treatment community and psychotherapy oriented on an individual, cognitive-behavioural therapy and elements of structural-strategic addiction therapy,
- integrated approach, cognitive-behavioural systems combining motivational interviewing,
- therapeutic and educational programmes within therapeutic community model in centres for children and adolescents,
- elements of cognitive-behavioural theories, humanistic-existential theories and systemic theories,
- cognitive-behavioural therapy, motivational psychology, critical intervention, therapeutic community, 12-step programme, Conti's social skill training, joint rehabilitation of individuals with and without mental disorders in a single group
- modified therapeutic community therapy integrating three treatment models: therapeutic community, 12-step programme and medical-psychiatric model.

This year a first therapeutic community-based rehabilitation centre in Poland combining methadone maintenance and total abstinence was opened. In all the remaining centres, despite frequent variations and changes in treatment approach total abstinence has been the basic residential treatment principle. Substance abstinence does not refer to cases when prescription drugs must be administered.

Life skill training, vocational improvement and school obligation are performed in most units according to financial and infrastructural capacity and needs of the target group. All residential centres for minors provide schooling on the premises or sign agreements with local schools. Most centres which in their philosophy are guided by the work ethic as a therapeutic factor provide their charges with vocational training opportunities. It often happens that in the residential centres which admit patients with co-occurring disorders there are training programmes for assertiveness, anger management and social skills. Patients at risk of HIV are sent from an ambulatory facility to independent consultation centres for testing and counselling in this matter. Providing drug treatment at one place and other services at HIV testing sites does not create formal problems as in such cases financing comes from separate sources.

Health care benefits provided in Polish therapeutic communities are divided into: preliminary benefits including treatment onset-relate procedures (medical and psychological assessment, interviews, consultations, social interventions), daily benefits (individual and group therapy, critical interventions, nursing activities, other rehabilitation) and periodical benefits (medical and psychological tests, treatment progress evaluation, rehabilitation terms) (Moskalewicz, 2006). All benefits are regulated by the norms guaranteed in the contract between the unit and the NFZ.

In 2011 in Poland there were 212 ambulatory substance treatment centres (Information brochure 2011). They provide a wide range of post-rehabilitation services for patients who upon completing residential treatment need support while re-entering society. They offer individual and group therapy, social assistance or training to get adapted to new conditions.

11.3. Quality management *(Katarzyna Sollich)*

11.3.1. Availability of guidelines and service standards for residential treatment

In order to improve quality and effectiveness of therapeutic services in Poland, drug treatment and rehabilitation standards were developed in 2004-2009. A special expert team was appointed by the Minister of Health for developing standards of drug treatment, rehabilitation and harm reduction and accreditation of health care units providing drug treatment, rehabilitation and harm reduction (Bukowska, 2012). The works involved such institutions as the National Bureau for Drug Prevention, Institute of Psychiatry and Neurology, State Agency for Prevention of Alcohol-Related Problems, Centre for Monitoring Quality in Health Care as well as therapists from drug services. The standards have not been formally approved; however, they are presented at conferences, training seminars and widely available publications. They can be used in everyday practice and contribute to steady improvement of the quality of services provided. The guidelines based on American and British publications and the experience of the Centre for Monitoring Quality in Health Care that since 1997 has been implementing in Poland the system of accreditation of health care units. The guidelines were divided into sections including patient’s rights, continuity of treatment, patient’s care, general management, information management and infections control (Bukowska, 2012).

The residential drug treatment standards are divided into three sections: quality structure, quality of care process and quality of treatment outcome. It is assumed that in order to ensure solid quality of services there must components such as number and education of staff, proper service infrastructure, procedures related to hygiene and broadly understood organizational structure.

Patient's rights section of the standards contains the following principles:

- granting written consent by patients to be admitted to treatment,
- evaluating patient status while respecting their privacy,
- informing all patients of their rights and obligations,
- respecting patients' rights by staff,
- patients' written approval of the rights limitation which in any case is preceded by previous discussion of relevance thereof,
- developing individual treatment plans which include patients' needs, objectives and are then accepted in writing,
- providing a patient with clear and easy to understand information on his or her health,
- holding a list of procedures requiring additional consent, e.g. participation in tests,
- holding a list of correctional interventions in line with patient's rights,
- holding a procedure for securing patient's property,
- in treatment units admitting minors, holding procedures in line with child protection regulations.

In order to receive accreditation regarding continuity of treatment, the standards must contain:

- procedures for admitting patients and referring them inside and outside,
- specific excluding criteria,
- procedures for handling a patient in special circumstances and planned discharge of a minor, an incapacitated patient or an individual obliged to complete treatment by court's order,
- procedures for unauthorised self-discharge from treatment,
- principles of providing patients with information on further conduct upon discharge from facility, deadline of receiving his or her medical history file and its content.

Patient's care section lists activities aimed at improving patient's mental and physical condition:

- determining drug treatment unit's target group,
- providing services for children and adolescents in place and time other than for adults,
- procedures for diagnostic and psychotherapeutic conduct,
- procedures for conduct with addicted individuals requiring special interventions,
- information which must be passed to a patient upon admission to treatment unit and time of physician consultation,
- developing a preliminary plan of care and a plan of individual therapy,

- collaboration with patients' families and relatives,
- education on harm reduction,
- access to programmes for vocational training and alternative leisure time activities,
- qualification of staff providing specific services and regularity of staff training at all levels.

The standards also to large extent refer to organizational issues:

- defining mission statement known to all staff,
- holding an updated organizational structure plan,
- defining qualifications for all positions,
- developing and implementing a staff training plan,
- staff's clinical supervision options,
- organization of clinical meetings,
- adaptation programmes for charity workers and interns,
- guidelines on content of medical records and procedures ensuring completeness thereof,
- hands hygiene, tidying rooms and conduct after professional exposure.

In June 2012, upon acceptance of the Accreditation Council, a revised package of standards in residential drug treatment was re-submitted to the Ministry of Health and is awaiting approval.

In 2007, Code of Practice for Addiction Therapists was adopted. It contains principles on therapist conduct. The code is supervised by the Ethics Commission by the National Bureau for Drug Prevention. The National Bureau publishes the list of therapists who accepted the code and a list of treatment units whose staff accepted the principles. The code was developed on the basis of the Code of Practice for Psychotherapist of the Polish Psychiatric Association and the Code of Practice for Psychologists. It is not a universally binding law. General principles include performing professional duties while respecting the patients' rights, providing services according to existing standards and professional competences, not using therapeutic relationship for personal and material gain as well as raising professional qualifications. Specific provisions include questions such as moral judgement of individuals in therapy, abiding by the Act on patient's rights and Ombudsman for patient's rights, Act on personal data, determining therapy methods, duration and setting, providing information on therapy objective and progress, ensuring adequate conditions for therapy, responsibility and principles in keeping professional secrecy, aspects concerning violence towards patients and forming private relationships, over-interference with patient's private life, judging and commenting on other therapists' work and consultation with other specialists if needed.

Pursuant to the Act of 29 July 2005 on counteracting drug addiction, there is also a certification system for drug therapy instructors and specialists. The instructors and specialists are granted the right to provide services for harmful drug users, drug-dependent individuals and their families. Legal regulation of this issue makes it possible to introduce norms regarding the knowledge of drug treatment staff. The requirements which should be met by drug treatment training entities, framework of

training programmes, mode and manner of holding final exams, composition of the examining panel and specimens of certificates for drug therapy instructors and specialists are appended to the Regulation of the Minister of Health on addiction treatment training.

In 2010, a report of the Helsinki Foundation for Human Rights was published on monitoring patient's rights in drug treatment centres. The foundation staff monitored residential centres and assessed their infrastructure, principles and methods of therapeutic work, use of coercive measures, therapy payment and duration, rules for rights and obligations of patients, consequences for failing to abide by the rules as well as legal framework for residential drug treatment. Out of 20 units visited by the foundation, 18 agreed to take part in the project, which accounts for almost 25% of all residential drug treatment facilities in Poland. The visitors studied internal rules and activity plans, held interviews with patients, staff and treatment graduates. The final report pointed out frequent discrepancies between the rules and procedures in respective centres, their vagueness and lack of clarity, no diversity concerning the range of therapeutic offer as well as unclear and inadequate application of penalties and enforcement of consequences for rules breaking. The Ministry of Health considered the report valuable contribution to the assessment of current state of patient's rights and found it in line with the National Programme for Counteracting Drug Addition. The Ministry also argued that the formal introduction of the abovementioned standards would remove most of the irregularities.

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