17th St. & Constitution Avenue N.W.
Washington, D.C. 20006
United States of America

Organization of American States

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INTER-AMERICAN DRUG ABUSE

CONTROL COMMISSION

C I C A D

Secretariat for Multidimensional Security

**CICAD HEMISPHERIC GUIDELINES ON THE CONSTRUCTION OF A HOLISTIC COMMUNITY-BASED MODEL
OF DEMAND REDUCTION**

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Hemispheric Guidelines on the Construction of a Holistic Community-based Model of Demand Reduction

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1.1. **Hemispheric Drug Strategy (2010)[1]**

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[1] http://cicad.oas.org/Main/Template.asp?File=/main/aboutcicad/basicdocuments/strategy_2010_eng.asp

Since its founding in 1986, CICAD has had a hemispheric drug strategy and plan of action. In 2010, all member states reached a consensus on the Strategy for 2010 – 2015, which addresses the various lines of action needed in dealing with the world drug problem. In the case of Demand Reduction, thirteen guidelines were defined for consideration both in the work of the Executive Secretariat and of the Expert Group and the member states.

This Strategy recognizes drug use and dependence as a chronic, relapsing disease which must be addressed and treated by the appropriate institutions, bearing in mind the bio-psychosocial implications, which also have to be addressed. It also established the need to address seriously excluded populations through the demand reduction prevention continuum, beginning with universal prevention through to rehabilitation and recovery support services for drug-using individuals and their families by working in community, school, work and family settings.

1.2. Plan of Action to implement the Hemispheric Drug Strategy (2011) [2]

This Action Plan was adopted by the Inter-American Drug Abuse Control Commission (CICAD) at its forty-ninth regular session in May 2011 and adopted by the OAS General Assembly at its forty-first regular session held in San Salvador, El Salvador in June 2011. In the area of Demand Reduction, the Action Plan has eleven specific objectives and actions to implement the guidelines in the Hemispheric Drug Strategy 2010 – 2015. The guidelines set out and developed by the Expert Groups will seek to follow up on the Action Plan to ensure that it is implemented in the member states.

1.3. Forty-eighth and forty-ninth regular sessions of CICAD

At its forty-eighth regular session held on December 6—8, 2010 in Washington, D.C., the Commission elected the United States, in the person of Mr. David Mineta, Deputy Director for Demand Reduction of the U.S. Office of National Drug Control Policy (ONDCP), as chair of the Expert Group on Demand Reduction. The Commission also elected Brazil, in the person of Dr. Paulina Duarte, Director of the National Drug Policy Secretariat (SENAD), to serve as Vice Chair of the Expert Group. The incoming chair expressed his support for the work of the Group and its plan to make policy recommendations of particular importance to the member states, particularly at the community level.

During the forty-ninth regular session of CICAD in May 2011, the Chair of the Expert Group presented his work plan for 2011 – 2012, which, in accordance with the Hemispheric Drug Strategy

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[2] http://cicad.oas.org/Main/Template.asp?File=/main/aboutcicad/basicdocuments/plan-action_eng.asp

and its Plan of Action, will develop hemispheric guidelines and recommendation on the following topics: *Integrated communities, Drugged driving, Information for the development of demand reduction policies, and prevention of prescription drug abuse.*

These papers were to be developed by the Expert Group and presented to the Commission for approval and adoption by the member states.

1.4. XIII meeting of the Group of Experts on Demand Reduction.

The XIII meeting of the Group of Experts on Demand Reduction was held on September 27—29, 2012, and the bases for each of these topics were presented. These bases were developed jointly by the Chair of the Expert Group (United States), the Vice Chair (Brazil) and CICAD's Demand Reduction Unit. For purposes of the present document, the experience and basic guidelines having been presented, the country representatives asked to participate in drafting the document, so as to develop comprehensive, hemispheric guidelines that would incorporate the countries' experiences in a community-based setting. The member states that offered to work on this initiative were: Argentina, Brazil (Vice Chair), Chile, Colombia, Costa Rica, Mexico, Panama, United States (Chair) and Uruguay. The Ibero-American Network of NGOs working on Drug Dependence (RIOD) also requested to participate in this work, as essential members of civil society.

1.5. Meeting of the Working Group, Santiago, Chile.

Bearing in mind what was agreed during the XIII meeting of the Demand Reduction Expert Group, the Demand Reduction Unit of the CICAD Executive Secretariat convened the countries and institutions to work on developing this document, and asked them to name a representative with the necessary experience and technical knowledge. Bearing in mind the fundamental role played by civil society in this process, RIOD was also convened to contribute to the document and to send some RIOD representatives and advisors. The abovementioned countries, along with representatives of RIOD and CICAD, met in Santiago, Chile in April 2012 in order to examine the different community-based strategies and interventions that had been carried out in their countries and local settings, on the basis of which the present document, the *CICAD Hemispheric Guidelines on the Construction of a Community-based Model of Demand Reduction,* was prepared.

2. Policy framework

2.1. Recommendations to member states[3]

- Responses that seek to address problem drug use should take a comprehensive approach that is based on human rights and that takes into account the economic, legal, psychological, health, social, cultural and educational dimensions. This will ensure a comprehensive approach to the problem. The different approaches must be coordinated among the different government agencies or Ministries. The necessary budgetary resources must be made available for these tasks.

- A drug policy that seeks to become embedded into society for the long term must necessarily coordinate public sector activities with civil society, and be made into a policy of the State, in order to be safeguarded against the ups and downs of politics and institutions and assure its continuity over time.

- The demand for treatment for persons with problem drug use has increased. However, many of the region's citizens continue to experience a lack of care. Government policies must therefore take account of these shortcomings and make mobilization of society as a whole an essential part of the response, as well as coordinate the various stakeholders and institutions that are addressing these problems.

- The role of the State in addressing the prevention and treatment of problem drug use should be restated in light of current challenges. This does not mean that we should ignore or undervalue the efforts that have been made thus far. The experience and infrastructure that the public sector, NGOs and various stakeholders have built up should be the starting point for any drug policy.

- No State/Government policy should overlook the goal of instilling an approach of comprehensive prevention. This refers to the fact that the area of prevention has achieved poor coverage, both in the public and private spheres, and in many cases, prevention programs have limited budgets and are poorly planned and executed.

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[3] These recommendations draw on a document by FONGA, Guidelines for a comprehensive understanding of the drug problem: Drug addiction education, prevention and treatment from the standpoint of non-governmental organizations. Buenos Aires, June 2010. (Spanish only), as well as CICAD's Basic principles of the treatment and rehabilitation of drug-abusing and drug-dependent persons in the hemisphere, October 2009.
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2.2. Recommendations to the Executive Secretariat of CICAD

- Social policy on drugs should not lose sight of the fact that drug users are citizens and as such, their rights must be assured (access to health and treatment, prevent social and health harms, change the stigma they experience because of their drug use).

- It is necessary to support the Governments in the technical planning of prevention activities within structures that will enable the different programs to be sustainable, and to this end, should include mobilization of society.

- It is essential to work with Governments to optimize resources for drug use programs, through evaluation and documentation of program outcomes.

- It is necessary to promote Coordination and conciliation of the various methods or theories being used to address this problem should be promoted, so that they are not to be seen as in competition, or else discredited or lacking in effectiveness.

- It is important to draw up a list of institutions and stakeholders working on the topic, as well as to document the experiences and knowledge in the countries, that is, the road travelled so far, and what is left to be done.

2.3. General considerations

- Recognize that the individual lives in a world of interrelated and interacting parts, which must be addressed as a whole.

- Recognize that the individual is an integral being who is also part of the solution.

- Recognize the processes of the construction of society during intervention in social and health problems.

- Recognize the impact of drug use on social, economic and political structures.

- Understand drug dependence as a chronic, relapsing disease that must be treated in multisectoral, interdisciplinary ways given its social, health and economic impact, recognizing social, cultural and ethnic differences among countries and within each country.

- Continue to promote a discourse that is different from the stigmatizing view of drug users.

- Expand treatment services for those who use psychoactive substances.

- Recognize and promote the creation of community-based services and facilities.

- Base the work on a human rights perspective.

- Bear gender differences in mind.

- Work with indigenous populations.

- Promote a comprehensive view by using communications, interactive and participatory mechanisms.

- Develop tools and mechanisms for community participation in order to carry out specific actions.

- Mitigate the risks and adverse consequences associated with drug use.

- Foster the integration of services by forming social protection networks.

- Promote collaborative, participatory work among different stakeholders who may have different interests but who are well-disposed to cooperate.

- Involve members of the community in prevention and intervention teams.

- Promote decentralized policies that respond to the social needs of each country, by developing plans, programs and projects in association with civil society.

- Carry out local participatory assessments, using a qualitative approach, in order to understand the stakeholders' circumstances, and the meanings that they attach to drug use.

- Promote horizontal cooperation initiatives and exchanges of experiences and good practices among countries.

- Specialized training in demand reduction should be infused into trainings that are related to processes of constructing community participation.

- Assure program sustainability, monitoring and evaluation.

- Promote policies for specialized training of health care personnel in drug abuse prevention, treatment and rehabilitation.

- Work on mobile treatment.

3. Basic principles of prevention programs, risk approach and health promotion

For about a century, medicine and the law have regarded drug use as an "anti-social" activity that causes a biological and psychosocial disorder. Dangerousness and threats to others produced by drug use was the argument most often used to justify the treatment that specialists recommended for "drug addicts".

The meanings of the terms "addict", "drug dependent person" or "drug addict" are constructs that varied over time, and depend on the different groups using them in society. To analyze these concepts, we must look at the different ideological models underlying them. The main difference between them is the level of importance they attach to each of the interacting elements –drug,

individual, context– and there follow from that very differing kinds of social, prevention, legislative or health measures, depending on the particular approach taken.

The model known as the *ethical-juridical* model was the first to provide a response and attempt to address this problem. It focused on the substance as the main reference point, and emphasized legal and criminal measures. The drug user is seen as a "criminal" who is breaking the law. Since "the drug" is seen through the optic of crime, it leads to the criminalization and stigmatization of users, while creating an ever more powerful black market.

For the *medical-health* model, however, the "drug addict" is considered to be "ill", a person to be cured (diagnosed, prescribed and treated) and returned to society. In the first fifty years of the last century, medical interventions had a central role, but were overshadowed by the important role that the previous model was taking on in society. The idea that drug addicts were not criminals, but rather were ill gathered force at the beginning of the 70s; this meant that they had to be institutionalized in medical facilities, first as ill patients, then as convalescents, and in some cases, half way between re-entry and a degree of chronic disorder, they assumed a new social role as "former drug dependent persons" or "recovering addicts" (Romaní, 1999).

Economic and social changes in our societies over recent decades have transformed peoples' more or less predictable lives into life courses where uncertainty is the predominant factor. Ties of social integration have become more fragile, and society is fraught with many inequalities and diversities, and cases of exclusion and vulnerability. This means that analyses of social problems are more complex, as is the search for solutions.

Although problem drug use has a long history, it has become more prevalent in society, both because it has increased and also because of its consequences for the individual and for society, and is one of the major topics of concern is almost all of the countries of the region.

In this part of the document, we shall discuss the different theoretical frameworks that underlie the responses that have been provided to drug use. We examine below, from a social and historical perspective, the various approaches that have been taken in the region: prevention, risk approach, and health promotion.

3.1. Primary, secondary and tertiary prevention

According to Caplan's classic definition (1980), prevention may be categorized into primary, secondary and tertiary prevention, referring to: connection to the health care system prior to the appearance of harm or illness; care and treatment once the illness has taken hold, and recovery following treatment. These three levels, when applied to drug use prevention, were defined as follows: Primary prevention starts with the assumption that no drug use is present and that tools must therefore be employed to prevent first use. Secondary prevention should identify those cases in which drug use is present and where primary prevention did not work, in order to treat it and avoid other associated risks or medical or psychiatric pathologies that may follow from drug use. Tertiary prevention is designed to rehabilitate the drug user and prevent relapse.

Subsequent developments have introduced other, more complex approaches to the topic.

We shall look first at the application of the classic scheme of primary, secondary and tertiary prevention to the topic of drug use, and then discuss subsequent developments.

Primary prevention

Primary prevention prevents the appearance of a problem or reduces the incidence of it, through intervention by health personnel working in the community. It may be specific, if it is designed to prevent an illness or group of illnesses in particular, as with immunizations; or non-specific, such as providing guidance on the use of free time, or on improving the quality of life.

In the case of problem drug use, specific primary prevention is done by conducting programs geared to providing information about drugs or strengthening attitudes that will prevent drug use. Non-specific primary prevention involves organizing ongoing sports, cultural or work activities, for example, as resources that can motivate people sufficiently to cause them not to use drugs.

Non-specific prevention means promoting or favoring social integration through responsible participation, a critical attitude and respect for differences, proposing activities having to do with people's desires so that they have the opportunity to find areas of wellbeing.

Specific prevention in the areas of our concern has been questioned since the nineteen eighties. As Picchi has said (1990), prevention cannot be done by talking about drugs: it is essential that young people's intellectual autonomy be expanded so that they can discern and make choices about manipulation, group pressures, massification of culture; prevention is something that cannot be delegated – rather, it is done every day by those who are in touch with social groups.

The idea is that beyond merely giving out information, it needs to be put in context, made interesting to the groups we are working with, and be wrapped into other prevention activities.

Secondary prevention

Secondary prevention is based on early diagnosis, timely outreach and appropriate treatment of various health disorders. A diagnosis is made to allow early identification of the harm and early treatment. Psychological treatment, therapeutic communities and programs to mitigate risk and adverse consequences for problem drug users are examples of this type of prevention.

Tertiary prevention

Tertiary prevention seeks to rehabilitate and return the individual to society once the problem has been diagnosed. Physiotherapy, occupational therapy and psychological therapy attempt to help individuals adapt to their situation and be useful – and feel themselves useful—to themselves and to society. Programs called "social reinsertion", or "recovery support" which are carried out in some therapeutic communities as the final stage of treatment, are one example of this type of prevention.

It is important to understand that not all drug use requires secondary or tertiary prevention. In many cases in which drug use does not constitute abuse or has not produced dependence, or in which family and/or affective ties are strong, the phase of rehabilitation or "social reinsertion" will not be necessary.

3.2. Universal, selective and indicated prevention

We also have the proposal by the U.S. Institute of Medicine (IOM), which divides the prevention continuum into three: prevention, treatment and rehabilitation, while in turn, prevention is also divided into three different levels, known as *universal, selective and indicated*.

Universal prevention

Universal prevention seeks to address the entire population, and covers prevention in all spheres of life, ranging from the schools to the community, the family, the workplace and other areas without distinction as to age, social group, or gender. At this level of prevention, the intervention consists of providing information and teaching life skills that reduce the possibility of drug use. The assumption is that the risk of using drugs is the same for the entire population, without the need for screening to determine who is at greater or lesser risk of drug use. Universal prevention strategies are implemented with large groups, and are based on the assumption that all participants can benefit from them.

Selective prevention

Selective prevention is done with populations who may be at higher risk for drug use. They are divided into subgroups, depending on a set of characteristics that may be biological, psychological, social or environmental. For example, we could look at children of alcoholic parents, young people outside the school system, young people living in the streets, people who have been physically or

psychologically abused, or socially vulnerable groups. The risk is calculated to be the same for all those within one subgroup simply because they belong to that group, independently of whether drug use is already present, as may occur in some cases.

Indicated prevention

Indicated prevention is appropriate for individuals or groups who use alcohol or other drugs, even though their characteristics of use do not present with the symptoms classified in the DSM-IV or the ICD-10. That is, even though drug use is not yet considered problematic, this type of prevention with these groups may help prevent them reaching the stage of abuse. In such cases, the strategies tend to focus more on the individual's behavior than on changing the individual's environmental or family factors.

It is important to note that, according to national and international surveys, most drug use by youth in our societies is experimental, driven by curiosity or peer pressure; this shows us that the way of addressing and anticipating drug use is through primary prevention work. It is therefore very important to work with individuals on projects that help them reflect about problem drug use and show them the interests that lie behind drugs. That is to say, projects that they themselves have prepared, and that are "accompanied" by teachers, health professionals, community workers and leaders are those that will be credible and in tune with their own realities. The leaders must be aware of the different types of social and health responses available in their communities for those cases that require secondary prevention. We should bear in mind that not all treatment is the same, and that not all persons with problem drug use require the same response. Having information about the availability of different treatment types, and doing a good assessment of the response that is needed may prevent the individual from having to pass through several different treatment facilities and relapse time and time again into drug use. In many cases, relapse is due more to the lack of appropriate treatment than to the individual's lack of desire to stop using drugs.

3.3. Risk and protection approach

Another dimension to be taken into account in prevention is what is called the risk approach. Developed by epidemiologists and public health doctors, this approach consists in associating certain vulnerabilities of social groups with the notion of *risk factor*, defined as a circumstance that increases the probability that a harm or undesired outcome, such as an illness or a habit such as drug dependence, will occur.

This approach seeks to deal with the illness and reduce the harms associated with it, by classifying different groups according to their degree of vulnerability. It is understood, then, that this is an approach used mainly in primary care, given that it allows for determining which are the priorities for care at the moment the level of risk is determined.

In order to assess the risk of each person in a community, given that not everyone faces at the same risk, protective factors and risk factors are taken into consideration. These factors can be analyzed for each person from different perspectives: personal and family environment, the immediate social context and the sociocultural environment.

Risk factors cover all of the environmental, social, economic and biological and behaviors associated with increased vulnerability to risky situations or behaviors. Protective factors refer to all those individual, social and environmental characteristics that lessen the possibility that a person will engage in risky behaviors such as drug use, or if that person uses drugs occasionally, that it will grow into problem use. Note that protective factors are not always the opposite of risk factors.

Thus, it may be said that prevention programs that are based on a risk approach should identify the risk factors that may be present in the target population, so as to carry out strategies to attenuate their impact. Protective factors should also be identified.

Adoption of the concept of *protective factors* has enriched the usefulness of this approach, and, unlike the risk approach, has made it possible not to stigmatize persons using drugs, since the emphasis is placed on health promotion rather than on the prevention of possible harms. Protective factors facilitate the achievement or maintenance of health, and may be found in the individual himself, in the characteristics of his or her microenvironments (family, school, and so forth) and/or in institutions in the wider community (education, work, housing, and so forth).

Many of the risk factors for drug abuse are not specific to this problem of drug use. They are also present in other practices that lower the quality of individual and community life, and changing them is an important objective in prevention and education. The same may be said of protective factors, that is, circumstances such as social climate, family, school and positive friendships that help an individual avoid becoming a drug abuser.

3.3.1   Risk and protection approach at the individual level

Risk factors:

- Lack of information about the problem,
- Encouragement of competitiveness and individualism,
- Promotion of passivity and dependence,
- Existence of dominant relationships that are unbalanced and discriminatory,
- Lack of encouragement to participate,
- Lack of recreation, sports and cultural activities,
- Lack of a clear policy and rules on rejecting drugs,

- Availability of drugs,

- Inappropriate models of prevention and treatment,

- Poor training of professionals, teachers and community leaders in the area of drugs and a comprehensive approach to them.

Protective factors:

- Promotion of personal autonomy,

- Fluid, two-way communications,

- Encouragement of participation and reflection by community members,

- Promotion of solidarity and integration,

- Existence of coherent policies on drug use,

- Training of professionals, teachers and community leaders in a comprehensive approach to problem drug use,

- High quality of education,

- Employment policies,

- Health care coverage for all,

- Participatory work methods,

- Reinforcement of the positive values of the communities,

- Recognition of achievements, merit and mutual help,

- Existence of alternatives: recreational, cultural and sports.

The concept of risk is currently held to have been developed from a generally individualistic point of view that does not take sufficient account of collective issues, and that it should be complemented with other models.

3.3.2. Risk and protection at the community level

Risk factors:

- Crisis of values,

- Few educational opportunities,

- Rising poverty,

- Social exclusion,

- Unemployment,

- Prevention programs that are insufficient and not diversified,

- Presence of drug distribution networks,

- Trends in society that favor rather than limit drug use.

Protective factors:

- Effective programs to prevent drug trafficking and drug use,

- Support network of governmental and non-governmental organizations,

- Opportunities for study and employment exist,

- Promotion of human and social development,

- Non-dominating, inclusive relationships are present,

- Promotion of cooperation and solidarity,

- Establishment of relations of equality.

Even though the concept of protective factors has complemented that of risk factors, it has remained at a level of generality. It will be necessary to develop some aspects further and provide programs with more specificity.

3.4. Health promotion

The *Conference Health for All by the Year 2000*, convened by the World Health Organization (WHO) and held in Alma Ata, USSR in September 1978, adopted for the first time a broad definition of health, understood as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. This definition includes biological, psychological and social factors, thus creating the context for viewing health promotion as a matter of priority interest.

We may summarize the paradigm of health promotion by saying that it seeks to link individuals with their environments and to mobilize the community, meaning that people organize themselves and participate more actively. The perspective is one of intersectoral work and coordinated action by all those involved, such as government, the health sector, civil society and the media. In short, health promotion will be defined more broadly, since it aims to improve health in general, as well as the quality of life via actions to change the determinants of health (Restrepo and Málaga, 2001).

References to health promotion generally refer to the Ottawa Charter, produced by the First International Conference on Health Promotion held in 1986 in Ottawa, Canada, and adopted by 112 participants from thirty-eight countries. In that document, health was viewed not as an abstract state, but rather as a means of achieving an end, as a resource enabling individuals to lead personally, socially and economically productive lives. Health is a resource for daily life, and not the goal of life. It is a positive concept that stresses social and personal resources as well as physical aptitudes.

In the nineties, according to Czeresnia (2001), scientific discourse incorporated changes that had arisen in the paradigm of collective health. There emerged recognition of values such as personhood, concept of autonomy, and difference. It was an attempt to link up different levels and ways of understanding and apprehending reality, no longer taking systems of thought as the reference point, but rather the events that move people to design and intervene in their own reality.

Health promotion, therefore, as part of a new conception of public health, raises the need to go beyond the bio-medical model and consider the social and environmental influences on health and health-related behaviors. It may be said that prevention of illness and harm to health is part of health promotion, but health promotion goes beyond prevention. It is important to note that the concept of health promotion went through several stages. In the first instance, it stressed giving out messages as an effort to encourage people to form healthy habits. It then began to be related to individual lifestyles, changes in which would encourage behavior change. Finally, it was accepted that it is a concept that should be concerned with community. Changes must be made in the economic, social and symbolic living conditions of a group so that changes can be made in their health care.

3.4.1. Towards a model based on health promotion

It has often been said that prevention interventions should not merely give out information, but should also stress knowledge about how to prevent. In face-to-face prevention interventions, it is very helpful to prepare people to deal with situations that may arise. Small-group techniques, which favor interaction through role-playing, for example, are a valid strategy for producing changes in attitudes and intentions about behavior.

Health promotion thus operates on three basic models (Kornblit and Mendes Diz, 2004): *informational*, when information is given out; *empowerment*,[4] which encourages peoples' capacity to act on circumstances and identify the potential choices they can make, and third, *community,* which conceives of health on the basis of changes in the community achieved through collective action. It should be borne in mind that in order for promotion and prevention activities to be successful, it is important to work with the three models at the same time.

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[4] The process whereby individuals who participate in social development interventions are helped to strengthen their capacity to control their lives, by facilitating their access to resources and decision-making, and helping them see themselves as capable of participating in decision-making. Empowering people is an attempt to encourage their capacity to act on their circumstances, by means of participatory learning techniques that help them identify the choices they can make. Empowerment has traditionally been of women, so that they do not take on gender mandates that will lead them to attitudes of submissiveness. Finding greater self-affirmation in relations with their spouses or partners is a difficult task that requires continuity over time. The family and the schools are places in which these topics, as well as the possibility of self-care, should be dealt with.

A change in practices is achieved not only by persuasion and communication, but also requires that individuals participate in the process of change. It is has been clearly shown that the informational model alone is not enough to have people take steps to care for themselves. In order to change practices, attitudes and beliefs, it is essential that the individuals participate in the learning process. Working with this model means getting rid of the modus operandi of formal education, which is top-down and offers explicit models, and replacing it with one in which the learning process becomes a joint project in which openness to others and to one's environment becomes very important. The key is to listen, learn and understand, inasmuch as the idea of health is built by society in accordance with the different cultures.

According to the anthropologist Eduardo Menéndez (2005), it is not helpful to understand health as a finished state; health should, rather, be viewed as a collective process of health-illness-care.[5] These processes are at once organizing principles of daily life, and spring from the historical life of any society. This must all be thought of in a context of conflict and dispute among the various stakeholders, in which the various power relationships become evident and are related in complex ways with economic, social, political and cultural issues.

Bjarne Bruun Jensen (1997) proposes that health promotion activities should be conducted in four instances that make up a model that he calls *action-competence.* We describe each of these four stages below:

Knowledge/insight

Fosters the participatory construction of a coherent knowledge base about the nature and complexity of the problem as seen by individuals, and examines how it arose and developed, its consequences and the possibilities for conquering the problem. Rather than a mere passive acquisition of information, this definition revives the constructive, open meaning of education, which must begin with the individuals' prior experience and knowledge.

Commitment

Commitment is linked to the above, and is a bridge that ties together knowledge and practice. For that reason, the individuals' degree of involvement and genuine participation in the activities is one of the objectives that should be assessed.

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[5] The construction of the concept: health-illness-care cannot be understood outside of its sociocultural context, since the values, beliefs and expectations of a group are what define what each understands and lives as the health-illness process. This dynamic process also involves the ways in which population groups take care of and recover their health when it has worsened.

Visions/images of the future

From the outset of activities, it is essential that attention be paid to the individuals' differing visions of how they would like their lives and social and structural conditions to be. Developing and giving more texture to of these images of the future is essential to the involvement of individuals.

Action experiences

In order to delve more deeply into the problems and knowledge developed earlier, and increase people's commitment, it is essential that in the course of the entire learning process, specific actions be taken to change the social, structural and personal conditions identified as placing limits on wellbeing. Even though these experiences may come up against certain limitations (conditions that are outside people's possibility of changing them), they will serve to reformulate earlier views, making them more specific and improving their possibility of producing real changes.

If health and educational institutions carry out health promotion activities based on this type of thinking, new possibilities for dialogue open up among the people taking part in them every day, and will also incorporate ethical and aesthetic dimensions of life – the visions and images of the future.

3.4.2. Differences between the illness prevention model and the health promotion model

With the rapid development of medical science and technology, health quickly became an increasingly individual problem, characterized by a direct relationship between personal life styles and the prevention practices that were adopted. The primacy of the individualist approach, which makes individuals directly responsible for being or not being in "good" health, began to be questioned in the nineteen eighties, starting with the First International Conference on Health Promotion, organized by WHO, the Canadian Public Health Association, and Health Canada. The charter of that conference took up the definitions of health from previous documents, and revived the community, policy and sociocultural dimensions that influence health.

This approach produced another, which makes the State responsible for assuring policies to promote health. It is the State (or government) that must act to lessen social and economic inequalities in health. The State, however, cannot be responsive to and concerned about its citizens unless they take charge of and demand their rights. At the same time, the State must coordinate health policies that facilitate choosing healthy alternatives (policies on full employment, housing, health, transportation, among others), which could never be produced by stakeholders alone.

As stated in other sections of this document, prevention[6] and promotion are often seen working together in practice, but we must clarify that there is in fact a difference between the two. The ultimate goal of prevention is to prevent the onset and development of illness and conditions that

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[6] We refer here to prevention in general, but strictly speaking, we are speaking of non-specific, primary prevention.

are harmful to health in the broad sense. Since this idea is linked to the idea of health promotion, we give below a chart showing the main differences between the two.

Chart 2: Differences between prevention and health promotion

Category	Disease prevention	Health promotion
Idea of health	Absence of illness	Positive, multidimensional
Intervention model	Medical	Participatory
Target population	High-risk groups	Entire population
Strategies	Generally a single strategy	Varied and complementary
Approaches	Normative, persuasive	Awareness, training
Program goals	Focused on individual changes	Changes in status of individuals, groups and environments
Program executing agents	Health professionals	Social movements, cities, regional and national agencies, civil society organizations, grass-roots organizations, religious groups, neighborhood committees

Source: Adapted from Statchenko and Jenick (1990)

Despite the change implied in the new paradigm of health promotion, we have seen that the outcomes of the many experiences that have used this approach in recent years have not been all that was expected, since they continue to work only from the informational approach, neglecting the other two, namely, empowerment[7] and community.

As we understand it, the lack of correspondence between many of these actions and the health problems they are intended to address is the result, in large part, of dissociation between theory and practice. In these cases, underlying the health promotion model is the separation between body and mind that stems from the classic concept of the individual. This stands in the way of the

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[7] For a ciritical reading of the concept of empowerment, we recommend the publication *Promoción de la salud. Un instrumento del poder y una alternativa emancipatoria* by M. del C. Chapela Mendoza, 2007.

consolidation of the health promotion paradigm around a holistic view of the person. These specific actions must therefore go hand in hand with a change in the ways in which we conceive of individuals, health, illness and community (Camarotti, 2010).

Other, more radical criticisms of the health promotion model are summarized by Wald (2009), who explains that programs that work specifically on the basis of the health promotion concept, without resorting to joint prevention programs, are very few and far between in Latin America. In most cases, these projects have been unable to put innovative interventions into practice, and it is for this reason that some writers consider that health promotion in our region should go beyond talk and move to practical action (Grimberg, 1998; Paiva, 2006). The central problem is that although health is defined in terms of wellbeing, praxis continues to be organized around the concept of illness (Czeresnia, 2006). Thus, most of the programs carried out in health promotion are in reality prevention interventions, and respond, in the final instance, to theoretical models that are individualist and behaviorist (Restrepo and Málaga, 2001; Wald, 2005). Further, the desired intersectoral and transdisciplinary approaches have not been widely used, and as a result, health promotion programs are generally managed only by the health sector (Paiva, 2006).

In short, the lack of correspondence between many of these health promotion actions and the problems they seek to address is largely due to a gap between: a) the professional knowledge and practices that predominate in health and educational establishments on the one hand; and b) the multiplicity of lifestyles, forms of socialization and construction of identity on the other. The dominant institutional responses in this field tend to close rather than open up areas where they might meet (Di Leo, 2009).

In light of the above, we consider it necessary in our work to reorient this paradigm to a view that will be truly comprehensive. To do this, the concept of health must first be complemented and supplemented. Starting with the WHO definition of health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity", we should recognize that all things in a society at a given time that we describe as capable of producing a feeling of wellbeing belong under the rubric of health.

Health promotion should take account of these matters, which are grounded in the particularities of the groups with whom the practices will be carried out. The concept of health, then, should be understood in a broad sense, as one of the aspects involved in personhood. We begin with the idea of personhood as ways of being and living in the world; this concept emphasizes the idea of building identity based on linkages with others (Kornblit, 2009).

4. Basic principles of community-oriented early intervention, treatment, rehabilitation and social integration

This section of the document will review the social and health responses to problem drug use that are being used in various countries of the region.

The World Health Organization defines a drug as a substance that, when ingested, produces changes in cognition, affect, personality or behavior and can produce in the user the need to continue to use the substance. We should not forget that there are different ways of relating to drugs. Any of them can cause harm to individuals, if drug use becomes problematic.[8] Following El Abrojo's definition (2007), drug use may become problematic if it adversely affects –either occasionally or chronically-- one or more areas of life: a) physical or mental health; b) primary social relationships (family, spouse or partner, friends); c) secondary social relationships (work, study), and d) relationship with the law.

However, experimental or occasional use may also become problematic if the drug use is excessive, even for one time only. What is particularly problematic is the fact of having lost control of oneself, or while under the effects of a substance, having engaged in practices that are risky to self or to others (for example, driving a vehicle after having drunk alcohol, or taken another drug).

Romaní (1999) finds that a new phenomenon called drug dependence has emerged in contemporary urban industrial societies: an individual's use of one or more drugs, more or less compulsively, and the organization of his or her daily life around this fact. The substances involved in drug dependence may be illicit (cocaine, marijuana, crack, Ecstasy, cocaine paste) or licit (alcohol, tobacco, psychoactive drugs). In this first part, we shall not discuss the work being done in the areas of prevention or health promotion, but rather the responses being used in cases in which drug use has become problematic and/or addictive.

As stated in the report of the Argentine Scientific Advisory Committee (2009),[9] of the universe of people who use drugs, the great majority will not engage in problem drug use. Problem drug use will occur among individuals who are in a particular situation of biological and psycho-social vulnerability. For those who are not using drugs, specific and non-specific universal prevention should be used. For those at a higher risk of beginning to use drugs, selective prevention and health promotion can be the approach used. For those who are using drugs and whose drug use is not problematic, indicated prevention measures, which are specific and specialized, should be used.
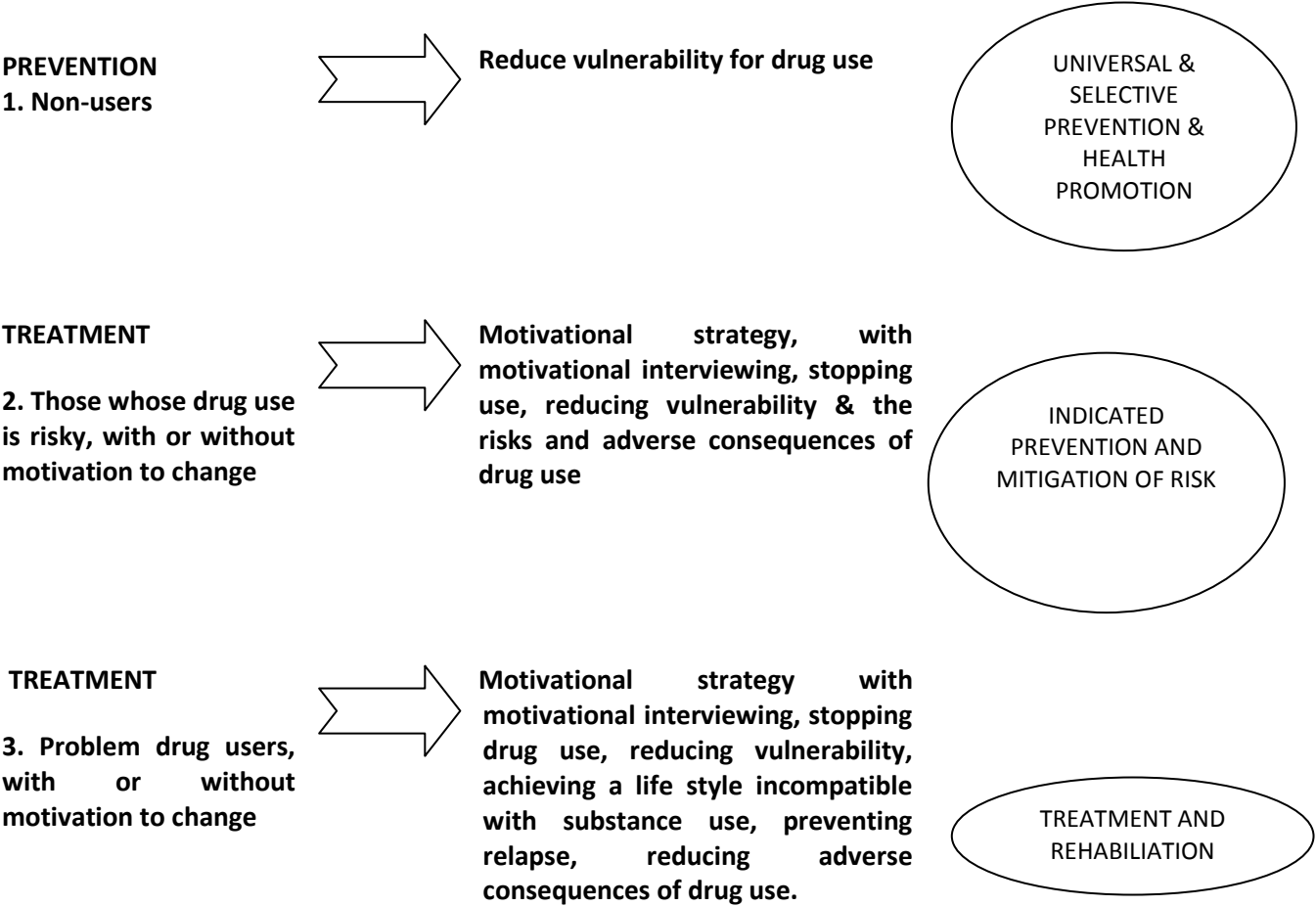
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[8] It is important to refer to the tenth edition of the WHO International Classification of Diseases, which classifies mental and behavioral disorders due to substance use under its classification F19. These disorders are as follows: acute intoxication, harmful use, dependence syndrome, withdrawal state, withdrawal symptom with delirium, psychotic disorder, alcohol or drug-induced amnesic syndrome, alcohol or drug-induced residual psychotic disorder and late-onset psychotic disorder, other mental or behavioral disorders induced by alcohol or other psychotropic substances, and finally, alcohol or drug-induced mental or behavioral disorders.

[9] Scientific Advisory Committee on the Control of Trafficking in Narcotics and Psychotropic Substances, and Complex Crimes against Drug Users and Policies to Address them (Argentina, 2009). (Spanish only).

Drug dependence occurs in individuals who increase their drug use, quantitatively and qualitatively, to the point where they have no life plans beyond substance use. Their autonomy is seriously compromised. Self-administration of substances no longer gives them pleasure, even though they seek it without success, but is mainly focused on avoiding unpleasantness. These persons need appropriate treatment. Treatment interventions should allow for many options, given that there are many different situations which, in addition to structured treatment and rehabilitation matched to different profiles, should include measures to mitigate the risks and adverse consequences of drug use.

The figure below summarizes the different levels of demand reduction.

Demand reduction: a true holistic approach based on diversity

PREVENTION **1. Non-users**	⟹ **Reduce vulnerability for drug use**	UNIVERSAL & SELECTIVE PREVENTION & HEALTH PROMOTION
TREATMENT **2. Those whose drug use is risky, with or without motivation to change**	⟹ **Motivational strategy, with motivational interviewing, stopping use, reducing vulnerability & the risks and adverse consequences of drug use**	INDICATED PREVENTION AND MITIGATION OF RISK
TREATMENT **3. Problem drug users, with or without motivation to change**	⟹ **Motivational strategy with motivational interviewing, stopping drug use, reducing vulnerability, achieving a life style incompatible with substance use, preventing relapse, reducing adverse consequences of drug use.**	TREATMENT AND REHABILIATION

A high-quality prevention program should be conceived as long term, should mobilize the relevant stakeholders and institutions, and have clear goals. There is evidence in the literature that the better planned and designed programs are those that receive better evaluations and are more effective than programs carried out without planning or a theoretical basis. These are nearly always programs that use social influence models (working with normative beliefs, social skills), behavioral norms, motivation or self-control.

In the following section, we shall address points 2 and 3 above, that is, those persons who have begun to use drugs and have developed a risky and problematic relationship with drug use, which means that they need some type of treatment or intervention. It is therefore essential that treatment be available, accessible, timely, individualized of good quality, and effective.

Having available a set of multiple responses means that individuals whose drug use is problematic may move through treatment at their own pace. In 2006, NIDA made some suggestions about the treatment of drug users: it said that the provision of services should be individualized and respond to individual needs. Treatment should consider age, gender, ethnic and cultural origins of the users, and the severity of the problem. Services should be provided either individually or in groups, depending on the user's response. It also suggests that treatment should last for a minimum of three months, and that the drug user should receive a series of supplementary services, that is, treatment should focus not only on changing the pattern of substance use.

4.1. Summary of social and health responses to problem drug use

As we said earlier, the complex nature of problem drug use and the multiple contexts in which it takes place require a variety of interventions that provide different responses that complement each other and that share the concern to create a comprehensive system of care that brings together the various different responses.

The heterogeneity of health care responses causes difficulties when we try to find criteria for classifying the treatment facilities. We think it useful to order the classification by low or high threshold program goals.

Table 1. Social and health responses to problem drug use, organized by treatment goals

Treatment goals	With a community approach	Without a community approach
Low threshold	• Programs using motivational strategies, mitigation of risk & adverse consequences of drug use	• Motivational interviewing • Brief intervention. • Some psychotherapeutic approaches
High threshold	• Some therapeutic communities • Psychiatric clinics • Half-way houses • Narcotics Anonymous & Alcoholics Anonymous	• Most therapeutic communities • Some psychotherapeutic approaches • Day/night hospitals • Detoxification programs

We understand *low threshold* programs to be those whose main goals are to use an effective motivational strategy, to include motivational interviewing, to mitigate the adverse consequences of problem drug use on the individual and on social groups, and, as far as possible, to leave them in a position to begin structured treatment. These programs do not necessarily aim at having the individuals stop using drugs, but rather at encouraging improvements in their quality of life. They are geared to people who are not very motivated to change and to stop using drugs, and who have perhaps gone through some other type of treatment that was not effective for them; they may be people with significant physical and or mental deterioration, problems of exclusion, lack of social support, difficulty in obeying the rules. These programs may at times be the gateway to other, higher threshold social and health responses.

High threshold **programs** are those that focus on the possibility of holistic development of the person who uses drugs, based on his or her abstinence from drug use and achieving a lifestyle that is incompatible with drug use. They are geared to individuals, motivated to change, whose problem drug use is very seriously affecting their lives and surroundings,   High threshold treatment includes all programs designed for problem drug users at different levels of severity and different bio-psycho-social compromise, and different populations (adult males, adult females, adolescents using a gender approach, people living in the street, offenders, and so forth). They are delivered in a variety of therapeutic facilities, whether private or public, outpatient or inpatient hospitals, with ongoing psychiatric and other periodic monitoring. The initial outpatient contact may take place in primary health care facilities, where a diagnosis is made of the type of drug user. If the user is at risk, a brief intervention is carried out, including motivational interviewing and resolves the

situation. If the person's use is problematic, a brief intervention is conducted, with motivational interviewing and he or she is referred to specialized treatment matched to the level of complexity. If the problem drug user has a moderate bio psychosocial disorder and is motivated to begin treatment, he or she is referred to a basic outpatient program, which may be given in a public or private facility (mental health and/or addictions outpatient center), which has a specialized team in place to address this profile. If the problem drug user has a moderate to severe bio psychosocial disorder and is motivated to begin treatment, he or she is referred to a more intensive outpatient program, which may be given in a public or private facility (outpatient therapeutic community, day center or hospital), with a specialized team that is more robust than the former, and that is equipped to address this profile. If the problem drug user has a severe bio psychosocial disorder and is motivated to begin treatment, he or she is referred to a residential or in-patient program, which may be given in a public or private facility, with a robust specialized team, in a drug-free environment, which is appropriate for this profile. If the problem drug user has a severe bio psychosocial disorder, is motivated to begin treatment, and also presents with severe intoxication and is unable to stop drug use and/or has a severe decompensated psychiatric comorbidity, he or she is referred to a short-stay program of ongoing psychiatric monitoring, which may be given in a public or private hospital setting (public psychiatric hospital service or psychiatric clinic), with a highly competent specialized team, in a drug-free environment, which is appropriate for this profile. If the problem drug user has a severe bio psychosocial disorder and presents with a physical emergency (acute intoxication, overdose), he or she is referred to the emergency service of a general hospital. If the problem user has a severe bio psychosocial disorder and presents with a psychiatric emergency, he or she is referred to a psychiatric emergency service of a general hospital. Self-help groups are non-professional groups that are of enormous help in treatment, but are not considered to be treatment per se.

All treatment teams, regardless of the level of complexity, should have competence in drugs and alcohol, motivational interviewing and motivational strategy, psychiatric and physical comorbidity (dual diagnosis or dual pathology), gender, human development (childhood and adolescence, family (family intervention and family therapy), criminology (for offenders), high level of social vulnerability (ethnic groups, culture, territory and community), and social integration.

A community approach covers programs that take into account the social, cultural and economic context in which people who use drugs live day to day, and involves the networks that make up a person's social fabric in a response.

Treatment is understood as a set of interventions and strategies that have the goal of helping people overcome their problematic relationship with drugs. Treatment facilities include all

therapeutic institutions, public and private, whether specialized or not in addressing problem drug use, to which individuals come asking for treatment for a problem of psychoactive substance use. Treatment activities are provided in a framework of medical, psychological and social care, with defined goals directed to the mitigation or elimination of the problems.

Treatment of drug dependence usually consists of an initial phase of detoxification or stopping drug use and overcoming withdrawal symptoms, and a second phase of breaking the habit, in which the main goals are to prevent relapse and achieve a life style that is incompatible with the use of drugs. Physical and psychiatric complications are also addressed in the cessation process, along with family, social, legal, work and educational needs, among others.

Treatment centers are the core around which care is provided to people who have drug use problems. Treatment centers usually perform the following functions: assessment and diagnosis of the patient; detoxification and outpatient; health education and counseling to reduce the risks and harm associated with drug use; basic urgent health care; prevention of infectious and contagious diseases; monitoring of infectious diseases, physical pathologies and comorbid mental disorders, in close coordination with the general health care system; coordination, support and actions to address the personal, social work and legal needs, among others, of persons presenting with drug use problems, in cooperation with existing community resources.

4.2. Specifics and differences in responses to problem drug use

4.2.1. Low threshold treatment programs

Programs to mitigate the risks and adverse consequences of drug use

Mitigation of the risks and adverse consequences of drug use is understood as a process that does not give up on motivating the user to stop using drugs, but failing that, also seeks to reduce drug use, and have the individual participate in programs that promote health prevention. To understand these programs, we should look at two types of goals: the short-term goal of attempting to prevent the problems or conflicts provoked by drugs (for the individual, the community and society), and the long-term goal that seeks partial, or if possible, total abstinence from drug use.

Programs that seek to reduce the adverse consequences of drug use start from the difficulty that many people have in stopping using. This approach can therefore be understood as complementing the work done by treatment services to achieve abstinence.

Programs to mitigate the risk and adverse consequences of drug use deal not only with drug use per se, but also with the individual and societal damage that comes hand in hand with drug use; they also bring drug users into contact with health facilities and access to care, seek to reduce morbidity and mortality, prevent communicable diseases and improve drug users' quality of life by providing access to information and prevention.

Psychotherapeutic approaches

Brief intervention

The concept of brief intervention covers a range of various therapeutic activities. Operationally, brief interventions may be defined as a time-limited intervention that is shorter than treatment. In general, it is not expected that the individual will seek a brief intervention, but rather, the contact opportunity is used to motivate, among other goals. El sense is to mobilize an individual's personal resources toward a change in behavior.

The concept includes interventions that are directed to individuals who are not seeking the help of specialized professionals, and that take place at an opportune moment in primary care or other non-specialized settings. This type of intervention is done by doctors or other health professionals such as nurses or social workers. Brief intervention may be of two types:

- *Simple*: structured advice lasting only a few minutes. It is sometimes called a minimal intervention, and at others, a simple advice.

- *Complex or extensive*: structured therapy normally requiring 20-30 minutes in the first instance, and more than one intervention over time. This is sometimes called brief therapy.

Individual therapy

The goals of individual therapy are, *inter alia*: to identify and treat psychological conflicts; stimulate the drug user's motivation and commitment to recovery through treatment; work on the circumstances that prevent abstinence; help change significant areas of psycho-social functioning, and examine beliefs or feelings that may be producing emotional instability.

Therapeutic groups and group workshops

This setting should allow for work on different topics, either by putting a conflict into words, or through self-expression: painting, writing, music, psychodrama and other techniques. The workshop experience enables the participant to become an active agent in his or her individual and

collective process. At the same time, each patient's particular history and mental condition will require individual, specific paths. Group workshops are dynamic, forge solidarity, and facilitate individual change, and can operate both on and individual and small group level. The workshop experience changes the participant's role and makes him an active agent who is responsible for his own processes, and at the same time, encourages him to develop the critical thinking that is so necessary to making decisions leading to healthy, holistic behavior. Holistic health covers both affect and behavior, so as to help the person develop the skills to deal with conflict situations that arise in his life and build social ties.

Thus we see the need to conduct workshops that address an individual's different spheres of life–artistic, work, educational–and that give him or her the tools he needs to be part of the society in which he happens to live (Foundation Convivir, Argentina).

4.2.2. High threshold treatment programs

Socio-therapeutic settings may be inpatient or outpatient. They work with groups, individuals and families, and seek to repair the physical, mental and social damage caused to the drug user, whether or not related to substance use, and also rebuild ties to enable him to take his place in society; this involves many actions that include an assessment of how the individual is integrated into society assessment of his employment competences, and job training. Therapeutic programs work in different areas that are coordinated amongst each other. The length of each modality is in accordance with the needs and requirements of individuals entering treatment.

We discuss below the different characteristics of each type of program as offered by treatment centers:

Outpatient treatment may be offered in various health facilities, both public and private. These treatment programs are delivered in the following ways: basic outpatient, community outpatient, and intensive outpatient are designed for people with different levels of severity, both in terms of problem drug use, and in terms of bio-psycho-social compensation.

Basic outpatient: may be delivered in primary health care facilities as well as in mental health and/or addictions outpatient centers.

Community outpatient is geared to people that are highly socially vulnerable or living in the streets. It may be delivered in primary health care facilities, as well as in mental health and/or addictions outpatient centers, and has a component of proactive involvement in the community, and not just in the center itself.

Intensive outpatient plan: May be given in mental health and/or addictions outpatient centers, "day hospitals", and/or outpatient therapeutic communities.

Day hospital: is similar to a therapeutic community. The goal of this phase is to have the patient maintain abstinence from drug use, become aware of his problem, and develop mechanisms of caring for his physical, mental and sometime spiritual integrity. When this phase is over, he should continue with social insertion or outpatient treatment. This modality of treatment is geared to those problem drug users with a severe bio psychosocial disorder, severe but compensated psychiatric comorbidity may or may not be present and who meet the conditions of family support so that they may spend the night at home.

Night hospital: the resident must comply with treatment guidelines just as in a day hospital. The difference lies in the fact that he has a job, but not sufficient family support. The resident sleeps in the community, and has two group sessions per week, which are supplemented by individual and family discussions.

Weekly groups: Geared to those who do not need to be in residential care, who are in a basic outpatient plan and/or an outpatient community plan, or to those who already went through the inpatient phase. The tools used are: group therapy, family therapy and recreational therapy. The treatment sessions work with the patient and particularly with his family. The program offers different settings that help to consolidate and strengthen relationships between the two, so that they may together prevent the possibility of relapse into drug use.

Narcotics Anonymous/Alcoholics Anonymous or other self-help groups are not considered to be structured professional treatment, but are groups much needed in supporting treatment and helping in recovery, among other activities.

Residential treatment programs may be offered, inter alia, in a therapeutic community or in an inpatient (residential) center that does not operate as a therapeutic community.

Therapeutic community: This modality uses a staged intervention model, divided into three phases of treatment: adaptation, treatment, pre-release and follow-up (or aftercare), in which the levels of individual and social responsibility are progressively increased, in addition to a process of repairing the drug user's physical, mental and social harms associated or not with drug use. Peer intervention, introduced via different group processes is used as a tool to help residents learn and assimilate social values and skills. Rules are clear and very much present, and are reinforced as they are satisfactorily complied with over the changing phases; this seeks to develop self-control and responsibility in the people who live in these institutions.

These specialized facilities are geared to persons who have difficulty in dealing with breaking their drug habit in an outpatient setting (they may have long histories of addiction and many relapses, severe dependence, poly-drug use, a history of previous failures in less intensive treatment, compensated psychiatric comorbidity, serious legal problems and/or lack of social support).

As stated in a paper produced by Fonga (Argentina, 2010), treatment in therapeutic communities is often geared to people with severe deterioration not only because of their compulsive drug use but also because of a serious crisis in their social contexts and family groups. This means that the minimal conditions of support and care that can be provided by these contexts have deteriorated to the point where the individual's life and physical and emotional life is in serious danger, particularly when those affected are children and adolescents.

Treatment in a medically monitored program

These programs consist of an in-hospital detoxification under medical monitoring and a plan to treat dual diagnosis (dual pathology) or severe psychiatric comorbidity. Such medical monitoring plans may take place in the psychiatric service of a general hospital, in a psychiatric hospital, or in a psychiatric clinic.

Detoxification programs (may be delivered in three ways):

- At home: a professional goes to the individual's home to supervise the detoxification. This requires great cooperation from the family.

- Outpatient: the individual goes to a center, accompanied by someone he trusts, in order to undergo detoxification.

- Hospital: is done in a hospital, and lasts for fifteen to thirty days (called short-stay). Is used when dependence is severe or there is a severe, not acute, intoxication with one or several substances; there may or may not be psychiatric comorbidity, and family support may or may not be present. Acute intoxication is to be effected in a medical emergency service of a general hospital.

- Severe psychiatric comorbidity and psychiatric emergencies are to be addressed in a psychiatric emergency service (including suicide attempts and psychomotor agitation).

Breaking the habit: Is a process geared to breaking the psychosocial dependence on a substance. The individual must change her lifestyle. This may be offered in three settings:

- In an outpatient center: the person goes to the center when necessary, which enables the dependence to be addressed in his or her own environment.

- In a therapeutic community or inpatient center. This is suited to more complex profiles, as already explained above.

- Day center: the individual goes to a center during the day since outpatient care is insufficient, but a therapeutic community or inpatient center is also not the most appropriate for this level of complexity as described above.

Comprehensive, precise diagnoses are essential, since they allow for correct referral according to the individual therapeutic needs   An interdisciplinary diagnostic assessment must therefore be carried out, and intervention models delivered in accordance with that diagnosis, leading to different instances of psychosocial support and therapeutic approaches.

Drug-related problems should be understood as part of a "path that has interruptions, twists and turns, reversibility of the process" (Kokoreff, 2004), with moments when achievements are consolidated, and others where there is slippage backward.

The history of drug use and the successive treatment episodes of persons using drugs, which make up the individual path of treatment, are not always listened to or heard by the specialists in the services consulted. Thus, we should question the bias involved in the idea of "an addictive career"[10] and the idea in some facilities that they should begin from scratch in each treatment episode.

We describe below the theoretical and conceptual bases for policies on drug prevention and treatment.

5. A holistic community-based model for drug demand reduction

5.1. Towards the construction of a holistic community-based model

Drug use has generally been examined from differing disciplines, often characterized by a fragmented view of the phenomenon, as demonstrated by earlier responses. As stated earlier, we start from the assumption that drug use is a complex matter, which cannot be addressed in isolation from the social contexts in which it takes place; this leads us to require creative, flexible responses that take a transdisciplinary, multisectoral view in which economic, social, psychological,

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[10] "Drug use career" or "addictive career" are understood as an unstoppable escalation of drug use, in which the person begins by using less harmful substances and goes on to "harder" drugs; this is in contrast to the idea of "drug use patterns", where there are differences between use, abuse and dependence, on the understanding that drug use may become more or less stable throughout a person's life.

cultural and medical theory and practice converge with perspectives gained from experience and lessons learned.

For this reason, responses should be developed together with the groups that are experiencing the problems, so that the responses can be geared to the circumstances and situations that gave rise to them.

A holistic community-based model should start from the idea that the meaning given to drugs is determined not only by their pharmacological properties, but also by the way in which a society defines the use of drugs and by the prevention and intervention strategies it uses. The basis on which it rests is that a prevention policy cannot be removed from the socioeconomic structure or from the psychological and cultural issues of drug users.

Possible causal factors in the massive emergence of drug abuse may include: urbanization and industrialization without adequate planning, and the meanings that individuals and societies attribute to drug use—that is, the place that these practices hold in the history of social groups and the way in which they are intertwined with affect, emotion and experiencing pleasure and pain, as well as the inequalities, lack of opportunity, exclusion, vulnerability, poverty, unemployment, school drop-out, discrimination, illiteracy, stigmatization of those who use drugs regardless of their socio-economic level, and lack of dignified housing.

This is a model less frequently used in today's society, and it is therefore unusual to find explanations of drug abuse that take these issues into account. This model emphasizes the meanings that individuals give to risk and health care practices as a result of belonging to particular social and cultural contexts. The holistic concept proposed by Roseni Pinheiro and Ricardo Burg Ceccim appears very helpful here:

> Linking concepts, perceptions and sensations in order to generate knowledge about holistically-based practices requires us to take a critical and creative stance that will enable us to recognize possibilities and take up the challenge of an "opening to what is possible". Such an opening up will emerge from the meeting points we establish between the known and the unknown, and give rise to "experiencing" something, rather than imposing what is already known onto what is unknown. (Pinheiro and Ceccim, 2009: 23).

The history of the holistic community-based model that we are proposing can be traced back to the last decades of the twentieth century up until today, when interventions and approaches have tried to relate health questions to structural dimensions and subjective experiences, by contrast to what was defined as the dominant medical model.[11] Thus, a community-based model seeks to

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[11] The *medical dominant model* is a concept proposed by the Argentine anthropologist Eduardo Menéndez. It refers to the health care system organized by bio-medicine, and is defined as "the set of practices, knowledge and theories generated by the development of what is known as scientific medicine". The model sets the following as the main parameters for understanding and acting on health and illness: a) focus on biology, ahistorical and asocial, that is, it reduces individuals to their physical dimension and removes them from any social, historical or spiritual condition; b) idea of illness as a breakage, deviation and difference, and health as the statistical normal; c) curative practice based on

expand the paradigm that began in the social sciences of collective health, social medicine and health promotion, putting them all together but with an emphasis in the work on the dimension of community.

A holistic, constructivist view of health seeks therefore to enable individuals and collective actors to participate actively in redefining health: by deconstructing and thinking about the socio-structural determinants and their influence on practices, individuals begin to develop their potential for changing both elements into a wellbeing that is constructed and reformulated on the basis of their own experiences (Jensen, 1997; Kornblit, 2009).

Unlike community-based treatment that seeks to ensure broader coverage and greater adherence to drug treatment by individuals, families and groups where established (institutional) responses did not produce the anticipated results, or gave results that were unsatisfactory, (Milanese, 2012), the holistic community-based model seeks to construct spaces for linkage, meeting and empowerment for social groups (whether or not they are highly socially excluded) where they too are responsible for charting the road ahead, either on their own initiative or else by joining in work initially begun by other groups (professionals or not).[12]

It is the stakeholders who must construct the possible responses—together with agencies of the State—based on what exists and on what can be generated. This approach understands that drug use problems are not the problem only of drug users and their families, but that it is the community as a whole that needs to be involved. If we understand this, we become part of the problem and of the solution. By community we understand, in the words of Efrem Milanese (2009; 2012), the system of inter-relationships established between an individual (the subjective dimension), the group (interpersonal dimension, informal networks), and institutions (interpersonal dimension, formal networks) that are part of any given geographical area. The local community is, therefore, the set of social networks that define and give life to a particular geographical area. Milanese summarizes the central elements of a community as follows: a set of networks that define a geographical area (giving dynamic and original form to the local dimension[13]) and that organize it (contribute to constructing its culture and what it produces).

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eliminating the symptom; d) assymetrical relationship between doctor and patient, with social and technical subordination of the patient; e) health-illness as traded goods, with a tendency to induce medical consumerism; f) medicalization of problems; and g) ideological identification with scientific rationalism as the manifest criterion excluding other models. In general, it is a mechanistic conceptualization of the human being, which leads, inter alia, to the separation of mind and body, and of the individual, society and the universe; to the search for certainties and absolute truths; to the belief in linear causality as the only form of relationship, and to undervaluing personhood. (Menéndez, 1990; 2009).

[12] These groups are made up of people with different training and/or experience in community work who have been able to systematically document their experience and knowledge and put together an overall picture of the process. This means that new groups that take on this type of process will not venture into practices that other experiences have already shown not to be effective. In any event, this is a process and as such, should be constructed along the way.

[13] "Local" refers both to the geographical or spatial and to the cultural or symbolic dimension.

Networks are by definition flexible and open, and communities are therefore also flexible and open.

We are not trying here to make the communities responsible for having to provide the proper solutions to these problems; rather, we consider that an approach of this type should help the community to come together and move forward with what exists, with what needs to be improved, and with what is lacking.

The aim of the holistic community-based model is to prevent and promote health, and in order to do so, it tries to anticipate the problems that drug use may cause. Its emphasis is therefore basically on non-specific prevention, but expanding it with the developments in health promotion. When health promotion is referred to, it is generally linked to the Ottawa Charter, produced by the First International Conference on Health Promotion held in 1986 in Ottawa, Canada, and adopted by 112 participants from thirty-eight countries. That document considered health not merely as an abstract state but rather as a means to an end, as a resource that enables people to live individually, socially and economically productive lives. Health is a resource for daily living, and not the goal of life. It is a positive concept that accentuates social and personal resources as well as physical aptitudes.

This model does not ignore health care and/or treatment, but indeed seeks to address them together as one. Health care and treatment should ensure that people's *spontaneous demand* is coordinated with the availability of *State and civil society* responses to the problem.

This approach seeks to understand and give due value to all proposals for health promotion, prevention and/or treatment that have demonstrated some effectiveness, and not replace any of them but rather include new alternatives. It tries to encourage dialogue, exchanges and openness among the different response levels, but does not lose sight of the minimum quality standards that they must meet in order to be included. This approach also seeks to identify strengths, weaknesses, obstacles and lessons learned from implementation.

This holistic model of a community-based approach rests on four inter-related ideas:

1. Empowerment, defined as the mechanism or process whereby individuals, organizations and communities take charge of their lives, by developing their capacities and resources, in order to transform their environment in accordance with their needs and aspirations and at the same time, transform themselves (Montero, 2003, Chapela Mendoza, 2007).

2. *Social participation*, according to Muller (1979), helps people develop their creative capacities, express their needs and demands, defend their interests, fight for clear objectives, involve the community in its own development, and participate in shared control over decision-making.

3. Associativeness, defined as the density of the social fabric, of relations among individuals and among groups and organizations, which produces in the members of a community relational practices of care, safety and protection.

4. The *sense of community* refers to the community members' feeling of belonging, who feel that they are important to the group and share an emotional connection.

An approach that seeks to work holistically on the problem of drug use should have the goal of coordinating its actions with other individual and societal stakeholders: the health, education, social and economic development, employment, security and justice sectors. It should be remembered that this must be a two-way street: a) inwardly, attracting all the stakeholders, institutions and networks that are working directly on the problem, and b) outwardly, reminding the other sectors of the topic of drug use, and participating in any coordinating bodies.

Bearing in mind that a basic characteristic of modern societies is a decline in social participation as expressed in large part in a waning of the rituals that linked people to each other, socio-community programs favor social mobilization, particularly "relinking" people", that is to say, developing group identities and a sense of belonging. Involving people in collective activities challenges individualism and apathy, and therefore overcomes the breakdown of society and favors the autonomy of individuals and groups (Menéndez, 2006).

Community psychology offers a useful framework for looking at these issues, since, as Lapalma y Delellis say (2012), it rests on five basic points: a) the need to include people in the social interventions that involve them; b) have the goal of changing social and environmental conditions that are obstacles to full development of individuals and communities; c) the goal of anticipating consequences or harms that may stem from those conditions, that is, the prevention approach; d) the goal of human development and the wellbeing of persons and groups; e) recognize the dimension of power.

Most useful in achieving this goal are what are called "participatory policies" (Giorgi, 2012), which rest on three basic ideas: the active role of individuals as rights-holders, building citizenship that goes along with that, and achieving autonomy.

Strengthening social mobilization, the sense of community and the empowerment of the community produces a growing "associativeness", defined as the creation of networks and organizations (Torres y Carvacho, 2008; Krause et al. 2012). In the context of the Eco2 proposal, a social network is a field of relationships that people establish in a particular time and place (Milanese, 2012). This meeting place enables people to construct their identity and be acknowledged by others in their own context. Thus, a social network may be thought of as a self-reproducing system, which reproduces not only its structure but also its component parts (individuals). For this reason, no component part exists independently of the others, but all are the products or outcome of the system. (Machín, Velasco, & Moreno, 2010:111 in Milanese, 2012).

The chart below shows the characteristics of what we call the holistic community-based model, by contrast to what we call the normative-moralizing model (also understood as the medical dominant model (Kornblit, Camarotti, Di Leo, 2010, 2012). This table summarizes two very different approaches to this type of problem.

Table 3. Models for addressing social problems

Dimensions	Normative-moralizing model	Holistic community model
Idea of health	• Closed category: model of medical dominance (Menéndez, 2005) geared to illness • An individual problem	• Open-ended category: critical of the medical dominance model • Personal and community experiences and conditions • The common good – right to health
Goals of community-based action	• Promote changes in individuals by intervention in their immediate environment, seek to modify patterns of behavior. • Attempt to prevent risks and/or harms.	• Stress the mutual influence among individuals & their environments, and encourage thinking about the problems of macro-structural and exclusion factors, prevent problems from becoming "natural".
Concept of the individual	• Passive beneficiaries/recipients of social interventions. • Individuals centered on self	• Holders of legal rights participating actively at all levels of community action. • Concept of inter-relations among persons/the struggle for recognition
Operating framework	• Promotes health as a role model • Community participation: medical professionals participate in institutions by giving talks or speeches • Promotes individual improvement (self-esteem, development of skills, resilience), which means searching for individual solutions to collective situations.	• Is based on the four components of the action-competence model (Jensen; 1997). [14] • Strengthening of the individual and the collectivity, bearing in mind power relationships. • Creation of networks among collective actors. • Promote critical awareness and the recognition and exercise of rights. • Posits participation as a right, and views decision-making as a joint endeavor, redefining the role of professionals as dialogue with the community. • Increase people's sense of belonging to their communities.

Source: Kornblit *et al.*, (2012).

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[14] Further developed on page 20 of this document.

By way of example, we may note how the holistic concept was incorporated into the Constitution of Brazil in 1988, on the basis of the Brazilian Health Care Reform. This concept is defined as:

- Integration of actions in the health field to promote, protect, recover and rehabilitate

- Professional practice that includes biological, psychological and social dimensions to guarantee continuity of care

- Coordination of public policies through intersectoral action, so as to impact the determinants of health and standards of living.

Using these postulates, health services working with a holistic approach adopt certain premises:

- Priority of prevention and health promotion

- guaranteed care at the three levels of complexity

- coordination of prevention, promotion, care and rehabilitation

- a holistic approach to the individual and the family

5.2. Addressing social vulnerabilities

Taking up the proposals by Ayres *et al.* (2008), we find that a concept that has been shown to be useful for this type of approach is the idea of *vulnerability*, which seeks to make more visible those groups and individuals who are socially, politically and/or legally fragile and to promote, protect or guarantee their rights as citizens. This concept was introduced into public health as a result of the intersection between AIDS activism and the human rights movement, as an effort to move beyond the notion of individual risk and adopt a new perspective of social vulnerability.

The epidemiological concept went from being the group at risk to risky behaviors, which tends to remove the weight of stigma from individuals, broadens concern over the problem, and fosters active involvement in prevention. Thus, this concept makes it clear that a change to protective behavior is not achieved merely by information and willpower, but rather with cultural, economic and legal resources that are currently unequally distributed among groups.

Vulnerability analyses do not supplant epidemiological risk studies. Finding probabilistic correlations between the distribution of drug use in the population based on different objectively measurable conditions such as sex, age, profession, sexual practices, etc., will continue to be an important source of information. It is not a question of accepting risk as a condition determined by poverty or lack of resources, but rather of not being satisfied with the lack of options, of which risky behavior is only one expression.

Vulnerability is not binary, but rather multidimensional and relational; it is not unitary, for there are always gradations; it is not stable, but changes constantly over time, and individuals are not by nature vulnerable, but rather are in a *state of being vulnerable*. Attempts to reduce vulnerability have tried to expand the goal of the interventions from the individual level to the societal level. A constructive attitude is best in helping people find and appropriate the type of information that makes sense to them, mobilize themselves, and find practical alternatives that will help them overcome the situations that are making them vulnerable.

François Delor and Michel Hubert (2000) propose looking at vulnerabilities as a process—and not as a snapshot of a situation--and examining the connections between the individual and society from three inter-related points of view:

a) *individual life courses*: take into account people's different biographies, that is, the events, facts and situations that were turning points in their lives and that must be considered if we are to understand the changes in their practices and/or levels of exposure to risky situations;

b) *links and interactions*: risky practices require that at least two people come together, acting on the basis of their own experiences, the positions they hold in the interaction and the type of relationship they form with each other;

c) *socio-institutional contexts*: social, political and cultural norms and institutions condition and mediate the practices and relations among individuals, by providing or denying them access to certain resources and capital and therefore affecting their levels of exposure to risky situations.

5.3. Knowledge and practices in care: a broader category

Practices in health and other types of care come about in direct relation to vulnerabilities. One way of reducing vulnerabilities is to increase the possibilities of generating practices of care. The notion of "care" has been directly or indirectly related to the health care system. However, we cannot ignore the fact that it also includes other practices and knowledge, and other ethics.

This understanding of care requires beginning with a particular geographical area, that is to say, we must understand that it is all of the social actors that are part of the community space who receive and carry out practices of care on themselves and with others. "Care" can be understood only on the basis of relationships among people. It is therefore important to give new meaning to the work being done in this area. Individuals construct and establish practices of care beyond the health care centers, and this often translates into more effective forms and outcomes of care. The reason may be that this type of practice generates more sensitivity, trust, sense of belonging and peer-to-peer feeling, which translates into greater wellbeing.

It is in this sense that we propose networks as a form of *relational care*. Networks are the expression of the links that exist between people, and are a community's principal resource, but we cannot ignore the fact that they may also be the source of suffering and exclusion from society.

These networks, which often already exist in the community, need to be made visible and the linkages strengthened, so that we may reclaim and understand the care practices that are both present and absent in the community (Milanese, 2012).

5.4. General considerations and a step-by-step approach to holistic community responses applied to drug demand reduction

5.4.1 General considerations

The work plan should not forget the characteristics of the holistic model of a community approach. We summarize below the basic aspects:

- Understanding drug use as a multidimensional process in which the substance, the person's individual processes and the organization of society all interact with each other.

- Emphasizing prevention and health promotion in a group, rather than individual care.

- Always working to promote community participation in projects and interventions.

- Begin by reducing the harm associated with drug use, in order to change individuals' relationship to and/or stance towards drugs.

- Identifying and working towards changing the conditions or circumstances that favor or facilitate the use of drugs, in an effort to strengthen safety and relationships and promote participation and autonomy.

- Working across sectors or agencies to strengthen networks in an effort to produce more and better results, and share responsibilities among the different sectors.

- Attempting to understand the world view of the people to whom the programs are directed, since the lack of a shared vision makes it difficult for the interventions to be relevant and pertinent.

- Respecting the agency of individuals and groups, and trusting the capacity of vulnerable people to produce ways of caring, protection and safety.

5.4.2. The community process step by step

A holistic community-based model should begin with the resources that already exist in the community (people, ideas, links, relationships, structures, institutions, budgets), link them up and start a dialogue. As we said earlier, this work may begin from the demand that comes from the community itself: for example, we might begin from a specific demand for "other/new/different responses to drug use", because people understand that existing responses are either inadequate, do not provide the expected results, or because there are no responses. Or, we may begin with a

group of stakeholders who understand that this community is fertile ground for beginning to construct a holistic community-based approach on the basis of existing responses and including all of the actors who are working on the issue and providing some type of response.

In both cases, we begin with and prioritize the demands of the community, and therefore, the priority elements of this type of practice are respect and the capacity to lead a process of participatory construction. To start with, we may highlight the following actions, which should be understood as being carried out simultaneously to ensure feedback and cross-fertilization:

IDENTIFYING	• **The problem(s) of the area (neighborhood)** • **Stakeholders (individuals and groups); government institutions, civil society organizations. Human, financial and program resources.**[15]
BRINGING TOGETHER	Different stakeholders to discuss and think about joint actions.
ORGANIZING	A process of joint awareness and training.
STRENGTHENING AND COORDINATING	The resources that already exist in a community.
WORKING	Representatives of the community, civil society organizations and government institutions work together to design responses for this community.

In order for this process of organization, strengthening, coordination, work and economic independence (a guarantee of continuity and sustainability over time) to be possible, the relationships developed with the people who live in the area are essential and are the starting point for all community work.

5.4.2.1 IDENTIFYING the community's problems

Identifying what one is going to work on means investigating the community's needs and problems. By collecting information on the community's concerns and identifying the community's strengths, participants can understand which issues they should work on in the future. It is important to begin

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[15] These include the responses that already exist in the community: programs, activities, actions, networks, etc.

by listening to the community, in an effort to achieve the greatest possible consensus among stakeholders and thus ensure that they are more involved in the practices that will be carried out.

Multimodal and participatory diagnostic methods are recommended (qualitative and quantitative). A number of methods are available for a community to construct the problem situation, such as the *Participatory Rapid Assessments*, the *ASIS Health Situation Analysis*[16] and the *System for Strategic Situational Assessment* (SiDiES)[17]. The data available in the area's information systems (health, education, social welfare, the police, and the planning department, among others), the community's experiences in dealing with the situation, and earlier interventions or approaches to the problem situation should all be used. This means a dialogue that respects and values the wisdom of those whom the community recognizes as leaders (see opinion leaders in Milanese, 2012, p. 122).

Building the database

Data that are important for identifying the problem and the subsequent development of a community project are of two types:

- Identification of secondary data that already exist in the community, such as case records, statistics, and so forth, that make up the health information systems[18] (surveillance of existing and new cases, health care visits/consultations related to drug use, school dropout, family ties or the perception of lack of security in the neighborhood).
- Mapping, showing the neighborhoods or areas in which drug use or related risky behaviors may occur, along with the networks, community and health care services that are available, and the stakeholders involved.

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[16] ASIS is a methodology promoted by WHO/PAHO in the framework of the initiative on the Essential Public Health Functions (EPHF) for decision-making across sectors in order to maintain and improve health and wellbeing. See: Epidemiological Bulletin, PAHO (1999). Methodological Summaries in Epidemiology: Health Situation Analyses (HSA), Vol. 20, No. 3.

[17] SiDiES is a participatory method for understanding and thinking about the community that enables a strategy for action to be developed for situations that the community itself considers to be problematical. See: Modelo zonas de Orientación Escolar (ZOE) en Colombia (*Spanish only*).

[18] Health information systems have subsystems that gather information on economic resources and individuals, such as records on health care visits in the different services. In addition, the epidemiological surveillance subsystem records events of public health interest, such as mandatory notifications, resources and the environment and infrastructure. There are also knowledge management mechanisms, such as Observatories, which collect and analyze data and publish information on particular topics or events of interest in the public health field.

Once the information has been collected on the problem and how it is framed in the community, the responses provided by institutions and organizations are documented, along with the responses that the community itself has been providing. The data collected must be then be analyzed and interpreted, that is, the meaning of that information for this particular group must be teased out, in order to assess what exists versus what still needs to be done.

As stated by Rootman and Moser (1985), it must always be remembered that examining the connections between factors and special variables and problems generated by drug use will be of little use unless these problems can be changed by community intervention: the collecting of information, the analysis of the data, and the presentation of the findings should all emphasize those factors that the community is in a position to change.

5.4.2.2 IDENTIFYING the "community"

When we speak of community work, we emphasize strengthening links among individuals, as well as their rights as citizens, by involving them in collective projects as a way of reducing the risk of social exclusion.

A community is made up of individuals and groups that live in the area or neighborhood, civil society organizations, government institutions--the formal and informal networks that in one way or another seek to improve living conditions. We will seek to work with all of these stakeholders in a holistic community-based approach. What we seek, then, is a "map" of the stakeholders and the relationships between them.

Identifying the human, financial and program resources is a way in which the community can take ownership of them, decide on how they will be used, and use them for their own needs.

5.4.2.3. BRINGING TOGETHER. The importance of community responses

The first step is to acknowledge that relationships existed among the stakeholders before the external facilitator arrived. We seek to bring together the representatives of the organizations and leaders in the community so that they can to get to know each other, know what each other is doing, and how they are doing it, and to give them room to think together about the basic aspects of this type of approach. Both individuals and groups that join in the work should bear in mind the following general points that must be present in community-building interventions:

- Embracing the view that health as a right, which means that the State/Government guarantees universal and equal access to health protection, promotion and recovery services and actions at all levels.

- Encouraging critical analysis of individuals' living conditions and the situations that they face, to encourage thinking about causes and consequences.

- Highlighting the existence of social networks and encouraging them to link up together.

- Promoting participation as a right, encouraging shared decision-making and stimulating dialogue among members of the community and the professionals that are involved in community projects.

- Promoting and giving new value to the community's traditions.

- Working on possible exclusion of different members of the community.

- Working on the gender dimension in order to promote egalitarian relations between men and women.

- Developing the capacity for self-expression – talking, listening and being listened to (community listening).

- Monitoring the existence of practices in educational and health establishments that might violate people's right to receive an education and health care.

- Recognizing the existing resources, capacities, potential and strengths in individuals and communities.

- Developing the capacity to work in a team.

- Opening up channels of communication among generations, based on mutual respect.

5.4.2.4. ORGANIZING. Awareness and training of professionals, key stakeholders, community workers, community leaders and members of the community

On the topic of the awareness and training of professionals and community leaders to carry out this type of program, Ornelas *et al.* discuss three priority areas:

a) training in prevention and health promotion;

b) empowerment of individuals and groups, and

c) work on the planning, implementation and evaluation of community-based programs.

Community practices require that participants, and particularly the organizers, have certain specific skills, the most important of which are:

- Inter-personal skills, including a capacity for empathy toward the particular problems of individuals, and organizational capacities.
- Communications skills to express oneself and listen to others.
- Ability to work in a team.
- Capacity to deal with dissent and arrive at a consensus.

These skills can be developed through training, internships, exchanges of experiences among peers, demonstration projects (not only those that were successful); the format will vary according to the goals of the project. The trainings may be given in segments over a long period of time (weeks or months), or intensively over a weekend, or a combination of both. The first type will probably ensure that a larger number of people participate; the second enables people to get to know each other and form a team, while a combination of the two may allow for both things. The ultimate goal is to examine and document the communities' weaknesses, strengths, capacities and potential, in other words, to make visible the resources available in the community.

5.4.2.5. STRENGTHENING AND COORDINATING. Bring existing responses into dialogue with the community's needs

Organize meetings/events to allow people to get to know each other, understand what they do and how they do it, with whom they are doing it, what links and relationships they have established so far, and which might be established in the future.

Diagnostic assessment of community responses and gaps:

1. Start with a listing of the responses that have been or are being conducted.

2. Analyze the responses according to their fields of work

3. Identify the obstacles and strengths of their operations.

Qualitative techniques should be used as the methodology for the work, which should be planned in three stages:

a) Pre-workshop: the goal of which is to draw up a description of the status of interventions in prevention and drug treatment in the community. This will be based on interviews with community stakeholders (organizations, academia, area community teams), a list and mapping of the experiences, interviews with coordinators, professionals, technical experts and/or users/beneficiaries.

b) Workshop: the various stakeholders, who come from many different backgrounds and institutions, will come together to discuss the document, and develop a consensus about the status of community actions.

c) Post-workshop: an executive summary will be prepared, showing the state of play and mapping of existing interventions. This will be shared with the workshop participants for their comments and contributions.

5.4.2.6. WORKING on the design and plan of action

Once the previous stage has been completed, the various responses catalogued and the role of each group and individual in the process listed, a system of responses should be constructed, in which there is dialogue and feedback, and stakeholders learn from the strengths and weaknesses of each response in order to build a network of responses.

In order to sustain this work over time and have an impact, the responses need to have ongoing interchange in order to develop feedback and a culture of acting together. When this process becomes a *system of community responses,* it will be in a position to counteract the power of the drug system, that is to say, will begin to weaken the force of the system that produces drug use in the communities.

6.5. Evaluation of community interventions

Project evaluation makes it possible to estimate the extent to which the objectives or goals that the community set for itself are being achieved in the project, or not. It is a tool that enables problems or difficulties to be captured, and actions already under way to be corrected in time.

5.5.1. Participatory evaluation

Participatory evaluation involves all those with an interest in the project – those directly affected by it, or those who participate in carrying it out – in understanding it and in applying that understanding to improving the work. The real purpose of an evaluation is not only to find out what happened, but also to use that information to improve the responses, and therefore should start at the very beginning of a project.

Participatory evaluation has a series of advantages, chief among which are the following:

- o It provides a better picture of the initial needs of the project beneficiaries and of the final outcomes of the project.

- o It may provide information that could not otherwise be obtained.

- o It indicates what worked and what did not work.

- o It may indicate why something worked or not.

- o It may point out improvements that should be made so that it does work.

o   It produces a more effective response.

o   It empowers the participants from the community.

o   It may give voice to those who often go unheard.

o   It provides training in skills that can be used in other areas of life.

o   It fosters collaborative work.

5.5.2. Types of evaluation

Three types of evaluation may be distinguished:

- *Process evaluation***:** also called follow-up, is an evaluation done during the course of project execution.

- *Outcome evaluation:* is the final or ex post evaluation that is conducted once the project has been completed; it looks at the outcome(s) of the activities as a function of the objectives originally proposed.

- *Impact evaluation* refers to substantive, stable and permanent changes in the problem situation(s) that are achieved through project execution.

A system based on minimum quality standards is recommended as providing an ethical and scientific overview that will make for ongoing improvement. It is important to bear in mind that under this system, key moments in the implementation of the responses are identified in order to carry out the necessary monitoring and make the appropriate adjustments, so as to achieve a long-term outcome.

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