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Promising Practices in Drug Treatment: Findings from Latin America



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PROMISING PRACTICES IN DRUG TREATMENT: FINDINGS FROM LATIN AMERICA



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PROJECT OVERVIEW

The State Department's Bureau for International Narcotics and Law Enforcement Affairs (INL) supports demand reduction efforts overseas to combat the rising consumption of illicit drugs around the world. In 1978, the INL developed the International Demand Reduction (IDR) program to assist foreign countries in mobilizing their public and private sectors to support national narcotic control policies and programs. The IDR program was enhanced in 1990 to assist foreign countries with the development of self-sustaining prevention, education, and treatment programs. The current goal of the program is to strengthen the level of determination of foreign Governments to fight illegal drug abuse and to increase the resources allocated to this effort.

In support of these efforts, the INL issued a grant to conduct an assessment of drug treatment and aftercare efforts as identified by the INL. Drug treatment programs in Europe, Latin America, and Southeast Asia were examined to identify promising programs and practices, and to assess lessons learned.

The project involved four phases:

- An initial gathering of background information;
- Fieldwork in the selected countries to obtain information from public organizations and nongovernmental organizations;
- Report generation to summarize findings by country and across countries or sites; and
- A descriptive report for foreign treatment programs that highlights accomplishments and results.

The information presented in the following pages highlights key study accomplishments in Latin America.

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EXECUTIVE SUMMARY: DRUG TREATMENT IN LATIN AMERICA

Drug Treatment in Latin America: A Report on Promising Practices in Brazil, Peru, and Argentina

The State Department's Bureau for International Narcotics and Law Enforcement Affairs (INL) ensures that foreign countries receive assistance from the United States Government to address escalating drug use and help improve local treatment systems. Under this initiative, the State Department asked evaluators from Danya International, Inc., to conduct site visits in treatment programs on several continents to identify "promising practices." Promising practices are treatment approaches that, when effectively carried out, enhance the likelihood of success. Once these practices are identified, Danya, working in collaboration with the State Department, is charged with "getting the word out" so that these successes can be replicated by treatment programs across the country and possibly in other Nations.

In a series of site visits to drug treatment programs in Latin America, the Danya evaluation team collected many types of data; analyzed client records on drug use and treatment compliance; and conducted extensive interviews with staff members, volunteers, clients, and family members. Key study results from the work accomplished to date in Latin America are presented in this report.

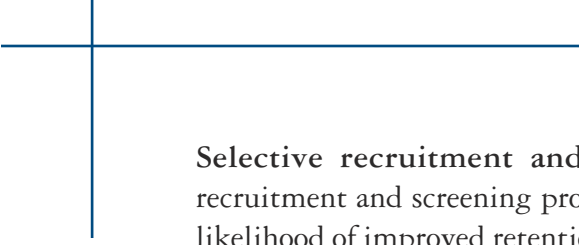
Latin America and the Therapeutic Community Model of Treatment

Most drug treatment programs visited are based on the residential Therapeutic Community (TC) model of treatment. TC treatment is an intense, emotional experience based on direct, sometimes confrontational interactions among peers. The daily schedule is highly structured, from early morning until "lights out." Treatment is considered a 24-hour-a-day, 7-day-a-week enterprise, requiring considerable dedication and commitment by community residents and staff members alike. The site visits conducted by Danya in Latin America focused primarily on TCs, and many promising practices are emerging from the adaptation of TCs to local cultures.

Following is an overview of cross-cutting promising practices in Brazil, Peru, and Argentina.

Promising Practices

Effective outreach and media strategies help recruit participants. In Peru and Brazil, street educators work to gain the trust of street children and let them know about the services available to them.



Selective recruitment and assessment practices improve retention. Careful recruitment and screening processes help programs identify clients who have a higher likelihood of improved retention and recovery. For example, the TC studied in Peru has a month-long period of assessment that includes multiple individual, group, and family intakes prior to placement in the program.

Tailored activities address local needs. The Promotional Association for Prayer and Work in Brazil was developed in response to drug use by various populations in the community. Different programs target street children, males, and females and offer specific activities to address their needs. Similarly, the INL program in Peru was developed to help local street children stop using drugs and find a better way of life.

Client development in all life domains is important. Latin American programs often focus on the individual's spiritual and moral growth and educational and professional development, as well as attempting to reduce substance abuse.

The **family unit** is seen as a system in need of treatment. Several of the Latin American programs visited work to restructure the home environment through family therapy sessions, family support groups, and home visits. Family members learn about the natural cycle of addiction and healthy ways to deal with problems such as relapse. Programs for street children attempt to reintegrate the children back into their families whenever feasible.

Motivated volunteers are strong program assets. Volunteers can be helpful in a range of tasks, from professional services to outreach work, to participation in games and sports with minors. The President of the Instituto Mundo Libre program in Peru is a volunteer and does not receive payment for her services.

Caring, committed staff members are the heart of the program. Some staff members in Argentina and Peru work for little to no pay, as an economic crisis has almost bankrupted the program. However, program residents consistently mentioned that positive staff attitudes are integral to their treatment. In Brazil, the President of APOT and Director of the program is a strong leader who is extremely committed to the program. He is very active in sharing program successes with the community as a means to obtain ongoing funding. Similarly in Peru, the Founder and Director is extremely committed to the program and highly regarded by the clients.

EXECUTIVE SUMMARY: BRAZIL

This report summarizes the site visit findings from the components of The Associação Promocional Orocão e Trabalho (APOT) (Promotional Association for Prayer and Work) Program in Campinas, Brazil. The site visit was conducted by a team of Danya evaluators from April 3 to April 12, 2001. Based on the evaluator's observations, several program factors were identified that appeared to be instrumental in achieving successful outcomes at APOT. Primarily, the program's goals reflect its strong commitment to each client's well-being and personal achievement. Promising practices found are presented below.

PROMISING PRACTICES

- *Involving key stakeholders in the entire program development process, from planning and implementation to sharing of recognition and rewards of success.*
- *Tailoring activities to local needs. The APOT program was developed in response to a need in the community to help drug users recover.*
- *Working with families as a unit. The APOT program recognizes the need for family involvement in treatment, and includes family therapy, family support groups, and mandatory family attendance at meetings.*
- *Investing in client development—focusing on the individual's spiritual growth, professional development, and general improvement of lifestyle.*
- *Achieving program sustainability through fundraising and by selling products made by residents.*
- *Applying effective outreach and media strategies.*
- *Recruiting and retaining motivated volunteers. The program has a group of volunteers that assist in various aspects of the program.*
- *Maintaining committed and strong leadership at both the program and community levels.*

EXECUTIVE SUMMARY: PERU

From July 2 to July 6, 2001, a Danya site visit team traveled to Peru to collect data on the Instituto Mundo Libre (IML) No Walls Foster Home for Street Kids, a TC in Lima, Peru. This report summarizes the findings of the site visit; promising practices are presented below.

PROMISING PRACTICES

- *A comprehensive approach to treatment, including support; self-help groups; educational and professional development; and emphasis on individual, group, and family work;*
- *Involvement of key stakeholders in the entire program development process, from planning and implementation to sharing of recognition and rewards of success;*
- *Investing in youth development, particularly in their moral, educational, and professional development, and general improvement of lifestyle by stopping the use of drugs;*
- *Applying effective outreach and media strategies to recruit participants, which is one of the primary ways children come to the program; and*
- *Recruiting and retaining motivated volunteers who assist in various aspects of the program.*

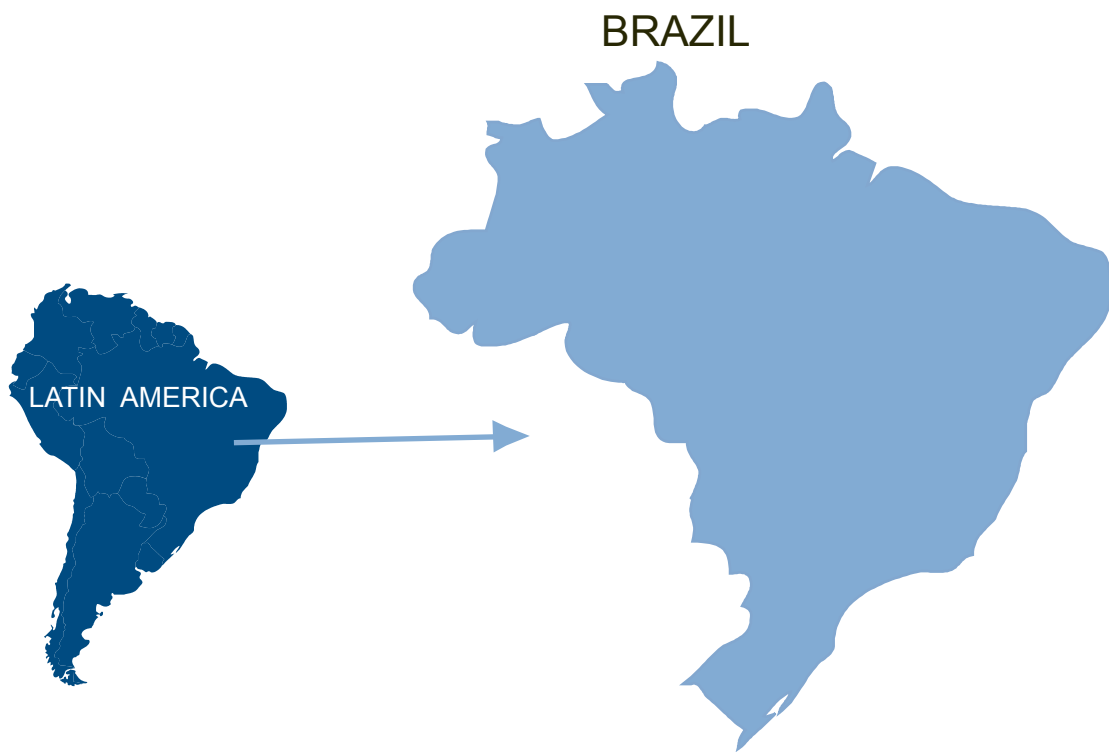
EXECUTIVE SUMMARY: ARGENTINA

From March 9 to March 17, 2002, Danya evaluators conducted site visits in Argentina to collect data on a variety of programs and services. This report focuses on Cambio, which means “change.” Cambio is a nonprofit, nongovernmental organization affiliated with Argentina’s Secretariat for Planning the Prevention of Drug Addiction and the Fight against Drug Trafficking (SEDRONAR). SEDRONAR is the office responsible for addressing drug abuse and drug trafficking, and is directly under the President of Argentina. The philosophy of the Cambio program is based on the belief that human behavior results from an interrelated system involving individuals, families, and all other elements of a person’s social support network. Therefore, the program adopts a “systems” approach, promoting changes in many domains of life as part of a comprehensive strategy for controlling substance abuse. Cambio provides both outpatient and residential treatment for adolescents and adults.

Evaluators conducted interviews and focus groups with representative clients undergoing various modalities of treatment. The evaluation team visited several of the Cambio treatment centers as well as other agencies that have linkages with Cambio. Some of the promising practices found are presented below.

PROMISING PRACTICES

- *A month-long period of admission and assessment ensures placement of the individual into the appropriate treatment milieu. The admission period includes multiple individual, group, and family intakes.*
- *The family unit is seen as a system in need of treatment. Cambio restructures the home environment through family sessions, family support groups, and home visits. Family members learn about the natural cycle of addiction and healthy ways to deal with problems such as relapse.*
- *A computer lab helps clients develop professional skills and engage in therapeutic online activities to educate themselves about addiction.*



BACKGROUND: BRAZIL

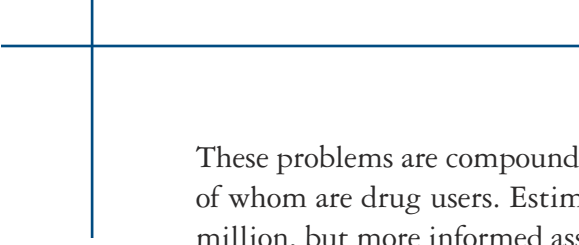
Brazil covers approximately half of the South American continent and has a population of over 170 million people. Approximately 29 percent of the population is under 15 years old, and in 1998 the life expectancy at birth was 67 years. The labor force in Brazil is about 74 million; however, it is estimated that about 17 percent of the population lives below the poverty line. In this setting, rising drug abuse rates are increasing demands on public health services and on society in general.



The most popular illicit drugs sold in Brazil are cannabis, cocaine, coca paste, and crack. Overall, opiate abuse in Brazil appears very limited, with a prevalence rate of less than 0.1 percent of the population over 15 years old. Cocaine use, however, is on the rise. In the late 1980s, the country emerged as a trafficking corridor for South American cocaine-producing countries (Colombia, Peru, and Bolivia), and by the 1990s there was a significant increase in the domestic demand for illicit drugs. There has been a corresponding upsurge in drug-related violence and weapons smuggling, and Brazil continues to be an important market for Colombian, Bolivian, and Peruvian cocaine.

Reports have suggested that crack cocaine is the new drug of choice among youth in Brazilian cities, especially São Paulo (U.S. Department of State 2000). A recent study indicated that 59 percent of individuals in drug treatment reported cocaine use, with 44 percent of those persons being addicted to crack (Inter-American System of Uniform Data on Drug Consumption [SIDUC] 1998). In the same study, 27 percent reported cannabis as their primary drug of abuse. About 51,200 homicides occur each year, and drug trafficking and the fight for drug distribution localities are thought to account for some 60 percent of these homicides (United Nations Office for Drug Control and Crime Prevention [ODCCP] 2000).

Several studies have found that the mean age of alcohol initiation is 10.1 years. Studies of secondary students in public schools in 10 Brazilian State capitals showed a significant increase in alcohol use in 7 out of 10 cities between 1987 and 1993. A household survey of Porto Alegre adolescents aged 10 to 18 published in 1995 found alcohol use prevalent in 70 percent of the sample (World Health Organization [WHO] 1999). For adults, 4 percent, 5 percent, and 9 percent of males in São Paulo, Brasília, and Porto Alegre respectively reported alcohol dependence. In 1995, 2 percent (1,112) of the total deaths in São Paulo were alcohol attributable. In addition, out of 530 homicides in São Paulo in 1994, 52 percent showed positive blood alcohol concentration. Similarly, 36 percent of the suicides, 36 percent of fatal falls, and 55 percent of drowning deaths showed positive blood alcohol concentrations. A national program has been set up to establish a countrywide policy on the treatment and rehabilitation of alcohol-dependent persons (WHO 1999).



These problems are compounded by the large number of street children in Brazil, many of whom are drug users. Estimates of the number of street children range from 7 to 17 million, but more informed assessments suggest that between 7 and 8 million children, aged 5 to 18, live and/or work on the streets of urban Brazil. Accounts of drug use among street youth are commonplace. Drug initiation among these children seems to be a consequence of street life and is part of their group lifestyle. Numerous scientific studies and media stories have reported the widespread use of inhalants; marijuana and cocaine; coca paste; Rohypnol, a powerful sedative; and Valium® among street children.

DESCRIPTION OF PROGRAMS VISITED: BRAZIL

In 1977, Father Haroldo J. Rahm, along with Professor Osvaldo Candido Ferreira and Nubia França, founded a philanthropic entity called The Associação Promocional Orocão e Trabalho (APOT) (Promotional Association for Prayer and Work). The objective of APOT is to treat those dependent on drugs and alcohol, with an emphasis on reintegrating clients back into their families and society. APOT seeks to provide:

- Sobriety from drugs;
- Increased education;
- Enhanced spirituality;
- Improvement of physical health; and
- Development of trusting relationships.

APOT consists of three distinct programs: Recovery Program for Drug Dependents and Alcoholics (male), Recovery Program for Drug Dependents and Alcoholics (female), and the Street Kids Program. All are located on the main campus of APOT, near the city of Campinas. Each program includes an educational component, called the Program of Alternative Creativity and Professional Development (CAP), to assist clients in attaining a sense of responsibility and improved technical skills. These are considered essential for entering the workforce.

Program goals include:

- *Getting addicted people—including adults, adolescents, and street children—off of drugs;*
- *Preparing clients for reinsertion back into the community;*
- *Instilling self-confidence;*
- *Increasing clients' level of education;*
- *Providing opportunities to acquire new skills; and*
- *Promoting spiritual growth.*

In 1984, Father Rahm established the Tough Love (Amor Exigente) movement to work with the families of the chemically dependent. Tough Love is integrated into the work done in the TC. Throughout the years, APOT has widened the scope of its activities to include a variety of underserved groups, including street children.

APOT Program Philosophy

The philosophy of the APOT program is based on spirituality, work, and support therapy. The spiritual dimension, as expressed by APOT, is “the dimension that leads humans to seek out the meaning of their own existence and the path in the direction to transcendence.” The purpose of work is to reorganize the life of the individual around enhanced structure and discipline. The support aspect of the program includes principles from TC programs and several 12-step programs, including Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Tough Love (AE).

Table 1 presents an overview of the APOT program phases for men, women, and youth.

Table 1: Overview of the APOT Drug Treatment and Rehabilitation Program

Population Characteristics	Outreach	Orientation & Triage	Detoxification & Treatment	Recovery & Social Reinsertion	Aftercare
Male Street Kids	Street Outreach & Judicial Referral	Open House (Downtown Area)	Middle House (Rural Area)	Jimmy House Wing B & CAP***	Psychology Clinic, AA, NA, others
Male Adolescents (Age: 14 to 20)	Walk-In or Referral	CAOT*	Jimmy House Wing A	Jimmy House Wing B & CAP	Psychology Clinic, AA, NA, others
Male Adults (Age: 21 to 45)	Walk-In or Referral	CAOT	Lord Jesus Farm (Rural Area)	São José House & CAP	Psychology Clinic, AA, NA, others
Female Adolescents (Age: 21 to 45)	Walk-In or Referral	CAOT	Guadalupe House	Guadalupe House & CAP	Psychology Clinic, AA, NA, others
Female Adolescents (Age: 14 to 20)	Walk-In or Referral	CAOT	Guadalupe House	Guadalupe House & CAP	Psychology Clinic, AA, NA, others
Female Adults (Age: 21 to 45)	Walk-In or Referral	CAOT	Guadalupe House	Guadalupe House & CAP	Psychology Clinic, AA, NA, others
Family Members (All Ages)	Walk-In or Referral	CAOT	Tough Love** & others	Tough Love & others	Psychology Clinic, Tough Love
Community at Large (All Ages)	Publicity through media & others	CAOT	Tough Love, AA, NA, others	Tough Love, AA, NA, and CAP	Tough Love, AA, NA, others

* CAOT refers to the attention, orientation, and triage center.

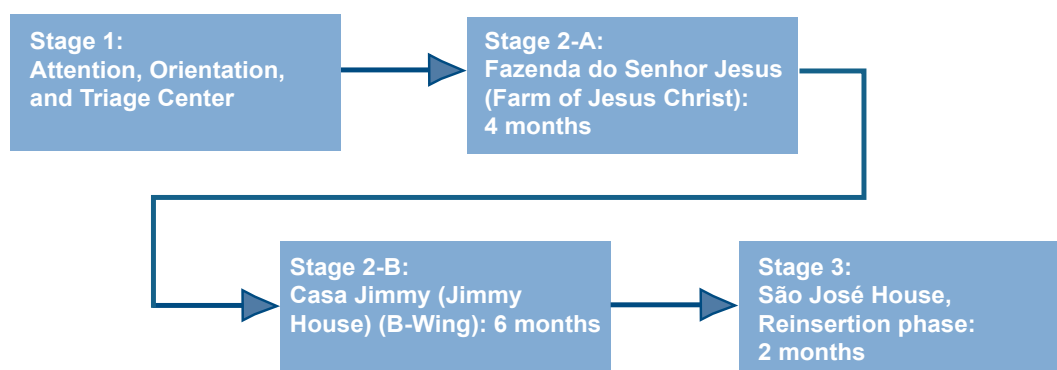
** Tough Love is a program founded by Father Rahm. Although it operates independently of APOT, residents' family members are required to attend Tough Love or a similar program regularly, to be allowed to attend monthly family visits to residents.

*** CAP refers to the Program of Alternative Creativity and Professional Development.

Recovery Program for Drug Dependents and Alcoholics (Male)

Founded in 1977, this therapeutic-educational program is located in a farm setting. It focuses on treating adult males who use alcohol and drugs. In addition to the basic APOT philosophy, the program also matches the life experience of the client to a professional track in preparation for a return to the community. The program, which runs approximately 6 months, follows a series of developmental phases, as shown in **Figure 1**. As clients progress through the program, each stage is associated with a different color name tag. Residents start with red and move up to yellow, green, and finally blue. Recognition from others and self-satisfaction with progress are evident in the colors worn, which serve as incentives to the clients. Each of the program's phases is described below.

Figure 1: Phases in the Recuperation Program for Drug Dependents and Alcoholics (Male)



STAGE 1: ATTENTION, ORIENTATION, AND TRIAGE CENTER (CAOT)

The objectives of Stage 1 are to orient candidates and family members to the program. Referrals come from other components of APOT, other social institutions, and support groups such as AE, AA, and NA. Staff members and volunteers answer telephone calls and provide information about the candidate's alcohol or drug use problem to the potential clients and family members. This interaction assists staff in determining the best approach to treatment. In addition, they present the steps of the recovery program, provide referrals to ineligible candidates, and discuss donations with family members.

In Stage 1, candidates participate in the "first interview," a meeting with the potential client and family members, conducted by volunteers from the support group or by a staff psychologist. Second interviews involve a meeting with the potential client and family members, conducted by a staff psychologist. An economic evaluation is then

completed, followed by a final meeting with the candidate and family members to help clear up any existing doubts. When all documentation necessary to begin the program has been completed, Stage 1 ends.

STAGE 2-A: FAZENDA DO SENHOR JESUS (FARM OF JESUS CHRIST)

This residential stage operates 24 hours a day and has the capacity for 70 adult males. The expected length of stay is 4 months. If an unanticipated need is identified after an evaluation with the program team and the client, the length of stay can be increased or decreased if all parties agree.

The major activities of Stage 2-A include daily meetings; spiritual activities, including prayer, reflection, and biblical studies; support groups for new residents; and support therapy, including groups such as AA, AE, and NA. Additional activities are:

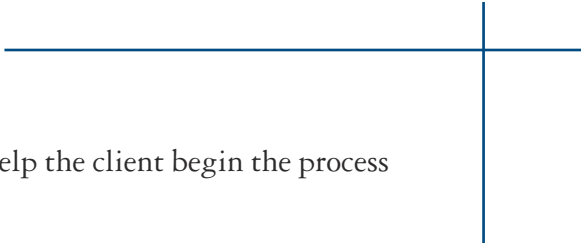
- Physical and sporting events;
- Educational activities;
- Cultural and recreational pursuits;
- Labor therapy, including work in the field, garden, chicken, and pig pen, kitchen, and laundry; maintenance; cleaning; landscaping; and other administrative duties; and
- Meetings with clients' family members (on the first Sunday of the month, coordinated by the CAOT Coordinator; on the third Sunday of the month, coordinated by the transdisciplinary team).

Stage 2-A uses biopsychosocial and spiritual aspects to help the client begin the process of recovery. The specific objectives of this stage are to:

- *Integrate the client into the TC;*
- *Create conditions for physical detoxification;*
- *Stimulate self-knowledge;*
- *Help the client learn the meaning of work and discipline in his life;*
- *Lead the client to awareness of social principles and values;*
- *Promote spirituality from an ecumenical perspective; and*
- *Stimulate the development of internal resources in order to work with relapse prevention.*

STAGE 2-B: CASA JIMMY (JIMMY HOUSE) (B-WING)

This residential stage operates 24 hours a day and serves male adolescents and young adults 14 to 20 years old. The facility has the capacity to house 10 youth from the Street Kids program and 30 from the recovery program. The expected length of stay is 6 months.



Stage 2-B uses biopsychosocial and spiritual aspects to help the client begin the process of recovery. Specific objectives of this stage are to:

- Integrate the client into the TC;
- Create conditions for physical detoxification;
- Stimulate self-knowledge;
- Help the client learn the meaning of work and discipline;
- Lead the client to recover social values and principles;
- Promote spirituality from an ecumenical perspective;
- Stimulate the development of internal resources to work on relapse prevention;
- Facilitate the return to social and family life; and
- Provide subsidies to the community for the continuation of the recuperation process in external support groups (AA, AE, and NA).

STAGE 3: SÃO JOSÉ HOUSE, REINSERTION PHASE

Stage 3 operates 24 hours a day and has the capacity to serve 48 adult males. The expected length of stay is 2 months. The time period can be increased or decreased depending on the individual's needs. In this phase, activities incorporate prayer, reflection, and biblical studies; support groups for new residents; and daily meetings during which all clients come together to discuss any concerns, such as the daily schedule. Support therapy offered includes AA, AE, and NA meetings; confrontation groups and group dynamics; individual attention; education; and relapse prevention. Other program activities are:

- Labor therapy in horticulture, kitchen and laundry work, maintenance, cleaning, gardening, and administrative work;
- Meetings with clients' families;
- Physical and sporting events;
- Recreational and cultural pursuits; and
- Professional courses.

Stage 3 reintroduces the client into society. The specific objectives of this stage are to:

- Stimulate self-knowledge;
- Help the client internalize the meaning of work and discipline in his life;
- Lead the resident to recover social values and principles;
- Promote spirituality from an ecumenical perspective;

- Promote participation in professional and creative courses;
- Facilitate the return to social and family life;
- Provide subsidies to the community to continue the recuperation process in external support groups (AA, AE, and NA); and
- Stimulate the development of internal resources and skills for relapse prevention.

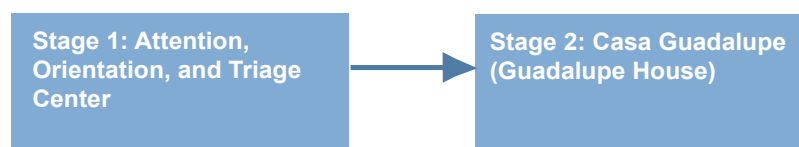
Recovery Program for Drug Dependents and Alcoholics (Female)

This program was initially formed to address the needs of girls who were involved in prostitution, drugs, and petty crime on the streets of Campinas. An increasing number of requests to treat young women who used alcohol and drugs necessitated the creation of a recovery program specifically for this population. To meet this need, APOТ leaders created the Casa Guadalupe (Guadalupe House) in 1996.

The program helps adolescent and adult women find positive options in all aspects of their lives: physical, psychological, social, and spiritual. The ATOP philosophy applies to this program; spirituality, work, and support therapy governs the program. Stages of treatment are shown in Figure 2.

Today, Casa Guadalupe functions as a TC serving homeless girls, as well as girls and women of all social strata. The program offers adolescent and adult women who are dependent on alcohol and drugs the opportunity to participate in a therapeutic-educational program. The main objective is recovery.

Figure 2: Recovery Program for Drug Dependents and Alcoholics (Female)



STAGE 1: ATTENTION, ORIENTATION AND TRIAGE CENTER (CAOT)

The first stage of the female program, consisting of the referral and screening process, orientation, and triage, is the same as that described for the male program.

STAGE 2: CASA GUADALUPE (GUADALUPE HOUSE)

Stage 2 operates 24 hours a day and serves females ages 14 to 45. It has a capacity of 17 residents. The stage helps female addicts to recover and reach a point of social reinsertion.

The specific objectives of Stage 2 are to integrate newcomers into the TC, create conditions for physical detoxification, stimulate self-knowledge, and help the client internalize the meaning of work and discipline in her life. Stage 2 is also designed to:

- Lead the client toward social values and principles that aid in recovery;
- Promote spirituality from an ecumenical perspective;
- Stimulate the development of internal resources for relapse prevention skills;
- Promote participation in professional and creative courses;
- Facilitate a return to social and family life; and
- Provide subsidies to the community for continuing the recuperation process in external support groups (AA, AE, and NA).

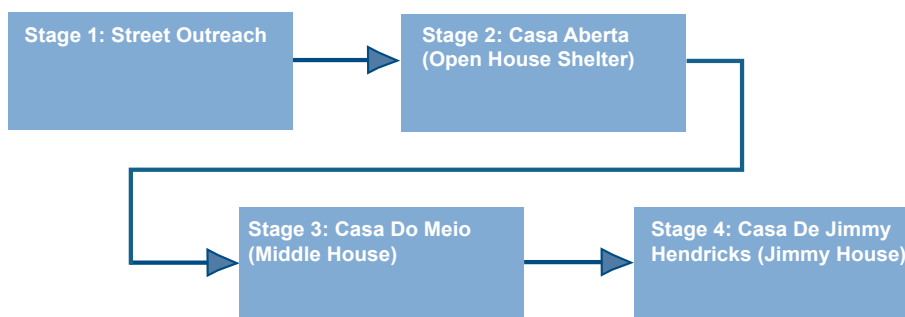
Street Kids Program

In 1989, the city of Campinas saw an escalating number of homeless children and adolescents who were involved in drugs and minor crimes. To combat this epidemic, Father Rahm, along with Isilda Fernandes Rudecke and Maria Lucia Villela, started the Street Kids program. The goal is to offer children and adolescents a therapeutic program intervention focused on recovery and family and/or social reintegration.

The program provides services to children and adolescents from 7 to 18 years old. Selection criteria include children and adolescents who are addicted to drugs or alcohol, homeless, have fragile or non-existent family ties, and may be involved with petty crime.

The Street Kids program offers children the opportunity to participate in a socio-therapeutic-educational process in a provisional and/or permanent home. Incentives are provided to develop alternative life strategies (physical, psychological, spiritual, and civic). In accordance with the APOT philosophy, the program is based on spirituality, work, and support therapy. Treatment stages are shown in **Figure 3**.

Figure 3: Street Kids Program





STAGE 1: STREET OUTREACH

During Stage 1, which takes place in the streets and parks of Campinas, program leaders observe childrens' dynamics to find out locations and times for youth meetings. By monitoring the street kids, they hope to establish contact with children and adolescents of both genders, aged 6 to 17. The goal of this stage is for program staff members to create ties of respect and friendship by educating and informing children, adolescents, and their families of programs that offer new alternatives in life. Another aim is to encourage street kids to think about their present condition and to offer possibilities for change.

STAGE 2: CASA ABERTA (OPEN HOUSE SHELTER)

In this stage, referrals and interviews take place to provide potential clients with information about the program and further their desire to change their lives. If the children are interested, staff members and volunteers help them advance to other phases in the APOT program or in other institutions. This service is available 24 hours a day and serves children of both genders.

STAGE 3: CASA DO MEIO (MIDDLE HOUSE)

This residential stage, which operates 24 hours a day, serves male adolescents ranging in age from 6 to 17 years old. It has the capacity for 50 youth and is located at the Farm of Jesus Christ. See **Table 2** for a schedule of weekday and weekend activities.

Stage 3 also provides treatment and detoxification to male adolescents and facilitates recovery using biopsychosocial approaches and spirituality. The specific objectives are to motivate and promote support therapy, teach hygiene and health habits, develop positive relationships, provide leisure and cultural activities, and restore family functioning to a healthy level.

STAGE 4: CASA DE JIMMY HENDRICKS (JIMMY HOUSE)

This residential stage operates 24 hours a day and is located close to the city of Campinas. It allows children and teenagers the opportunity to participate in a social-therapeutic-educational process that motivates them to attend school for both academic and vocational training. One of the main objectives of this stage is to help clients become productive members of society and return to their families or guardians. A schedule of daily activities for Stage 4 is included in **Table 3**. Other objectives of this stage are to promote support therapy, teach habits of hygiene and health, develop positive relationships, provide activities of leisure and culture, promote formal education, and provide family therapy as a way to form solid, healthy family ties.

Table 2: Weekday Activities of Middle House, Street Kids Program

Time	Weekday Activities	Newcomers	Stage 2	Stage 3	All Clients
0615	Wakeup		✓	✓	
0630	Wakeup	✓			
0630–0645	Breakfast		✓	✓	
0645–0700	Breakfast	✓			
0700–0800	Cleaning of the houses	✓	✓	✓	✓
0800–0820	Change of shift				✓
0820–1000	Morning meeting	✓	✓	✓	✓
1000–1130	Incentives and learning activities				
1000–1100	12-step meetings				
1000–1100	12-step meetings				
1100–1200	Incentives and learning activities				
1100–1200	Lunch	✓			
1200–1230	Lunch		✓	✓	
1300–1330	Revision of the house cleaning	✓	✓	✓	✓
1330–1430	Meeting—Indicators of behavior and discipline	✓	✓	✓	✓
1430–1600	Initiation of the 12 steps	✓			
1430–1615	Labor therapy		✓	✓	
1600–1630	Snack	✓			
1630–1700	Snack		✓	✓	
1700–1800	Bath	✓	✓	✓	✓
1800–1900	Spirituality	✓	✓	✓	✓
1900–1930	Dinner	✓			
1930–2000	Dinner		✓	✓	
2000–2200	Leisure—TV, video, ping pong, etc.	✓	✓	✓	✓
2200	Pickup	✓	✓	✓	✓

Table 3: Schedule for Casa de Jimmy Hendricks

Time	Weekday Activity	M	T	W	Th	F	S	Weekend Activity
0630	Wakeup Personal hygiene Prayer Breakfast			✓				
0700–0800	Wakeup Personal hygiene Prayer Breakfast Horticulture	✓	✓		✓	✓	✓	✓
0700–0800	Cleaning		✓					
0700–0800	Physical education (every 15 days)			✓				
0800–0900	Neurological reorg.		✓					
0830–0900	Cleaning	✓		✓	✓	✓	✓	✓
0900–0930	Daily meeting	✓	✓	✓	✓	✓	✓	✓
0930–1000	Ludoth*	✓	✓	✓	✓	✓	✓	✓
1000–1100	Ludoth*							✓
1000–1100	Scholar reinforcement	✓	✓	✓	✓	✓	✓	
1115–1145	Lunch	✓	✓	✓	✓	✓	✓	✓
1145–1245	Personal hygiene Closet organization	✓	✓	✓	✓	✓	✓	
1145–1245	Personal hygiene Ludoth*							✓
1300–1500	Ludoth*	✓	✓	✓	✓	✓	✓	✓
1500–1515	Snack (picnic on Saturday)	✓	✓	✓	✓	✓	✓	✓
1515–1545	Bath	✓	✓	✓	✓	✓	✓	✓
1530–1600	Alphabetization/games		✓					
1545–1615	Afternoon program**	✓	✓	✓	✓	✓	✓	
1630–1730	Free	✓	✓	✓	✓	✓	✓	
1800	Dinner	✓	✓	✓	✓	✓	✓	
1830	Dinner							✓
1900–2000	Personal hygiene Praise Free Video rental (Sunday)							✓
2000–2100	Bath Spirituality***	✓	✓	✓	✓	✓	✓	
2100	Pickup	✓	✓	✓	✓	✓	✓	

* Ludoth. Refers to Ludotherapy, which is defined as painting, theater, capoeira, fantasy (make believe), picnic, comic books recreation, drawing, and sports.

** Afternoon program is defined as 12-steps and citizenship.

*** Spirituality is defined as prayers, relaxing, praise, and reflection.

Program of Alternative Creativity and Professional Development

The Program of Alternative Creativity and Professional Development started in 1995. It offers the possibility of a better life for children, adolescents, and adults who use drugs; live on the street; have few or no family ties; and do not attend school, work, or have a profession. This program serves adolescent and adult APOT residents and members of the community who do not fit into the conventional vocational programs in the community. It has the capacity for 12 participants per activity.

APOT's Program of Alternative Creativity and Professional Development offers the following courses:

- Cabinetmaking;
- Information Technology and Computer Office;
- Practical Training for Attendant (Cafeteria) Internship;
- Artisanship;
- Sewing;
- Electricity; and
- Painting.

The main objective of the program is to provide students with the opportunity to acquire the knowledge and skills that make employment possible. Workshops are provided that allow students to better choose their future profession and increase skills and abilities. The program also provides opportunities for creative thinking and autonomy, and for students to demonstrate initiative. Clients improve

their self-knowledge and judgment as they identify goals and expectations. Overall, the program assists students in attaining a basic sense of responsibility.

Key Findings

Key findings from Danya's site visit to Brazil include the following:

- It is estimated that 17 percent of the population of Brazil live below the poverty line. Rising drug abuse rates in Brazil have put increasing demands on public health services and the society.
- The typical APOT adult client is in his or her mid-20s, began using drugs between the ages of 12 and 15, and has a family member who is also drug-dependent.
- In both adult programs (male and female), 60 percent of clients stayed in treatment for 2 months or longer.
- The average age of clients in the Street Kids program is 15 years old. Fifty-seven percent of residents stayed in the program 6 months or longer.

- Seventy-two percent of the children from the Jimmy Hendricks House were reinserted back with their families or found jobs in the community.
- Fifty percent of the children living in the Middle House were reinserted back with their families or found jobs.
- During focus groups with staff and clients, spirituality was the most frequently mentioned component as a key for success; labor therapy and support groups were also mentioned frequently.
- The philosophy of the APOT program is based on spirituality, work, and support therapy. It emphasizes reuniting clients with their families and reintegrating them into society.

The next section presents a brief analysis of data obtained from the APOT program database, summaries of the interviews conducted with staff and residents, and findings from the three focus groups. The analyzed data is presented separately for the Street Kids program, as the program maintains a separate database.

Demographic Characteristics: Adult Programs

Typical APOT clients are in their mid-20s, single, and started using drugs between the ages of 12 and 15. Most clients with drug abuse problems also experienced problems with alcohol use. Furthermore, many clients had at least one family member who was also drug-dependent. The age ranges of residents when entering treatment are shown in Table 4 and are based on data from the APOT database. The mean age of individuals entering treatment was 25.6 years old.

Table 4: Age of APOT Residents at Admission (n=4500)

AGE AT ADMISSION	PERCENT OF RESIDENTS
18 & Under	18%
19–21	21%
22–25	20%
26–30	17%
31–40	18%
41 & Older	6%
TOTAL	100%

More than half of APOT's clients (55 percent) began using drugs between the ages of 12 and 15. Twenty-six percent of clients initiated drug use between the ages of 16 and 19, 11 percent began using at the age of 11 or under, and 8 percent began using at the age of 20 or above. Half of the clients indicated that they had both an alcohol and drug problem. Thirty-six percent of clients indicated that they had only a drug problem, and 14 percent indicated that they had only an alcohol problem. Most clients (64 percent) indicated that a member of their immediate family was drug-dependent. In some cases, multiple family members were drug-dependent. Residents' age of first use and type of drug problem(s) are shown in Table 5 and are based on data from the APOT database.

Table 5: Age of First Use/Type of Drug Problem (n=4910)

AGE OF FIRST USE	PERCENT OF RESIDENTS
11 & Under	11%
12–15	55%
16–19	26%
20 & Older	8%
TOTAL	100%

TYPE OF DRUG PROBLEM	PERCENT OF RESIDENTS
Alcohol	14%
Other Drug(s)	36%
Alcohol & Other Drug(s)	50%
TOTAL	100%

Thirty-five percent of the adult program clients were referred to APOT by the legal system. Thirty-nine percent had been incarcerated previously; 61 percent had not. Twenty-one percent of clients indicated that they had been incarcerated only one time before, and 17 percent indicated that they had been incarcerated two or more times.

Time in Treatment and Reason for Departure: Adult Programs

Treatment duration for the program's 4,417 clients ranged from 1 day to over 33 months (33.2 months), with the average length of stay approximately 3.4 months. At the time this data was obtained from APOT, of the residents no longer in treatment, 32

percent had completed treatment, 47 percent had dropped out of treatment, another 20 percent had been expelled, and 1 percent transferred to another institution. The range of time in treatment is shown in Table 6.

Table 6: Time in Treatment

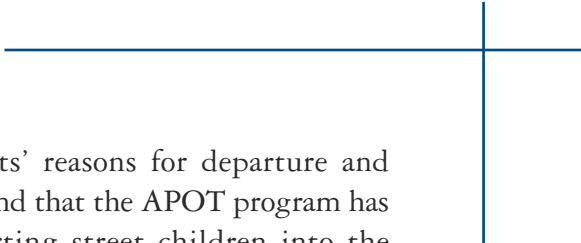
TIME IN TREATMENT	PERCENT OF RESIDENTS
0–30 days (up to 1 month)	26%
31–60 days (1–2 months)	14%
61–120 days (2–4 months)	24%
121–180 days (4–6 months)	11%
6–9 months	17%
9–12 months	7%
12 months+	1%
TOTAL	100%

Additional Data: The Street Kids Program

APOT has maintained a database on the Street Kids program participants since February 1992. At the time of the site visit, the database consisted of 750 individuals. Specific variables of interest were selected for analyses, including age, grade level, length of time in program, and reinsertion status. The average age of the street kids in this sample was 15 years old (n=651). The average grade level was fourth grade, and a majority of clients (57 percent) stayed in the program 6 months or longer. The educational levels of the 578 participants reporting this information are shown in Table 7.

Table 7: Street Kids Grade Level

GRADE LEVEL	PERCENT OF RESIDENTS
1st to 3rd grade	32%
4th to 6th grade	37%
7th to 10th grade	9%
Does not attend school	22%
TOTAL	100%



Analyses were conducted to examine the participants' reasons for departure and reinsertion status (n=573). The evaluation team also found that the APOT program has been very effective in its primary mission of reinserting street children into the community, with 72 percent of the Jimmy Hendricks House residents and 50 percent of the Middle House residents successfully reinserted back into the community.

Summary of Staff and Resident Interviews and Focus Groups

This section presents summaries of the interviews conducted with staff and residents regarding their view of the program, including strengths and weaknesses.

Staff Interviews

As part of the site visit, interviews were conducted with eight staff members from a variety of treatment programs. The average length of employment for staff interviewed was 5 years. Staff indicated that patients come to the programs for many reasons, including referrals from schools, churches, friends, family, or former patients who have benefited from the program. Seven out of eight staff members interviewed stated that people in the area or neighborhood viewed the program positively. Six out of eight staff members felt that group therapy, drug and alcohol education or seminars, and family therapy or family issues group were “extremely important” to the success of the program. Most felt that these services provide a sense of belonging and membership, and give clients a sense of self-worth. Staff believed that the opportunity to learn a profession, along with responsibility, respect, self-value, discipline, self-awareness, enlightenment through education, seminars about drugs and alcohol, and supportive therapies give participants meaningful roles and a sense of control over their lives.

Regarding clients' reasons for leaving the program, staff members indicated that clients leave the program before completion for a variety of reasons, mainly due to the desire to take drugs. They also cited the difficulty of the program's discipline and routine. Most staff members indicated that their program provides motivators or incentives to clients for staying in the program.

Staff members believed that their program made a positive difference in the community and was influential. They stated that financial resources to fight drug and alcohol abuse are an ongoing challenge.

The advice for success in treatment that staff would give to similar programs included:

- *Believe in the possibility of recovery from addiction;*
- *Value life and love;*
- *Give priority to treatment in conjunction with the resident's family; and*
- *Provide staff training on drugs and their consequences, how to handle an addict, and general management.*

Resident Interviews

Interviews were conducted with 14 residents (nine males and five females) participating in various APOT components. The residents ranged in age from 15 to 35 years old.

Most residents stated that they entered treatment voluntarily because they were losing control of their lives, killing themselves with drugs, or felt that they were at the “edge of death.” Goals of the residents when they began treatment included stopping drug use, receiving treatment, gaining control of their lives, and returning to a new,

healthy life. Most stated that they had reached their specific goals, either in part or in full.

The majority of the residents indicated that the parts of the program involving spirituality and/or prayers, including the 12-step program for Christians, were most helpful to them. Other aspects that were helpful included meetings (religious and self-help), parts of the program involving psychology or psychological therapy, and the sentiment group. Most residents thought that the program made a difference in the community, and most also reported that they would prefer inpatient treatment if they had to attend treatment again. Overall, the majority of the residents rated the program as “excellent” and all would recommend it to a friend who needed help for a drug problem.

Focus Group Summaries

This section presents summaries of the focus groups conducted with volunteers from the male adult program, the female adult program, and the Street Kids program.

Male Adult Program Focus Group

A focus group was held with a group of seven adult males who volunteered to participate. Participants were between the ages of 23 and 47, and they had been in the program 4 to 5 months. The residents indicated many beneficial aspects of the treatment program, including spirituality, relapse prevention, individual psychological counseling, and labor therapy. All seven residents felt that the program works.

Information gleaned from the focus group indicated that residents used a variety of drugs before entering treatment, including:

- *Alcohol;*
- *Crack;*
- *Cocaine;*
- *Marijuana; and*
- *Hallucinogens.*

Female Adult Program Focus Group

A focus group was held with six adult females who volunteered to participate. The participants were between the ages of 20 and 34 and had been in the program between 20 days and 5 months.

The residents used a variety of drugs before entering treatment, including alcohol, crack, cocaine, marijuana, and hallucinogens. They noted many beneficial aspects of the treatment program, including spirituality, the 12 steps, meetings designed for sharing feelings, labor therapy, self-awareness, and goal-setting meetings. All six residents felt that the treatment works for anyone who wants to recover.

Street Kids Program Focus Group

This focus group was held with a group of eight volunteer adolescent male street kids. Participants ranged in age from 12 to 18 and had been in treatment from 4 days to 7 months.

The residents had used a variety of drugs before entering treatment, including alcohol, marijuana, crack, cocaine, and glue. The many beneficial aspects of the treatment program noted by these residents included spirituality, respect, values, discipline, honesty, sharing of feelings, and the 12 steps. All eight residents felt that the program works mostly for those who come with a commitment to changing their lifestyle.

Several key components contributing to the success of the program were identified through the interviews and focus groups with staff and clients. Those components are:

- Spirituality;
- Labor therapy;
- Support groups, self-help meetings, and the 12-step programs;
- Relapse prevention;
- Individual psychological counseling;
- Work with the family, including family therapy;
- Professional training and reinsertion; and
- Meetings designed for sharing feelings and developing self-awareness.

The presence of Father Rahm seems closely linked to the positive force of spirituality in the APOT program. The benefits of labor therapy and the support groups were also frequently mentioned.

PROMISING PRACTICES: BRAZIL

The site visit team identified the following promising practices within the APOT program.

Involving key stakeholders. Throughout the program development process, from planning and implementation to sharing of recognition and rewards of success, Father Rahm collaborated with key stakeholders. He continues to share program accomplishments with them to sustain program funding.

Tailoring activities to local needs. The APOT program was first developed in response to a specific need in the community to help drug users recover. Later, the Street Kids program and Female Recovery programs were developed. This shows that the program is fluid and adapts to the needs of the community as necessary.

Working with families. The APOT program recognizes the need for family involvement in treatment, which includes family therapy, family support groups, and mandatory family attendance at meetings. Family relationships are examined individually to determine the best course of treatment for the family as a unit.

Investing in client development. This is an important component of the APOT program's philosophy. APOT focuses on the individual's spiritual growth, professional development, and general improvement of lifestyle.

Achieving program sustainability. The program has demonstrated economic and social stability since its origin in 1977. Through fundraising, selling products made by residents, and training residents, the program has been able to continue.

Applying effective outreach and media strategies. The program employs effective outreach strategies to recruit participants, particularly in the Street Kids program.

Recruiting and retaining motivated volunteers. The program has a large group of volunteers who assist in various aspects of the program.

Maintaining committed and strong leadership at both the program and community levels. The Director of APOT and Father Rahm, President of the program, are extremely committed to the program. They are also strong community leaders.

CONCLUSIONS: THE APOT PROGRAM

Most of APOT's clients enter the program with broken social ties resulting from their extensive histories of alcohol and drug use and involvement with the criminal justice system. The majority of program participants are single, and many reported that a member of their family is also drug-dependent. This presents the picture of chronic substance users who are likely to be challenging to treat. In addition, in the Street Kids program, APOT works with children and adolescents who have lost their families or family support very early in life. Prior to treatment, the street kids are involved in drug use, have received minimal education, and have little hope for getting out of their situations. This is also a very challenging group to treat. Based on the findings of the evaluation team, APOT has exceeded conventional treatment programs in reaching and helping these children.

As is very common in TCs, the majority of participants who left APOT did so in the first few months. Nonetheless, APOT has succeeded in obtaining high completion rates. According to the findings, nearly one-third (32 percent) of program participants graduated. This rate of completion exceeds that found in many studies. The high rate of graduation among the participants of the APOT program is critical, since treatment completion is related to positive outcomes, such as a reduction of drug use and reduced involvement in criminal activities.

Through the Street Kids program, APOT has achieved its goal of reintegrating participants with their families. The evaluation team also found that the APOT program has been very effective in its primary mission of reinserting street children into the community, with 72 percent of the Jimmy Hendricks House residents and 50 percent of the Middle House residents successfully reinserted back into the community. This is a remarkably high success rate.

Clearly, APOT helps its clients. Overall, both staff and residents consider APOT an effective program, and it has an excellent reputation in the community. By addressing community needs as they emerge, APOT's flexibility allows the program to continuously address the needs of the clientele.

PERU

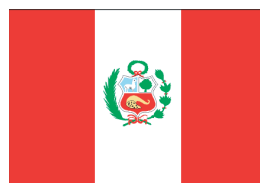


LATIN AMERICA



BACKGROUND: PERU

Peru is the largest producer of coca leaves, which is the chief ingredient used in cocaine production. Peru is also the primary exporter of cocaine base. The cultivation of coca leaves has been a significant source of income for Peruvian people for hundreds of years. Coca was cultivated for use by the Peruvian people for chewing, as medicine, and in rituals. The use of coca in the production of drugs is a more recent phenomenon. In the mid-1970s, organized crime began promoting the cultivation of coca in response to a growing global demand for cocaine. Consequently, peasant families soon became dependent on coca cultivation and drug processing to make a living (ODCCP Website 2001).



More recently, cultivation of coca leaves has declined due in large part to an increase in local and international drug interdiction efforts and a significant increase in the cultivation of coca by the neighboring country of Colombia. This decrease has led to a 50 percent drop in the supply of Peruvian cocaine on the world market. Nevertheless, 1 percent of the Peruvian people over the age of 15 use some type of cocaine-based product. Peru's lifetime prevalence of use of coca paste is the highest of all the countries in the Americas (ODCCP Website 2001). Cannabis use in the Peruvian population over the age of 15 is only slightly lower than cocaine use in the same population (ODCCP 2001). Only 5.6 percent of those treated for drug abuse were treated for cannabis-related abuse.

In addition, street children constitute a significant problem in Peru. Most are of Andean descent, with estimates of about 200,000 children working on the streets and about 6,000 actually living on the street in the city of Lima. Unfortunately, drug use is prevalent among street children. Several institutions provide services to street children in Peru. Hogar Juan Miguel is a home for street children that provides shelter, food, and psychological help. Villa la Paz is a center for destitute and abandoned children. Hogar de la Madre Teresa de Calcutta in La Perla, Callao, is a home for mentally ill and drug-addicted youth. Hogar "San Francisco De Asis" is a home for destitute and ill children. In addition, Centro de Información y Educación para la Prevención del Abuso de Drogas (CEDRO) runs shelters for street children. Villa Maria del Triunfo-Complejo Deportivo in San Gabriel runs a shelter for street children, an educational program, and a sports complex. Although there are several resources for street children in Peru, the Instituto Mundo Libre (IML), described in the following pages, appears to be the only program offering comprehensive drug abuse treatment services in a TC setting.

DESCRIPTION OF PROGRAMS VISITED: PERU

The Instituto Mundo Libre

The Instituto Mundo Libre (IML) No Walls Foster Home for Street Kids (Instituto Mundo Libre Comunidad Terapeutica de Puertas Abiertas) is a residential treatment program for homeless boys aged 9 and above who use drugs. In 1993, the U.S. Department of State's Office for Narcotics and Law Enforcement and the Pan-American Health Organization sponsored and provided funding for this program.

As part of their rehabilitation, the children receive psychotherapy, work skills, and training. Once the children are drug-free, they return to school. The single IML program site is in downtown Lima.

The two main features comprising IML's methodological approach are: (1) to offer street children a home where they are able to learn proper hygiene and eating habits, and, more importantly, (2) offer the children a family environment.

Philosophy

The philosophical cornerstone of the program is the profound belief that individuals (in this case, street children) can change if they are:

- Respected, listened to, and valued;
- Given loving care and attention;
- Offered the opportunity and conditions to change their lives; and
- Acknowledged as valuable and dignified individuals.

Treatment is administered based on love, the development of responsibility, and the development of life expectations and aspirations of the children involved. The treatment techniques are innovative and do not correspond to a particular school of treatment. Rather, the treatment offered in the IML program is a combination of several techniques, which makes this TC unique.

The program includes sports, recreation, and therapeutic and formative activities oriented to rehabilitation. The therapeutic plan is tailored to the individual. Through reorientation and dialogue, each youngster learns to accept the rules and self-discipline established in the program, and how to form interpersonal relationships. The program also provides motivators or incentives to clients.



Program Objectives

The fundamental purpose and final objective of the program is to reinsert clients into their families and/or prepare them to be independent. To accomplish this, the program facilitates rehabilitation and serves as an agent to reintroduce the street children into society. The general objective of the IML is to offer street children and adolescents a home where they will receive all of their basic emotional and physical needs (such as food, clothing, lodging, and health care) in a family environment provided by the project's staff. This environment, along with continued psychotherapy, helps them attain improved social skills, adequate hygiene, and good working and eating habits. The program also gives psychological and social assistance (individually and in groups), prepares children educationally, and trains them in pre-labor productive workshops. In addition, they provide guidance for the children's relatives to improve the relationships at home, and thus foster a reintegration with the family.

The more specific objectives of the IML program are as follows:

- Develop prevention and protection programs for high-risk children and adolescents, especially for those who have drug abuse problems;
- Rehabilitate street children from drug consumption and inappropriate behaviors acquired in the street environment;
- Increase the self-esteem of children and adolescents and help them develop a sense of social competence as they confront the challenges of daily life;
- Provide children with medical, psychological, and social assistance from trained professionals;
- Rehabilitate children through moral development, school training, and work skills;
- Reinsert children into their families and/or society as productive individuals;
- Make the public aware of the difficulties faced by abandoned children with drug addiction problems; and
- Develop permanent campaign programs against drug abuse through various mass communication media.

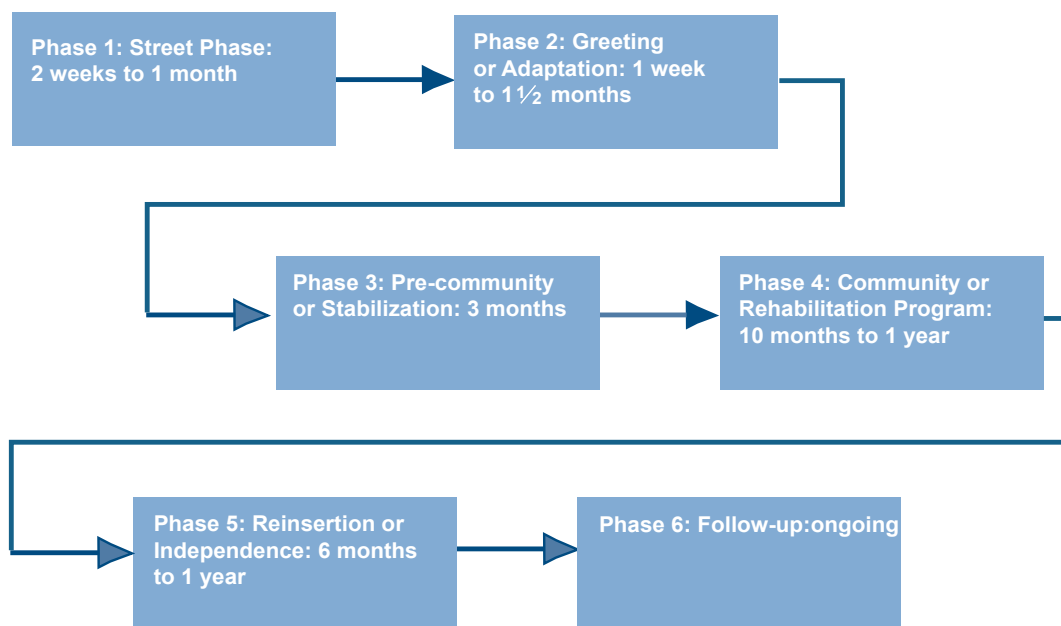
Services Provided and Phases of the Intervention

The therapeutic intervention at IML consists of six phases:

1. Orientation;
2. Intake;
3. Pre-community;
4. Community;
5. Reinsertion; and
6. Followup.

The criteria for moving to the next phase include: permanence on the premises, adaptation to social rules, involvement in activities (integration), and individual life projects. Each phase of the program is described in detail in the following sections and is depicted in **Figure 1** below.

Figure 1: Phases of the Intervention



PHASE 1: ORIENTATION

Initially, IML street educators wander through different locations in the city and establish contact with street children between the ages of 6 and 17. This may take 2 weeks to 1 month. The street educators talk and relate to the street children, who are

also called *pirañitas* (small piranhas) because as a form of survival they congregate, steal, and attack as a group.

Street educators recruit a large number of the clients at IML. They carry food, games and soccer balls, and a first-aid kit and medicine to treat minor wounds. When establishing contact with street children, the street educators always remember that they have entered the habitat of street children and should be comfortable with adapting to their rules.

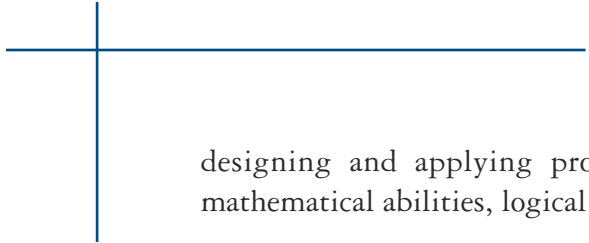
At first the educators will only observe the children, possibly buy the items some of them sell (mainly candies), and slowly get closer to each child. When the street educators have been able to get a child's attention and trust, they speak with the child about the IML program, its rules and regulations, and the activities that take place there. Each child who shows interest is invited to enter the program, with the hope that he or she will decide to stay.

In some cases, children who already have been in the program want to return. Although these children come spontaneously, the street educators' preliminary work with them is important in the decision to return. Other children may enter the program by orders of a judge or the police, or they may be referred by other nongovernmental organizations such as the "Children's Educators Network and Street Adolescents" (Red de Educadores de Niños y Adolescentes de la Calle) and The Institute for the Well Being of the Minor and the Family (El Instituto pro Bienestar del Menor y la Familia). Other referrals come from street children who know about the program or who have benefited from it. Parents of children that have been in the program also make referrals.

PHASE 2: INTAKE

In this phase, which can be considered the "Admission" phase, the child is received into the program. The main concept in operation at this time is "no pressure," and the phase can last from 1 week up to 1 month. In the beginning, the child undergoes psychological evaluations, drugs used are identified, and other background information is collected. A medical examination and several laboratory tests also are done. If any pathology is found, it is treated. Children receive medical attention at IML and at the Hospital del Niño (Children's Hospital). The child is kept under observation so that he or she can receive support during periods of possible withdrawal. When ready, the child is introduced to the other residents and he or she participates in basic workshops.

After a thorough medical, psychological, and social evaluation by professional staff, the child is informed of the characteristics and scope of the program. A multidisciplinary team, whose aim is to improve educational performance, works with the child,



designing and applying programs to improve attention, concentration, focus, mathematical abilities, logical reasoning, and memory.

PHASE 3: PRE-COMMUNITY

This phase, which is characterized by tolerance, is a stabilization phase and may take up to 3 months to complete. During this phase, the child begins periods of programmed individual and group therapy to reduce levels of aggressiveness or any other harmful traits identified. The child is also prepared to accept some responsibilities within the TC by participating as an assistant in its functions.

PHASE 4: COMMUNITY

Community is the intermediate phase in the program when “accountability” is the key term. This phase may last 10 months to 1 year. During this phase, the child is involved with responsibilities within the TC. For example, he or she attends school, as well as workshops that build professional skills, such as candlemaking, woodworking, and ceramics. In this phase, the child also participates in administrative areas and helps in the kitchen. Additional activities and services offered to youth during Phase 4 are:

- Art workshop (twice a week) and formative and occupational workshops (three times a week);
- Daily psychological assistance (depending on each resident’s need);
- Individual and group psychotherapy;
- “Friendly encounters” (addressing specific emotional and family problems, self-esteem issues, and expectations and projects for life);
- Group dynamics;
- Educational seminars with specific topics (sexuality, self-esteem);
- Assessment of drug use behavior (individualized frequency record);
- Daily activities (personal hygiene and household responsibilities);
- Recreational activities (twice a week);
- Socioterapy (weekly assemblies for the entire population);
- Daily morning meetings; and
- A weekly general assembly when children can speak openly about their concerns and needs.

PHASE 5: REINSERTION

In this phase, the child should feel capable of achieving stated goals, and the driving concept is “self-confidence.” Six months to 1 year is the length of this phase. Children often reach this stage as they approach 18 years of age, are stable enough to return to their families, or are independent. Independent children are those who return to the community, but do not have a family or have a family that needs therapy.

Reinsertion into family and society is the primary goal of the individual program for every child and family. As often as possible, reinsertion will take place in the child's nuclear family, or in his or her previous household.

If such reinsertion is not possible, the child will be reinserted in their extended family (grandparents, uncles, siblings, etc.). When family reinsertion is not suitable, the institution will train the child through readiness and occupational workshops, through which the child will begin to appreciate and recognize his or her own capabilities through work performance. Such training allows the child to perform well in life and function alone in society.

PHASE 6: FOLLOWUP

The Followup phase includes all children that have completed treatment. During this phase, adaptation is monitored and support related to daily living is provided. Followup is ongoing, as necessary.

Funding and Relationships in the Community

IML is a private, nonprofit organization officially recognized by the Peruvian Government through the Ministerial Resolutions-Education and Ministry of the Presidency. Internationally, IML is a nongovernmental organization recognized by the United Nations and its agencies (Pan-American Health Organization and United Nations International Children's Fund), as well as by the Organization of American States. IML is an active member of the World Federation of Therapeutic Communities, the Latin American Federation, and Peruvian Federation.

On December 16, 1998, the Ministry of Education issued a resolution that authorized the establishment of an occupational education center within the IML premises, acknowledging IML's training excellence through the occupational and readiness workshops.

Funding for IML comes from several sources, including the American Embassy's Narcotics Affairs Section, donations from interested parties and businesses, and self-financing through the sale of products manufactured by the children, such as

ceramics, candles, wooden objects, and so forth. Staff members indicated that the financing provided by the embassy had been reduced; therefore, resources in general have been insufficient to support activities at IML.

Key Findings

This section presents findings from the evaluation, including analyses of data collected by IML that was shared with the evaluators; interviews with staff, residents, and community members; and focus group reports. The evaluators conducted descriptive analyses on the data collected by the program. The data includes youth who entered the IML program from January 1994 to May 2001, and those who left the program between March 1994 and June 2001. In addition, some findings reported in IML's 1996 to 1999 reports are also included.

Description of IML Residents

Nearly half of all residents (48 percent) entered treatment between the ages of 11 and 13. Thirty-eight percent entered treatment between the ages of 14 and 17. The average age of residents entering treatment was 13 years. About half of the residents (48 percent) had never been in an institution previously or had been in only one institution. See **Table 8** below.

Table 8: Previous Institutionalizations

NUMBER OF PREVIOUS INSTITUTIONS (n=413)	PERCENT OF RESIDENTS
0	22%
1	26%
2	24%
3 or more	28%
TOTAL	100%

At the time they entered treatment, the majority of residents (56 percent) had been living on the streets for less than 2 years, as shown in **Table 9**.

Table 9: Length of Time on Street

TIME ON STREET BEFORE TREATMENT (n=389)	PERCENT OF RESIDENTS
Less than one year	37%
>1 year, but <2	19%
>2 years, but <4	23%
>4 years, but <6	12%
6 years or more	9%
TOTAL	100%

The majority of residents (74 percent) were in treatment at IML only once. Another 14 percent were at IML for a second time. Most residents came into treatment through an IML street educator (34 percent) or were self-referred (28 percent). A quarter of the residents were referred to treatment through a judge, police, or other source (such as the family or church). A list of referral mechanisms appears below in Table 10.

Table 10: Referral Mechanisms

REFERRAL MECHANISM (n=837)	PERCENT OF RESIDENTS
Educators	34%
On their own	28%
Judge	10%
Police	8%
Other (family, church, etc.)	7%
No data available	13%
TOTAL	100%

School Level

Normally, street children and adolescents drop out of school before abandoning their homes. These children are 2 years or more behind their normal grade level; therefore it is very difficult to reincorporate them into a standard age-based educational system. Hence, most of the population is enrolled in special educational centers. Only a small group at IML is able to attend regular school.

Place of Origin

Most of the children residing at IML (48 percent) come from marginal urban zones in metropolitan Lima, such as Comas, Huaycán, San Juan de Lurigancho, Villa María del Triunfo, Pamplona Alta, and José Galvez. A smaller number (32 percent) come from highland provinces, as well as from the central coast areas, such as Junin, Cerro de Pasco, and Ica, Chiclayo. The main area where street children live is downtown Lima, where trade and population are concentrated.

Seventy-four percent of the children at IML state that they ran away from home because of physical abuse paired with psychological abuse. Another 20 percent left because of economic problems, such as unstable housing, poor nutrition, lack of health services, and lack of resources to go to school.

Family and Street Histories

Most of the children (72 percent) come from reconstituted or incomplete families. The families of these street children typically have conflicting interpersonal relationships among their members. Spousal relationships in the families are often dysfunctional. There also can be a dysfunctional hierarchy among many families of street children, with parents and children each trying to impose their authority. In most of these families, rules and regulations that would guide the children's behavior are not clear. In fact, supervision and control of the children is scarce or nonexistent. This lack of attention drives children to spend more time on the street.

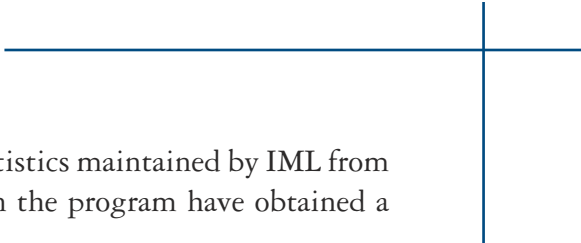
Drug Abuse

According to data collected by IML on program residents through 1999, 90 percent of the total population served by the institute had used drugs. Only 5 percent had never used them (n=460). Drugs used include inhalants, alcohol, marijuana, and cocaine-based paste.

Retention and Reinsertion Data

The mean length of stay in the program was approximately 4 months (125 days, n=541). More than half of the residents leave the program in the first 30 days (54 percent), with 45 percent of those residents leaving in the first 2 weeks. The remaining 46 percent stayed more than 1 month, including 24 percent who stayed more than 6 months.

Analyses were conducted to examine the residents' reasons for departure and reinsertion status. Overall, the success rate for the program was 48 percent reinsertion back into the community over the 6-year period, 1994 to 1999, with a success rate spanning 80



percent in 1994 to 38 percent in 1999. According to statistics maintained by IML from 1996 to 1999, street children who have participated in the program have obtained a high rate of drug abstinence (90 percent).

Staff Interviews

The program staff is comprised of a number of professionals, including educators, psychologists, a social worker, workshop instructors, nurses, administrative personnel, and volunteers. Staff members indicated that employees only work at the program for about 3 years on average because the salaries are very low and the facilities are limited.

Staff members felt that psychological therapy, the underlying system of the program at IML, and the fact that clients feel loved when they are in the program were the aspects of the programs most helpful to clients. They also considered the treatment plan, individual counseling, group therapy, drug or alcohol education, and psychological and psychiatric evaluations extremely important.

Client Interviews

Eight clients from IML were interviewed. Seven clients reported inhalant use. Other drugs used included cannabis, alcohol, hallucinogens, and cocaine. The average age at which clients started using drugs was 12 years old. Most clients had been in treatment before and entered treatment at IML voluntarily. Reasons given for entering treatment included wanting to change, to improve life, and to go to school. Clients wanted to stop inhaling and finish grammar school, increase their ability to study, and complete the program and procure a job. Clients rated the basic education classes, drug or alcohol education, treatment plan, art workshops, and health education as “extremely helpful.” Seven out of eight clients indicated that the program at IML was either “excellent” or “good,” and all eight said that they would recommend the program to a friend who needed help.

Community Member Interviews

Four community members were interviewed to determine how the program is viewed by the community. The community members were familiar with the purpose of the program and believed that it was good for the children. They also thought that the program made a difference in the community because it helps rehabilitate street children and provides them with a home, instructors, and psychologists who can help them. Additionally, all four community members indicated that they would recommend the program to someone they cared about who may need help.

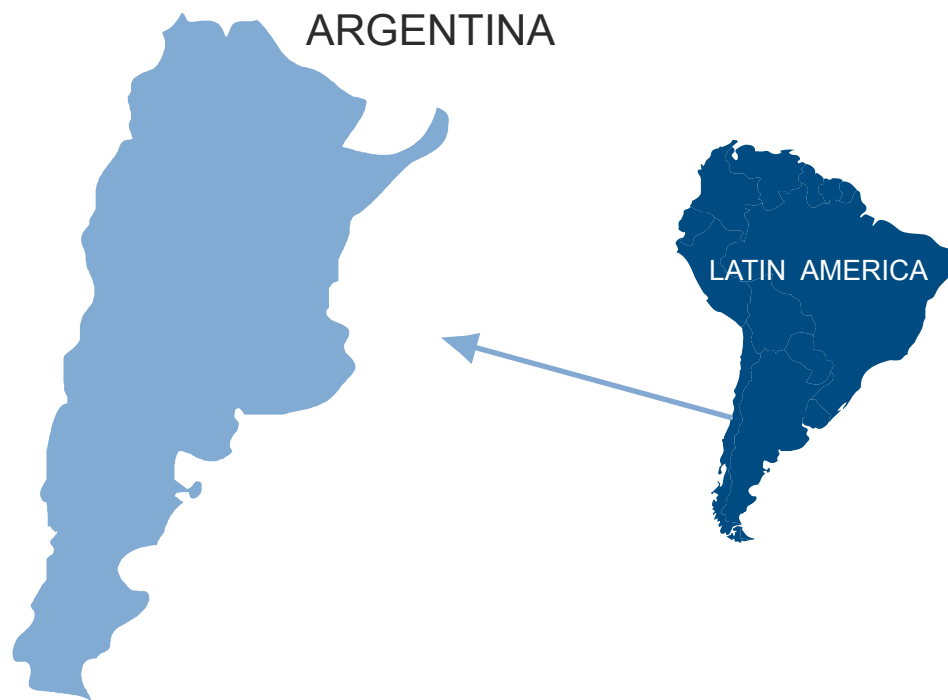
PROMISING PRACTICES: PERU

- **Involvement of key stakeholders.** Important community stakeholders are involved in the entire program development process, from planning and implementation to sharing of recognition and rewards of success.
- **Tailoring activities to local needs.** The IML program was developed in response to a need in the Lima community and in the country of Peru to help street children stop using drugs and find a better way of life. The program is fluid and adapts to the needs of the community as much as possible.
- **Decrease in substance abuse and maladaptive behaviors.** IML is successful in reducing substance abuse and other dysfunctional behaviors among the clientele. IML reports a 90 percent reduction in drug use among its residents, which contributes significantly to public safety.
- **Integrating family into the therapeutic approach.** IML's goal is reinserting street children back into their families, and it has been successful at meeting this objective. Forty-three percent of the residents rejoined their families. IML recognizes the need for family involvement in treatment. Family relationships are examined individually to determine the best course of treatment for each child.
- **Investing in client development.** The IML philosophy focuses on the individual's educational and professional development, moral growth, and general improvement of lifestyle.
- **Applying effective outreach and media strategies.** The program employs effective outreach strategies to recruit participants and motivate youth to come to the program. Street educators work in places with a high concentration of street children. They have specific techniques for engaging the children and letting them know about the program.
- **Recruiting and retaining motivated volunteers.** Volunteers provide company to the children and help with their games and sports activities. In certain instances, a volunteer may perform professional tasks or conduct outreach.
- **Identifying, recruiting, and retaining clients based on their needs and program objectives.** Through careful recruitment and screening, the program identifies the clients it can best serve. In addition, the ability to retain clients increases the likelihood of recovery.
- **Contributing to the removal of social, cultural, and economic barriers within and beyond the community.** Achievements with its campaign for social sensitization include the exhibition and sale of products at cultural fairs and trips for youth to other Nations. The goal is to help the community understand that people in recovery can be productive citizens.

CONCLUSIONS: THE INSTITUTO MUNDO LIBRE



According to these findings, IML is the only program of its kind in Peru. The children who come to IML have suffered incredible mistreatment in their homes, so they prefer to live on the streets, seeking affection and better living conditions. They often end up as victims of prostitution, child labor exploitation, and delinquency. Many youth also have serious problems related to both alcohol and drug use. Most began drug use early and have a history of physical and emotional abuse. This is a very challenging group to reach and to treat. By offering the structure of a TC to street children, IML has found a way to work with this group and help improve the lives of many of these children.



BACKGROUND: ARGENTINA

SEDRONAR estimates that approximately 1 percent of the population of Argentina seeks assistance for substance abuse treatment, and the organization provides scholarships for 230 clients annually. Cambio program staff members indicated that the characteristics of drug abusers in Argentina have changed dramatically over the past 10 years. Previously, the substance abusing population typically had well-defined social structures. Substance abusers sometimes committed small thefts and were involved in minor disputes with the law. Today, however, a greater percentage of drug users are much younger, are experiencing an absence of structure at home, and live in violent environments. Consumption patterns are far greater than before, with use of increasingly dangerous substances.



Rapid social and political changes in Argentina have had a devastating affect on the Government's response to the drug problem. A total of 400 drug treatment programs are registered on paper, but only 43 receive any kind of government subsidy. Many treatment programs have recently closed their doors due to a lack of funding.

The individual who heads SEDRONAR had been in office only 10 days at the time of the Danya site visit to Argentina. There was no written strategic plan in place to address the situation of illegal drug use. The short-term plan, however, was to assess all treatment programs registered on paper and then verify their current status, treatment modalities, and success indicators.

DESCRIPTION OF PROGRAMS VISITED: ARGENTINA

Cambio

Cambio is a nonprofit, nongovernmental organization affiliated with SEDRONAR. The administrative, directive, and therapeutic structures are linked in such a way that costs are lessened and the program operates quite efficiently. Staff members at the Cambio program have worked together for over 10 years, developing a coherent, unified philosophy based on the TC concept. Over the years, this team has integrated effective practices from other treatment models. The current philosophy of the program views human behavior as the output of an interrelated system involving individuals, families, and all other elements of a person's social support network. Therefore, the program adopts a "systems" approach, promoting change and restructuring of systems, including the family, as part of a comprehensive strategy for controlling internal and external triggers for drug use. During the treatment process, the drug abuser takes responsibility for re-educating and changing his or her social networks.

The family is the primary focus of treatment in this systems therapy approach. Staff members refer to the number of "families in treatment" rather than the number of individuals in treatment. Therefore, one of the requirements for entry into the residential program is a supportive family unit that is willing to become part of the treatment process. Many fathers, mothers, aunts, uncles, brothers, sisters, and even neighbors were participating in the program.

Cambio defines its philosophical and ideological model as Socio-Therapeutic-Educational. It believes that the change that takes place during a drug addict's rehabilitation is facilitated through social readjustment, psychotherapy, medical approaches, and a variety of daily learning experiences.

Other foundational program philosophies include the belief that the individual can learn to use cognitive-behavioral tools to regain control of his or her behavior. Relapse is accepted as part of the rehabilitation process. This view is based on the success rates of relapse prevention programs and on learning theories. The

process of social reinsertion (preparation for life in the community) is begun at the time of the first contact between the addict and the program, and continues until treatment is completed. Cambio has a spiritual emphasis on values that is reinforced throughout the treatment process, based on the TC model.

As part of the educational and social reinsertion component of the program, professional skill-building and research are conducted in a computer lab housed at the main facility and are accessible to both program residents and staff members. Community members can also use the computer facilities for a small fee.

Staffing

A decade ago, recovering drug abusers accounted for many of the staff members in treatment programs in Argentina. However, Cambio's current staff members told evaluators that this approach frequently led to problems, as program directors and therapists often relapsed. Since then, a purposeful effort has been made to encourage the professionalization of therapists in substance abuse treatment programs throughout Argentina. In particular, they prefer to not use therapists who are in recovery. The program now operates through a multidisciplinary approach that uses highly trained professionals in all aspects of treatment. Members of the professional staff include 2 physicians, 12 licensed psychologists, 6 licensed social workers, 3 counselors, and 2 staff members with a Master's in education. Currently, there are no professionals in recovery among the Cambio program staff, with the exception of some TC staff.

Services

The treatment modalities include ambulatory or outpatient treatment, a day community, and TC residential treatment. The admissions and initial diagnostic processes take approximately 1 month. This allows each case to be channeled to the appropriate type of treatment, with a treatment plan developed to include the family unit or a strong social network. In the TC, residents are sometimes allowed weekend home visits once the client and the family unit are stabilized. This usually occurs about 15 days after admission. Plans for social reinsertion back into the community start on the first day of admission and continue until each resident has a well thought out life plan that will be shared with his or her social support network.

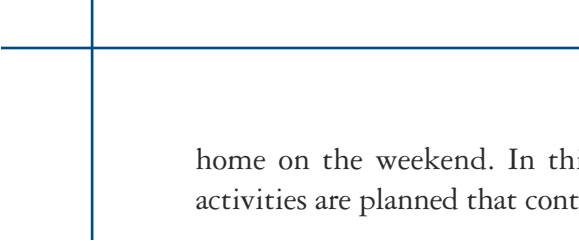
Types of Adult and Adolescent Treatment

"Adult (or Adolescent) Outpatient Treatment" is for clients who have a strong desire to end their drug addiction. They attend therapeutic groups several times per week while residing at home.

In "Day Community," individuals participate in therapeutic groups and activities such as workshops, sharing meals, and homework sessions. They spend significant time at the program, yet return home after the day is over.

In Cambio's outpatient unit, separate programs address "alcohol only" problems and "drug addiction" problems that involve drugs other than alcohol.

In the "Boarding House in the Therapeutic Community," clients are housed in a farm that is part of Cambio on weekdays and return



home on the weekend. In this beautiful place, specific therapeutic and recreational activities are planned that contribute to recovery.

Phases of Adolescent Outpatient Treatment

Cambio works closely with the families and communities of adolescent clients in the day program. This allows for continuity in the adolescent's life, as outpatient treatment can take place without having to cut off all ties with school, friends, and activities in which the adolescent takes part.

The admission process takes place during a 1-month period. The key objectives are to:

- Reach a diagnosis and evaluate all possibilities for treatment;
- Obtain a commitment to treatment on the part of the adolescent;
- Determine what is motivating the client to participate; and
- Promote the acceptance of initial program rules and guidelines.

Under the Work Plan for this phase, the adolescent clients meet for treatment three times weekly. Parents can attend the family support groups once a week. A weekly family interview is also held as a method of involving the parents and encouraging them to take some responsibility.

Phase A lasts approximately 6 months. The key objectives are to:

- Sustain and evaluate adherence to the initial rules of treatment;
- Generate and sustain the development of responsibilities such as studying and work;
- Strengthen the life context to reduce the risks of a return to drug use; and
- Create new support contacts.

The adolescent attends two weekly self-help groups coordinated by professionals during this phase. The family attends one weekly support group. Two followup family interviews are held every 15 days, as well as individual interviews and workshops determined by the treatment plan. Topics of discussion may include:

- High-risk situations;
- Relapse prevention;
- Desires to use;
- Free time and plans for the weekend;
- Money management; and
- Formal responsibilities.

RULES FOR THE ADOLESCENT DAY TREATMENT PROGRAM

Abiding by these rules and the norms of this modality of treatment will serve you in your changing process. If at the beginning you don't understand why you have to follow some of the rules, then you must ask so we can analyze the requests together. It is your responsibility as well as ours that this house be a secure and important place for you. Let us make something different of this house. Respect it and demand respect from others toward it.

- *You must comply with all the rules.*
- *If you come in later than 9:15, you will not be allowed to enter the house.*
- *You must follow the schedule of the house exactly.*
- *During your daytime schedule, you will not be allowed to go out to the street unless it is for a planned therapeutic activity.*
- *When you need to use the restroom, you must let the person in charge know.*
- *You may not smoke in the groups or in the areas that are carpeted.*
- *There may not be more than two lit cigarettes in an enclosed area at one time.*
- *You may only enter the staff office if you've been authorized to do so.*
- *If you need to use a tool or any material for a job that you are working on, you must ask the person in charge.*
- *You must complete all activities in the program.*
- *You may not date and/or have any sexual relations with anyone in the program.*
- *You may not physically or verbally assault anyone.*
- *You may not answer or use the telephone without prior authorization from the staff.*
- *If you are taking any form of medication, you must turn it in to the staff.*

Phase B lasts approximately 8 months. The key objectives are to:

- Focus on the personal and family history and work through aspects that are related to substance abuse;
- Strengthen the commitment to any personal goals that have been set; and
- Sustain the life context that helps limit the risks of relapse.

Under the Work Plan for this phase, professionals coordinate a self-help group during the week. Family support groups are held monthly. Family and individual interviews are also held monthly, and appropriate workshops are conducted. Topics of discussion include:

- Self esteem;
- Relapse prevention;

- Personal and family history;
- Building of an alternative support network; and
- Development of a life project.

Phase C of the Adolescent program lasts approximately 6 months. The key objectives are to:

- Evaluate the progression of treatment;
- Sustain and enhance a support network;
- Evaluate the need for receiving other types of individual and family assistance; and
- Prevent relapse.

The weekly schedule for the adolescent day program is shown in Table 11.

Table 11: Weekly Schedule

Time	Weekday Activity	M	T	W	Th	F
0900	Arrival	✓	✓	✓	✓	✓
0915–1030	Investigation biography workshop		✓			
0930–0950	Breakfast	✓				
0930–1100	Common group			✓		
0930–1100	Group FA Group FB					✓
1000–1130	Group FA	✓				
1045–1230	Group FA Group FB		✓			
1110–1245	MATES (tea time)					✓
1115–1245	Labor areas			✓		
1145–1245	Computer workshop	✓				
1230–1300	Free time		✓			
1240	Duties	✓	✓	✓	✓	✓
1300–1400	Lunch	✓	✓	✓	✓	✓
1430–1530	Writing and reading workshop	✓				
1430	Departure FA		✓			
1430–1530	Program group weekend					✓
1430–1600	Parent groups and physical education workshop			✓		
1500	Departure FASE					✓
1600	Departure FA			✓		
	Colloquium interviews	✓	✓	✓	✓	✓



Phases of Adult Outpatient Treatment

The general objective of outpatient treatment for adults is to achieve abstinence from drugs, in part by brainstorming about the reasons for drug dependency. Soon after the first consultation, the client enters the Admission phase, which lasts approximately 1 month. The Admission phase is designed to obtain a commitment to treatment and to promote the acceptance of program norms. The client attends individual and family interviews twice weekly for approximately 1 month. An individual evaluation is conducted concerning the individual's personality traits, drug use, and family and social situation. The families attend a weekly support group.

Phase A lasts about 6 months. The objectives are the same as for the adolescent outpatient; however, greater emphasis is placed on identifying the behaviors that facilitate drug use. Discussion topics address relapse prevention, ways to spend free time constructively, development of a social network, and increasing levels of responsibility in life areas such as money management and work responsibilities.

Professionals coordinate self-help groups twice weekly during this time. Therapy addresses how to identify risky situations and remain abstinent. Families and other persons in the individual's social network are interviewed by therapists. They hold their own group meetings approximately twice a month. Individual interviews are conducted according to necessity as determined by the therapeutic team.

Phase B lasts approximately 8 months. Again, objectives of this phase are similar to those of adolescent outpatient treatment, with more emphasis on strengthening decisionmaking abilities. Areas for discussion are generally the same as for adolescent treatment. As part of the Work Plan, during Phase B professionals coordinate weekly self-help groups, family support groups meet weekly, family interviews are conducted monthly, and individual client interviews are done as needed.

Phase C is approximately 4 months long and has as its objective an evaluation of treatment progress, including a final evaluation of the substance abuse problem. Topics discussed include release from treatment and related fears; feelings about drug use; development of a personal, family, and social life plan; and decisionmaking and autonomy. Professionals coordinate a self-help group once every 15 days during the first 4 months of this phase and later, conduct two monthly evaluations and followup activities.

Focus Group Results

Perhaps the most valuable data collection method used in Argentina was the focus group approach. Several focus groups of staff members, program residents, national and academic authorities, and family members were conducted over the course of the visit. The site visit team also gathered information using an unstructured interview approach, which resembled an informal conversation. They scheduled client and staff interviews to talk with respondents one-on-one, or in some cases, conducted interviews with multiple respondents.

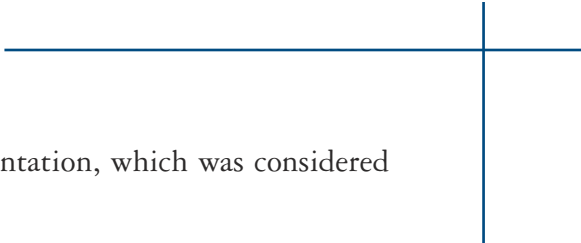
Focus Group with TC Residents

Evaluators conducted a focus group with 12 clients in the TC. The participants' ranged in age from 17 to 35 years old, with the average age being 23 years old. They had an average of 21.5 weeks in residential treatment, ranging from 1 to 52 weeks. Findings from the resident's focus group are as follows.

- Alcohol was the most common intoxicant that had been used by residents (92 percent), followed by marijuana (83 percent), and cocaine and tobacco (75 percent).
- Other drugs mentioned were pills (25 percent), hallucinogens (17 percent), and inhalants and ecstasy (8 percent). Heroin and other injection drugs were not mentioned by any of the participants.
- Ten of the twelve participants in the focus group reported using four or more types of intoxicating substances. The most frequent combination, reported by 50 percent of participants, was cocaine, marijuana, alcohol, and tobacco.
- The average length of time participants' reported having used intoxicating substances was 6.3 years.
- Half of the focus group participants were referred by either the judicial system (25 percent) or other treatment programs (25 percent). The remaining focus group participants were distributed evenly between family or voluntary referrals or other.

On average, the residents referred by the judicial system were older than residents admitted through other mechanisms (26 years old versus 22 years old), and had spent more time in treatment program (31 weeks versus 19 weeks).

Focus group participants considered the weekend pass the treatment component most important to them. The pass allows residents to visit family members over the weekend in a planned, controlled manner. Weekend passes are given each week. The second most



important component mentioned was the use of confrontation, which was considered very beneficial.

Focus Group with Graduates of Cambio in Cordoba

Evaluators interviewed four graduates from the Cambio program. The participants' ranged in age from 19 to 30 years old, with the average age being 24 years old. The average time in the program was 6 months. The average time since release from the program was 2 years.

Focus Groups with Families in Cordoba

This focus group consisted of 60 participants, of whom approximately 32 percent were men. Many family members spoke about how the program has helped them and transformed their lives. Within this group were a number of volunteers who now speak in the community and in schools about drug and alcohol prevention. They also provide support for other families who are just entering the treatment program. The most important component of the program, according to family members, was its emphasis on teaching families how to structure their home environment and handle relapses.

Focus Group with National and Academic Authorities

A focus group was formed with seven key members of the Rio Cuarto University of Cordoba, including the University President and Deans, and the Sub-Secretary of Planning for the Prevention and Assistance to Drug Addiction and Fight Against Drug Traffic. These participants from academia stated that the experience gained with the Cambio Program could be used as a model for formal university-level training programs. Addiction professionals could be sensitized to the needs of the client population and trained to manage a range of substance abuse issues.

The Sub-secretary suggested that the results of the Cambio program evaluation could be used to create a model to stimulate systematic evaluations of other rehabilitation programs in Argentina.

Key Findings

Key findings from Danya's site visit to Argentina include:

- Approximately 1 percent of the population of Argentina seeks assistance for substance abuse treatment, with a total of 140,000 people who need help for their drug problem.
- A purposeful effort has been made to encourage professionalization of therapists in substance abuse treatment programs throughout Argentina, and in particular, not to use therapists who are in recovery themselves.
- The Cambio program's philosophy is that human behavior is the output of an interrelated system involving individuals, families, and all other elements of a person's social support network. A minimum requirement to enter the residential program is a supportive family that is willing to become part of the treatment process.
- Ten of the twelve focus group participants reported using four or more types of intoxicating substances. The most frequent combination of drugs mentioned was cocaine, marijuana, alcohol, and tobacco.
- In a focus group with people who had graduated from the Cambio program, participants reported group therapy meetings, a caring staff, the presence of well-defined rules, and respect as the most helpful components of treatment.

Program graduates made the following observations about Cambio:

- *The most helpful components of treatment included the group therapy meetings, the caring staff, and the presence of well-defined rules and respect.*
- *The part of the program that needed the most improvement was the vocational workshops.*

PROMISING PRACTICES: ARGENTINA

- The **treatment emphasis is on the family**, not the individual. The family is taught that drug abuse is a symptom of a dysfunctional family system that needs to be adjusted. Thus, efforts are made to restructure the home environment and change communication and reinforcement patterns. In addition, family members learn about the natural cycle of addiction, including relapse and ways to deal with addiction problems.
- **Professionalization of the staff and program** was exemplary. The entire treatment staff had Master's degrees or higher in the health field. Most had university training that focused specifically on addiction treatment. The highly structured, yet flexible treatment process, the evidence of careful treatment planning, and the daily practice of documenting behaviors and interventions in the case notes all supported the finding of a highly professional staff and program.
- **Staff attitudes are caring, constructive, and supportive.** The staff members are committed and caring professionals who work for little to no pay, particularly now that the economic crisis has almost bankrupted the program. Many program residents mentioned that staff attitudes are integral to their recovery.
- **A month-long period of admission and assessment** is conducted before placement is made into the appropriate treatment milieu. This admission period includes multiple individual, group, and family intakes before placement.
- **Planning for re-integration into the community** as a productive member of society starts at the beginning of treatment.
- The **Cambio programs are highly structured**, yet flexible enough to accommodate the changing needs of the community.
- The **use of a computer lab to develop professional skills**, engage in therapeutic online activities, and in particular, educate participants about addiction is unique and highly effective, according to both staff members and residents.

CONCLUSIONS: THE CAMBIO PROGRAM

The Cambio Program has developed effective links and working relations in many sectors of Argentinean society, including political influence with governmental authorities, promotion of program internships with the academic community, collaboration on university training to ensure professional staffing to address drug problems, and close ties to community groups from all levels of society.

Rapid social and political changes in Argentina have had a devastating affect on the Government's response to the drug problem. Recently, many treatment programs have had to close their doors because of a lack of funding. Yet, there is genuine interest in improving the effectiveness of drug treatment and a purposeful effort has been made to encourage professionalization of therapists in substance abuse treatment throughout Argentina. Despite current problems with the funding for drug-related services, attention to drug abuse issues has not been lost in concerns about the economic environment. In fact, many of the service providers interviewed projected an optimistic outlook about their work and the ability to care for clients in the future.

APPENDICES

APPENDIX A METHODOLOGY

The main goal of the evaluation was to identify promising practices that seemed to be related to the program's success. Quantitative data and qualitative data was collected as appropriate during the site visits. Before conducting these site visits, information regarding the projects was collected to tailor the data collection plan and instruments appropriately. This information was collected through a self-study in which the Program Director (PD) and selected staff members and clients responded to questionnaires. If possible, information from records was also reviewed before each site visit. In addition, reports and other descriptive materials on the program were requested in advance. Once the site visits began, interviews with staff members, including the PD, clients (currently or previously in the program), family members of clients, and community members were conducted. Focus groups were conducted when possible. As part of this study, a full description of the program is being provided, including program characteristics, dynamics, outcomes, characteristics of clients, and information regarding the experience of clients in treatment.

The following describes the key forms of data collected:

- In-person interviews with key staff (three or four staff members, including the PD, a supervisor, a front-line person, and a medical staff member, if available);
- Abstraction of information from client records for data on retention, drug use, and treatment compliance (preferably from all clients or a random sample of clients currently in program), if available;
- In-person interviews with clients in treatment (five to eight clients); and
- Additional information available about the program, such as pamphlets, brochures, descriptions, reports, statistics, or findings from previous evaluations.

In addition, when possible, the following were conducted:

- Focus groups with staff members;
- Focus groups with clients;
- Interviews with family members of clients in treatment (one to three); and
- Interviews with clients who have left treatment (one to three).

APPENDIX B

DEFINING PROMISING PRACTICES

The critical first step in developing the protocols that would govern the collection of data and information on substance abuse treatment programs in Europe, Latin America, and Southeast Asia was to define the criteria that would be used in determining a program's successful implementation of a "promising practice." Promising practices would be those program components that, when effectively carried out, would enhance the likelihood of overall program success and, therefore, be considered promising for replication by programs in other areas of the country or in other countries. After a careful review of the literature, the following definition was developed.

We began with the premise that a substance abuse treatment program is a composite of structured intentions and that the practices employed by a program have an overall goal of making those intentions a reality. Not every intention can be expressed in a manner that reflects a measurable outcome. Therefore, a practice for the purposes of this project is defined as any discrete program component that can be isolated, defined, described, and observed. It may be as broad as "recruitment of at-risk youth" or as narrow as an "intake interview." In the first case, there will be a measurable outcome that will allow the practice to be identified as "promising" (for example, a steady increase in program participants). In the second case, there will be no such measurable outcome (only a sense that the interview collects the best information for working with prospective participants), but the manner in which the information is used may lead to a "promising" designation.

A "promising practice" must contribute to one or more of the following intentions:

- Involvement of key stakeholders in the entire program development process, from planning and implementation to sharing of recognition and rewards of success;
- Building partnerships and collaborative efforts to ensure that scarce resources are applied most effectively and avoiding nonproductive duplication of effort;
- Employing a "life-cycle" approach to development that includes needs assessment, development of specific objectives related to needs, planning and design, implementation based on a clear plan and specific design, monitoring of results based on objectives, and evaluation based on measurable results;
- Tailoring activities to local needs and drawing support from local strengths;
- Emphasizing positive, proactive, and prevention-oriented activities and outcomes as part of treatment;
- Reducing substance abuse and other dysfunctional behaviors;
- Empowering communities to take responsibility for themselves through the empowerment of individuals;
- Working with families as a unit or with whole systems;
- Investing in client development;
- Integrating multiple programs and activities and providing intergenerational services;
- Contributing to the removal of social, cultural, and economic barriers within and beyond the community;
- Contributing significantly to public safety and security;

- Providing for effective program management, especially through accountability;
- Achieving program sustainability;
- Improving the transfer of skills and technology within and among communities;
- Applying effective outreach and media strategies;
- Maintaining committed and strong leadership at both the program and community levels;
- Recruiting and retaining motivated volunteers; and
- Identifying, recruiting, and retaining clients based on client needs and program objectives.

APPENDIX C PROGRAM OBJECTIVES

The International Demand Reduction program established the following four objectives:

- Strengthen the ability of host Nations to conduct more effective demand reduction efforts on their own;
- Encourage drug-producing and transit countries to invest resources in drug awareness, demand reduction, and training to build public support and political will for implementing counternarcotics programs;
- Improve coordination of, and cooperation in, international drug awareness and demand reduction issues involving the U.S., donor countries, and international organizations; and
- Utilize accomplishments in the international program to benefit U.S. demand reduction services at home (INL 2000).

APPENDIX D
INSTRUMENTS/TOOLS USED TO CONDUCT SITE VISITS

INSTRUMENTS/TOOLS	NO. OF PAGES
PROGRAM DIRECTOR INTERVIEW	8
PROGRAM STAFF INTERVIEW	3
RECORD ABSTRACTION FORM	2
CLIENT EXPERIENCE INTERVIEW	3
FAMILY MEMBER INTERVIEW	4
CLIENT FOCUS GROUP QUESTIONS	1
STAFF FOCUS GROUP QUESTIONS	1

These instruments are available at:

Danya International, Inc.
8737 Colesville Road, Suite 1200
Silver Spring, MD 20910
Phone: (301) 565-2533

APPENDIX E REFERENCES

Inter-American System of Uniform Data on Drug Consumption (SIDUC). *Report: Brazil*. Inter-American Commission for the Control of Drug Abuse, 1998.

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