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DRAFT DOCUMENT: CICAD HEMISPHERIC GUIDELINES ON THE CONSTRUCTION OF A COMMUNITY-BASED MODEL OF DEMAND REDUCTION

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

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

5.2. Specifics and differences in responses to problem drug use

5.2.1. Low threshold treatment programs

5.2.2. High threshold treatment programs

6. The community model

6.1. Towards the construction of a community-based model

6.2. Vulnerability and health practices in the community-based model

6. 3. Identifying the “community”

6.4. Groups and social climates

6.5. Holistic community action

6.5.1. Community stakeholders

6.5.2. Training of community leaders and workers

6. 5.3. Problem identification

6.5.4. Building the database

6.5.5. Understanding the problem through data analysis

6.5.6. Building awareness and preparation of a community response

7.1. Evaluation of community interventions

7.2. Participatory evaluation

7.3. Types of evaluation

1. Introduction

We begin with the idea that social problems are not ontological entities, that they are not a given that can possibly be discovered or identified, but rather, are defined, that is, they are constructs built up as a process of interaction among the various stakeholders, each with his or her own strategies, interests and relative power (Moro, 2000). The search by the social sciences and the political sciences for objectivity should bring to light through ongoing *epistemological surveillance* the play between actors, interests and relations of power within which the research or action is carried out, rather than refer to pre-formed models or objects.

In general, those who use drugs are branded and condemned, making them "unworthy" of government policies that could offer them a better quality of life, inasmuch as they are thought to present with "self-destructive tendencies", "commit suicidal acts", "behave promiscuously". As stated by Silvia Inchaurraga (2001), this discourse is based on the common view that the "drugs" are responsible for an individual's risky behaviors, a view that obscures the dimension of personal and social responsibility. It is important that this assumption be changed, and that, as the author proposes, the question lies in discovering the individual's relationship with drugs and his position on drugs, risks, life and death.

We begin with the idea that "drugs" do not exist independently of the various different ways they are used. We consider that (…) the *determining factor is not the product, but rather the relationship of the product with the style of life into which it is inserted (...) There are various forms of drug use, which include frequency of use and amounts, and also the type of commitment to the use of drugs as defined by a system of relationships, with its rituals and sanctions organized around the use of the product* (Castel and Coppel, 1994: 230).

We understand drugs as being those chemical substances that are introduced into the human body and that are capable of modifying one or more bodily functions and whose effects, consequences and functions are conditioned by the social, economic and cultural definitions produced by different groups in society. Drug dependence is linked to a particular lifestyle, and not merely to a type of drug or to the pharmacological effect of a substance on an individual. That is, in the socio-cultural construct—in which we include, *inter alia*, social relationships, role negotiations, cultural expectations, identification and construction of the self or ego and/or strategies for interaction--pharmacology plays an important role but cannot be considered the causal factor of dependence.

The current social and health responses to problematic drug use may be grouped as follows: *out-patient* treatment in order to stop using drugs (outpatient clinics, day or half-day hospitals, weekly groups, Narcotics Anonymous/Alcoholics Anonymous, health posts) and *in-patient* (therapeutic communities[1] and psychiatric clinics and hospitals).

[1] Therapeutic communities have become more professional in recent years. They may be, variously, public or private, rural or urban, religious or non-religious, democratic or hierarchical, among other variables.

Treatment may include behavioral therapy, medication, or a combination of both, using practices such as detoxification and in-patient and out-patient psychiatric or psychoanalytic therapy that are designed to change the prejudicial or harmful patterns and attitudes of those who use drugs, in an effort to re-socialize them.

Other initiatives that arose in the nineteen nineties operate from the standpoint of mitigating the risks and adverse consequences of drug use, in order to moderate the negative effects of drug use on the health and social situation of those people who use drugs. Their work has two broad objectives: first, to change the delivery of care to include also services that meet the needs of those drug users who show themselves incapable of benefitting from a "drug-free" program, and second, to develop strategies to prevent and reduce the incidence and severity of drug use problems. Mitigation of the risk and the adverse consequences of drug use seeks to supplement and complement the "just say no", or "abstentionist" approaches, and demonstrates the need to coordinate all types of interventions into an overall policy that brings together primary, secondary and tertiary prevention, as defined below.

The present document is organized into three parts. The first is a summary of the social and health responses that have been practiced in the region. It also seeks to understand the paradigms underlying the practices; what have been the ways of understanding and signifying the person using drugs, and how those practices stand in relation to drug use. Until now, the social sciences have paid scant attention to these responses.

Secondly, we shall examine the various theoretical models that were developed over time as means of understanding and interpreting the use of drugs. Although these models developed sequentially, and each model includes more factors than the previous one, none has lost its relevance. All of them persist in the different terminologies used by those who attempt to explain and provide a response to the drug phenomenon.

Third, we shall develop the community-based model, since we feel that insufficient attention has been paid to it in the region, but that it does warrant particular study. This model posits that the meaning attached to drugs is determined not only by their pharmacological properties, but also by the way in which a society defines drug use and by the drug prevention strategies it uses. The basis on which a community-based model rests is that a true prevention policy cannot be taken out of the socio-economic structure, culture and context of drug users, and that the responses cannot be independent of social groups.

Understanding drug use means understanding that it is multi-faceted and complex, which means that approaches to it must be increasingly inclusive. Thus, this document seeks to assess the strengths and weakness of the interventions and treatment that are being used, and to offer proposals for thinking about and improving the performance of the institutions and organizations that deal with the topic, and for formulating public policies that address problem drug use and the social, health and educational responses in prevention and treatment in a comprehensive way.

2. Background

2.1. Hemispheric Drug Strategy (2010)[2]

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

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

2.2. Plan of Action to implement the Hemispheric Drug Strategy (2011) [3]

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

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

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

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

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

to make policy recommendations of particular importance to the member states, particularly at the community level.

During the forty-ninth regular session of CICAD in May 2011, the Chair of the Expert Group presented his work plan for 2011 – 2012, which, in accordance with the Hemispheric Drug Strategy and its Plan of Action, will develop hemispheric guidelines and recommendation on the following topics: *Integrated communities, Drugged driving, Information for the development of demand reduction policies, and prevention of prescription drug abuse.*

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

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

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

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

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

3. Policy framework

3.1. Recommendations to member states[4]

- Responses that seek to address problem drug use should take a comprehensive approach that is based on human rights and that takes into account the economic, legal, psychological, health, social, cultural and educational dimensions. This will ensure a comprehensive approach to the problem. The different approaches must be coordinated among the different government agencies or Ministries. The necessary budgetary resources must be made available for these tasks.
- A drug policy that seeks to become embedded into society for the long term must necessarily coordinate public sector activities with civil society, and be made into a policy of the State, in order to be safeguarded against the ups and downs of politics and institutions and assure its continuity over time.
- The demand for treatment for persons with problem drug use has increased. However, many of the region's citizens continue to experience a lack of care. Government policies must therefore take account of these shortcomings and make mobilization of society as a whole an essential part of the response, as well as coordinate the various stakeholders and institutions that are addressing these problems.
- The role of the State in addressing the prevention and treatment of problem drug use should be restated in light of current challenges. This does not mean that we should ignore or undervalue the efforts that have been made thus far. The experience and infrastructure that the public sector, NGOs and various stakeholders have built up should be the starting point for any drug policy.
- No State/Government policy should overlook the goal of instilling an approach of comprehensive prevention. This refers to the fact that the area of prevention has achieved poor coverage, both in the public and private spheres, and in many cases, prevention programs have limited budgets and are poorly planned and executed.

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

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3.3. Recommendations to the Executive Secretariat of CICAD

- **v** Social policy on drugs should not lose sight of the fact that drug users are citizens and as such, their rights must be assured (access to health and treatment, prevent social and health harms, change the stigma they experience because of their drug use).
- **v** It is necessary to support the Governments in the technical planning of prevention activities within structures that will enable the different programs to be sustainable, and to this end, should include mobilization of society.
- **v** It is essential to work with Governments to optimize resources for drug use programs, through evaluation and documentation of program outcomes.
- **v** It is necessary to promote Coordination and conciliation of the various methods or theories being used to address this problem should be promoted, so that they are not to be seen as in competition, or else discredited or lacking in effectiveness.
- **v** It is important to draw up a list of institutions and stakeholders working on the topic, as well as to document the experiences and knowledge in the countries, that is, the road travelled so far, and what is left to be done.

3.4. General considerations

- Recognize that the individual lives in a world of interrelated and interacting parts, which must be addressed as a whole.
- Recognize that the individual is an integral being who is also part of the solution.
- Recognize the processes of the construction of society during intervention in social and health problems.
- Recognize the impact of drug use on social, economic and political structures.
- Understand drug dependence as a chronic, relapsing disease that must be treated in multisectoral, interdisciplinary ways given its social, health and economic impact, recognizing social, cultural and ethnic differences among countries and within each country.
- Continue to promote a discourse that is different from the stigmatizing view of drug users.
- Expand treatment services for those who use psychoactive substances.
- Recognize and promote the creation of community-based services and facilities.
- Base the work on a human rights perspective.
- Bear gender differences in mind.
- Work with indigenous populations.

- Promote a comprehensive view by using communications, interactive and participatory mechanisms.
- Develop tools and mechanisms for community participation in order to carry out specific actions.
- Mitigate the risks and adverse consequences associated with drug use.
- Foster the integration of services by forming social protection networks.
- Promote collaborative, participatory work among different stakeholders who may have different interests but who are well-disposed to cooperate.
- Involve members of the community in prevention and intervention teams.
- Promote decentralized policies that respond to the social needs of each country, by developing plans, programs and projects in association with civil society.
- Carry out local participatory assessments, using a qualitative approach, in order to understand the stakeholders' circumstances, and the meanings that they attach to drug use.
- Promote horizontal cooperation initiatives and exchanges of experiences and good practices among countries.
- Specialized training in demand reduction should be infused into education courses that are related to processes of constructing community participation.
- Assure program sustainability, monitoring and evaluation.
- Promote policies for specialized training of health care personnel in drug abuse prevention, treatment and rehabilitation.
- Work on mobile treatment.

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

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

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

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

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

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

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

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

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

4.1. Primary, secondary and tertiary prevention

According to Caplan's classic definition (1980), prevention may be categorized into primary, secondary and tertiary prevention, referring to: connection to the health care system prior to the

appearance of harm or illness; care and treatment once the illness has taken hold, and recovery following treatment. These three levels, when applied to drug use prevention, would be defined as follows: Primary prevention starts with the assumption that no drug use is present and that tools must be employed to prevent first use. Secondary prevention should identify those cases in which drug use is present and where primary prevention did not work, in order to treat it and avoid other associated risks or medical or psychiatric pathologies that may follow from drug use. Tertiary prevention is designed to rehabilitate the drug user and prevent relapse.

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

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

Primary prevention

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

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

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

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

The idea is that beyond merely giving out information, it needs to be put in context and be wrapped into other prevention activities.

Secondary prevention

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

Tertiary prevention

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

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

4.2. Universal, selective and indicated prevention

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

Universal prevention

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

Selective prevention

Selective prevention is done with populations who may be at higher risk for drug use. They are divided into subgroups, depending on a set of characteristics that may be biological, psychological, social or environmental. For example, we could look at children of alcoholic parents, young people outside the school system, young people living in the streets, people who have been physically or psychologically abused, or socially vulnerable groups. The risk is calculated to be the same for all those within one subgroup simply because they belong to that group, independently of whether drug use is already present, as may occur in some cases.

Indicated prevention

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

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

4.3. Risk and protection approach

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

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

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

Risk factors cover all of the environmental, social, economic and biological and behaviors associated with increased vulnerability to risky situations or behaviors.

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

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

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

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

4.3.1 Risk and protection approach at the individual level

Risk factors:

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

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

Protective factors:

- Promotion of personal autonomy,
- Fluid, two-way communications,
- Encouragement of participation and reflection by community members,
- Promotion of solidarity and integration,
- Existence of coherent policies on drug use,
- Training of professionals, teachers and community leaders in a comprehensive approach to problem drug use,
- High quality of education,
- Employment policies,
- Health care coverage for all,
- Participatory work methods,
- Reinforcement of the positive values of the communities,
- Recognition of achievements, merit and mutual help,
- Existence of alternatives: recreational, cultural and sports.

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

4.3.2. Risk and protection at the community level

Risk factors:

- Crisis of values,
- Few educational opportunities,
- Rising poverty,
- Social exclusion,
- Unemployment,

- Prevention programs that are insufficient and not diversified,
- Presence of drug distribution networks,
- Trends in society that favor rather than limit drug use.

Protective factors:

- Effective programs to prevent drug trafficking and drug use,
- Support network of governmental and non-governmental organizations,
- Opportunities for study and employment exist,
- Promotion of human and social development,
- Non-dominating, inclusive relationships are present,
- Promotion of cooperation and solidarity,
- Establishment of relations of equality.

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

4.4. Health promotion

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

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

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

goal of life. It is a positive concept that stresses social and personal resources as well as physical aptitudes.

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

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

4.4.1. Towards a model based on health promotion

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

Health promotion thus operates on three basic models (Kornblit and Mendes Diz, 2004): *informational*, when information is given out; *empowerment*,[5] which encourages peoples' capacity to act on circumstances and identify the potential choices they can make, and third, *community,* which conceives of health on the basis of changes in the community achieved through collective

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

action. It should be borne in mind that in order for promotion and prevention activities to be successful, it is important to work with the three models at the same time.

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

According to the anthropologist Eduardo Menéndez (2005), it is not helpful to understand health as a finished state; health should, rather, be viewed as a collective process of health-illness-care.[6] These processes are at once organizing principles of daily life, and spring from the historical life of any society. This must all be thought of in a context of conflict and dispute among the various stakeholders, in which the various power relationships become evident and are related in complex ways with economic, social, political and cultural issues.

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

Knowledge/insight

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

Commitment

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

Visions/images of the future

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

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

Action experiences

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

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

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

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

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

As stated in other sections of this document, prevention[7] and promotion are often seen working together in practice, but we must clarify that there is in fact a difference between the two. The

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

ultimate goal of prevention is to prevent the onset and development of illness and conditions that are harmful to health in the broad sense. Since this idea is linked to the idea of health promotion, we give below a chart showing the main differences between the two.

Chart 2: Differences between prevention and health promotion

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

Source: Adapted from Statchenko and Jenick (1990)

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

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

consolidation of the health promotion paradigm around a holistic view of the person (Camarotti, 2010).

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

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

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

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

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

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

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

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

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

As stated in the report of the Argentine Scientific Advisory Committee (2009),[9] of the universe of people who use drugs, the great majority will not engage in problem drug use. Problem drug use will occur among individuals who are in a particular situation of biological and psycho-social vulnerability. For those who are not using drugs, specific and non-specific universal prevention should be used. For those at a higher risk of beginning to use drugs, selective prevention and health promotion can be the approach used. For those who are using drugs and whose drug use is

[8] It is important to refer to the tenth edition of the WHO International Classification of Diseases, which classifies mental and behavioral disorders due to substance use under its classification F19. These disorders are as follows: acute intoxication, harmful use, dependence syndrome, withdrawal state, withdrawal symptom with delirium, psychotic disorder, alcohol or drug-induced amnesic syndrome, alcohol or drug-induced residual psychotic disorder and late-onset psychotic disorder, other mental or behavioral disorders induced by alcohol or other psychotropic substances, and finally, alcohol or drug-induced mental or behavioral disorders.

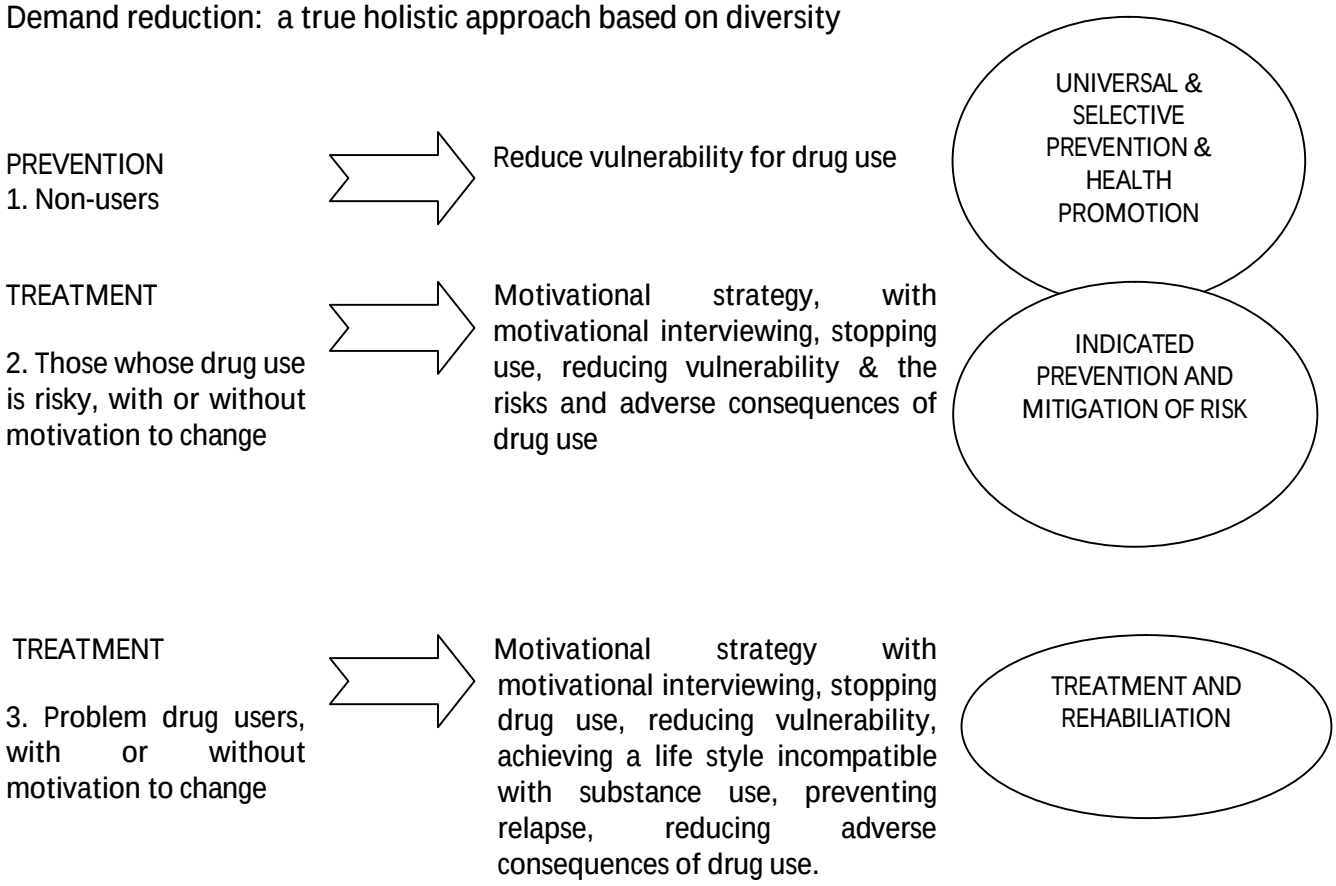
[9] Scientific Advisory Committee on the Control of Trafficking in Narcotics and Psychotropic Substances, and Complex Crimes against Drug Users and Policies to Address them (Argentina, 2009). (Spanish only).

not problematic, indicated prevention measures, which are specific and specialized, should be used.

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

The figure below summarizes the different levels of demand reduction.

Demand reduction: a true holistic approach based on diversity



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.2. Specifics and differences in responses to problem drug use

5.2.1. Low threshold treatment programs

Programs to mitigate the risks and adverse consequences of drug use

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

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

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

Psychotherapeutic approaches

Brief intervention

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

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

- *Simple*: structured advice lasting only a few minutes. It is sometimes called a minimal intervention, and at others, a simple advice.
- *Complex or extensive*: structured therapy normally requiring 20-30 minutes in the first instance, and more than one intervention over time. This is sometimes called brief therapy.

Individual therapy

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

Therapeutic groups and group workshops

This setting should allow for work on different topics, either by putting a conflict into words, or through self-expression: painting, writing, music, psychodrama and other techniques. The workshop experience enables the participant to become an active agent in his or her individual and collective process. At the same time, each patient's particular history and mental condition will require individual, specific paths. Group workshops are dynamic, forge solidarity, and facilitate individual change, and can operate both on and individual and small group level. The workshop experience changes the participant's role and makes him an active agent who is responsible for his own processes, and at the same time, encourages him to develop the critical thinking that is so necessary to making decisions leading to healthy, holistic behavior. Holistic health covers both affect and behavior, so as to help the person develop the skills to deal with conflict situations that arise in his life and build social ties.

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

5.2.2. High threshold treatment programs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Treatment in a medically monitored program

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

Detoxification programs (may be delivered in three ways):

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

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

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

may not be present. Acute intoxication is to be effected in a medical emergency service of a general hospital.

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

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

- In an outpatient center: the person goes to the center when necessary, which enables the dependence to be addressed in his or her own environment.
- In a therapeutic community or inpatient center. This is suited to more complex profiles, as already explained above.
- Day center: the individual goes to a center during the day since outpatient care is insufficient, but a therapeutic community or inpatient center is also not the most appropriate for this level of complexity as described above.

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

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

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

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

6. The community model

6.1. Towards the construction of a community-based model

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

For this reason, responses should be developed closely together with the groups that are experiencing these problems, so that the responses become personalized to the circumstances and situations that give rise to them. The community-based approach is developed in accordance with this objective.

The *community-based* model posits that the meaning given to drugs is determined not by their pharmacological properties, but rather by the way in which a society defines the use of drugs and by the prevention and intervention strategies it takes with users. The basis on which it rests is that a prevention policy cannot be removed from the socioeconomic structure and culture that form the social context of drug users. Inequalities, lack of opportunity, exclusion, vulnerability, poverty, unemployment, school drop-out, discrimination, illiteracy, stigmatization of those who use drugs, lack of dignified housing, urbanization and industrialization without adequate planning, and the meanings that individuals and societies attribute to drug use should also be considered as causal factors in the massive appearance of drug dependence. This is a model less frequently found in today's society, and it is therefore unusual to find explanations of drug abuse that take these issues into account. This model emphasizes the meanings that individuals give to risk and protection practices based on their belonging to particular social and cultural contexts.

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

We begin with the idea that problem drug use is a community problem and not an individual one, and it is therefore important to bear in mind that people can think about and decide their own futures (Chapela Mendoza, 2007). In this sense, the idea of a *project* means understanding an individual's situation on the basis of his living conditions, which leads to an emphasis not on the individual but on inter-personal relations and interactions that are built out of a common existence (Ayres, 2011).

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

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

Strengthening social mobilization, the sense of community and the empowerment of the community produces a growing "associativeness", defined as the creation of networks and organizations (Torres y Carvacho, 2008; Krause et al. 2012).

The chart below shows the characteristics of what we call the community-personhood model, by contrast to what we call the normative-moralizing model (Kornblit, Camarotti, Di Leo, 2012).

Table 3. Models for addressing social problems

Dimensions	Normative-moralizing model	Community-personhood model
Idea of health	• Closed category: model of medical dominance (Menéndez, 2005)[11] geared to illness • An individual problem	• Open-ended category: critical of the medical dominance model • Personal and community experiences and conditions • The common good – right to health
Goals of	• Promote changes in individuals by	• Stress the mutual influence among

[11] The *medical dominant model* is a concept proposed by the Argentine anthropologist Eduardo Menéndez. It refers to the health care system organized by bio-medicine, and is defined as "the set of practices, knowledge and theories generated by the development of what is known as scientific medicine". The model sets the following as the main parameters for understanding and acting on health and illness: a) focus on biology, ahistorical and asocial, that is, it reduces individuals to their physical dimension and removes them from any social, historical or spiritual condition; b) idea of illness as a breakage, deviation and difference, and health as the statistical normal; c) curative practice based on eliminating the symptom; d) assymetrical relationship between doctor and patient, with social and technical subordination of the patient; e) health-illness as traded goods, with a tendency to induce medical consumerism; f) medicalization of problems; and g) ideological identification with scientific rationalism as the manifest criterion excluding other models. In general, it is a mechanistic conceptualization of the human being, which leads, inter alia, to the separation of mind and body, and of the individual, society and the universe; to the search for certainties and absolute truths; to the belief in linear causality as the only form of relationship, and to undervaluing personhood (Adapted from *Cultura y salud, salud y cultura*, March 12, 2009).

community-based action	intervention in their immediate environment, seek to modify patterns of behavior. • Attempt to prevent risks and/or harms.	individuals & their environments, and encourage thinking about the problems of macro-structural and exclusion factors, prevent problems from becoming "natural".
Concept of the individual	• Passive beneficiaries/recipients of social interventions. • Individuals centered on self	• Holders of legal rights participating actively at all levels of community action. • Concept of inter-relations among persons/the struggle for recognition
Operating framework	• Promotes health as a role model • Community participation: medical professionals participate in institutions by giving talks or speeches • Promotes individual improvement (self-esteem, development of skills, resilience), which means searching for individual solutions to collective situations.	• Strengthening of the individual and the collectivity, bearing in mind power relationships, symbolic universes, and the possibility of self-determination. • Creation of networks among collective actors. • Promote critical awareness and the recognition and exercise of rights. • Posits participation as a right, and views decision-making as a joint endeavor, redefining the role of professionals as dialogue with the community. • Increase people's sense of belonging to their communities.

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

6.2. Vulnerability and health practices in the community-based model

Taking up the proposals by Ayres (2008), we find that a concept that has been shown to be useful in these new approaches is the idea of *vulnerability*, which comes out of the international advocacy of human rights and which includes politically or legally fragile groups and individuals in promoting, protecting and guaranteeing their rights as citizens.

It is introduced into public health as a result of the intersection between AIDS activism and the human rights movement, as an effort to move beyond the notion of individual risk and adopt a new perspective, which is social vulnerability.

The epidemiological concept went from being the group at risk to risky behaviors, which tends to remove the weight of stigma from individuals, broadens concern over the problem, and fosters active involvement in prevention. This idea makes it clear that the change to Following El Abrojo's

definition (2007), drug use may become problematic if it adversely affects –either occasionally or chronically-- one or more areas of life: a) physical or mental health; b) primary social relationships (family, spouse or partner, friends); c) secondary social relationships (work, study), and d) relationship with the law.

Protective behavior is not achieved through information or desire, but rather through cultural, economic and legal resources that are currently unequally distributed among groups.

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

The view that the possibility of changing practices does not depend solely on the individual will, but rather on the context in which individual traits develop and are made manifest gave rise to the need to focus action on the different susceptibilities to drug use observed in different populations. It is now considered that in order to overcome this susceptibility, we must work on social relationships; if we do not do this, we will not be able to change the behaviors and practices that need to be changed.

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

6. 3. Identifying the “community”

The concept of “community” is complex, but there are certain basic components that cannot be omitted from the definition of it: the sense of belonging, the inter-relationship between members of the group, and a common culture (Krause, 2001). With these points in mind, Montero (2005) defines the community as a group in constant transformation and evolution which, through its interrelationships, produces a sense of belonging and social identity, and whose members become aware of themselves as a group and are strengthened as a social unit and potential.

The idea behind development of the community approach to problem drug use is that uncertainty, inequalities and social exclusion, associated with the weakening of community ties, have

consequences for people's attitudes and behaviors, and lead them into apathy, passivity, indifference and unhappiness (Ayres, 2011). Thus we see the active role that living conditions play in people's health problems and their habits and behaviors.

When we speak of community work, we stress strengthening ties among people, and their rights as citizens, by involving them in collective projects in order to reduce the risks of social exclusion, which is one of the risk factors that may affect drug abuse.

The community approach has four inter-related key concepts:

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

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

Associativeness, defined as the density of the social fabric, or relations among individuals and among groups and organizations, which can help counteract psychosocial problems such as crime, violence and drug trafficking. By contrast, isolation and the breakdown of collective identities may translate into psychosocial problems.

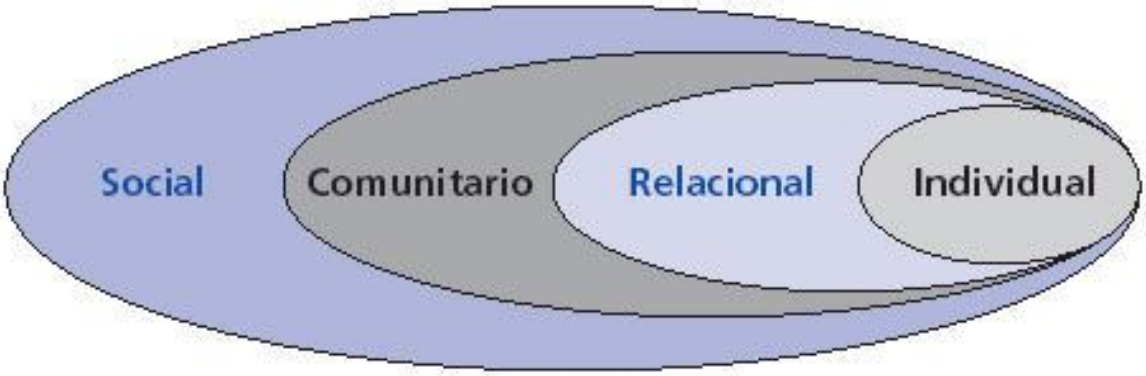
The *sense of community* refers to the community members' feeling of belonging, who feel that they are important to the group and share an emotional connection.

In order to achieve this, actions by all areas of government and civil society should:

> Advocate for health based on human rights and solidarity; invest in sustainable policies, actions and infrastructure to address the determinants of health; build capacity for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy; regulate and legislate to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people, and partner and build alliances with public, private, nongovernmental and international organizations and civil society to create sustainable actions. (6th Global Conference on Health Promotion, Bangkok, Thailand), 2005).

6.4. Groups and social climates

The individual has a set of more or less close relationships that must be addressed as a whole, and that is the subject of environmental prevention.



SOCIAL COMMUNITY RELATIONSHIPS INDIVIDUAL

When we speak of environmental prevention, we generally take account of all health-related factors that make up the physical environment in which individuals lead their daily lives. However, social psychology has also gone more deeply into the study of "social climates" in which individuals participate in the different spheres of their lives.

The concept of *social climate* may be defined as that set of psychosocial characteristics of an institution or a group that give it a particular style, which in turn conditions the interrelational processes that take place within it. What determines an institution's social climate are: a) the perceptions people have about the interpersonal relationships that are established within the group or institution, and b) the context or framework in which these interactions take place.

A study by Kornblit *et al.* (2011) on schools concluded that:

a) A negative social climate is related to a low level of participation, distant relationships, and lack of cooperation, predominance of routine tasks, a lack of clarity in learning objectives, and shortcomings in how the school is organized, whether as a result of failure to apply the rules, or because of excessive controls. Among the aspects of social climate in the school, it is particularly the degree of teacher authoritarianism – as perceived by the students—the variable that may produce the most obstacles to development of a dialogue among adults and young people, in order to address topics such as, for example, drug abuse.

b) On the other hand, if the school represents a support for the students and they perceive that interaction with teachers and administrators is positive, the social climate will be favorable. Indicators of this are: high level of youth participation in learning and extracurricular activities, clear rules consistently applied, with room for innovation, and clear goals for all involved in the school system.

Although direct causal relationships cannot be established between the social climate and the adoption of practices such as drug abuse, it can be said that favorable social climates in which dialogue is encouraged, channels of communication are kept open, effort is valued, authoritarian and competitive practices are kept to a minimum, and teaching practices foster student integration and participation, will considerably reduce young people's attraction to settings and practices that are related to drug abuse.

6.5. Holistic community action

This form of social response covers the full gamut of social practices geared to community-based health, with its particular groups and organizations, formal and informal networks and stakeholders that influence and promote health and wellbeing. The type of action will vary among communities, but is generally linked to the degree to which social participation has developed in efforts to build citizenship in health; that is, active, democratic participation of citizens in decision-making about health and the management of health services.

The principles of a comprehensive model thus involve:

- Democratic management to build health
- Health becomes a right of citizenship
- Public-sector services are geared to achieving a better quality of life, individually and collectively.

The conceptualization of health as holistic, seen from viewpoint of improving the quality of life, should be understood as an effort to explain the social determinants of health needs and problems, and address them on the basis of the particular characteristics of the various social groups.

Integration of the formal and informal health care systems means involving stakeholders in the strategies and actions needed to prevent and provide care for illness, and to promote health.

This form of health management helps the interventions and social response be of greater impact and be more rooted in society. This will ensure that the actions are sustainable, and also give them an intersectoral character that is required in the social construction of health.

6.5.1. Community stakeholders

Community stakeholders are individuals and organizations that have the power to influence policy or technical or operational decision-making of any kind or in any field of action.

A community approach and social participation in the primary care model, therefore, is not confined to having people participate in the management of services. In best of cases, they should take collegiate decisions, give their opinions about the quality of services, demand improvements, and so forth, in the framework of the individual as a biological and social whole who operates in a particular social and cultural context.

Holistic health necessarily means that the health care system acknowledges that the community participates in health as a vital entity, with self-care practices that are traditional among families or individuals, support networks, and common practices and knowledge that exist, coexist and interact with formal health care for individuals and the community.

6.5.2. Training of community leaders and workers

On the topic of the training of persons trained to carry out this type of program, Ornelas *et al.* discuss three priority areas: a) training in prevention and promotion; b) training regarding the empowerment of individuals and groups, and c) training in planning, implementation and evaluation of community-based programs.

Community-based interventions require that participants, and particularly the organizers, have certain skills, the most important of which are:

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

These skills can be developed through training, the form of which will vary according to the needs and planning of the project. Training may be given in segments over a long period of time (weeks or months), or intensively over a weekend, or a combination of both. The first type of training will probably ensure that a larger number of people participate; the second enables people to get to know each other and form a team, while a combination of the two may allow for both things.

Some of the areas in which training may be needed are:

- *Participatory evaluation:* how participatory evaluation works, its goals, the roles that individuals play in the process, and what may be expected from it.

- *Skills for participating in meetings:* following discussions, listening skills, dealing with disagreements or conflict, appropriate ways of making a contribution and responding, and so forth.

- *Interviews:* making people feel comfortable, learning about body language and tone of voice, how to ask open-ended questions and follow-up questions, managing interruptions and distractions, running group interviews.

- *Observation:* direct observation and participatory observation; selection of proper time and place for observation, information that it is important to include, keeping a record of the information.

For these training programs, problem-based learning is the learning method that is preferred over traditional methods of teaching.

6. 5.3. Problem identification

Identifying what the project will work on has to do with identifying what the community's needs are, and efforts should be made to achieve consensus among the participants as to what those needs are. By collecting information on the community's concerns and identifying the community's strong points, the participants can understand where to focus the project.

This means developing a plan (also called a logic model or practice theory) for carrying it out, which will include all the activities to be conducted, and how they will be coordinated.

The stages may be:

a. Form a coalition of organizations, agencies and community members that are concerned about the problem.

b. Recruit and form a work team that includes representatives of all interested persons and groups.

c. Collect statistical and qualitative information on the problem, and identify the community's strengths that could help address it.

d. If there are no secondary data, organize a participatory research project to develop the data needed.

e. Use the information to design a program that takes into account the complexity and the context of the problem.

f. Implement the program.

g. Conduct monitoring and evaluation to provide feedback on the extent to which the objectives are being achieved, and what should be changed in order to improve the program.

h. Use the information from the evaluation to adjust and improve the program.

i. Secure resources so that the program (or the outcomes achieved) can be sustained over time.

6.5.4. Building the database

Collection of data that are important in identifying the problem and in the subsequent development of a community project is of two types:

1. Identification of secondary data that already exist in the community, such as case records, statistics, and so forth, which make up what is called *epidemiological surveillance*, that is, surveillance of existing cases and of new cases, for example, consultations related to drug use.
2. Mapping, showing the neighborhoods or areas in which problem drug use may occur, along with the community and health care services that are available; this is what is called *health surveillance.*

6.5.5. Understanding the problem through data analysis

Once information has been collected on the problem and on how it is framed in the community, as well as the community's responses thus far, the data need to be analyzed and interpreted, to find out what the information means.

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

6.5.6. Building awareness and preparation of a community response

General issues that should be present in community-building interventions and community training include:

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

- Encouraging critical analysis of individuals' living conditions and situations, which leads to critical thinking about problems, rejects the idea that situations are "natural", and

encourages thinking about causes and consequences, following the methodology of Paulo Freire (1970).

- Locating the interventions in people's immediate surroundings, with stress on mutual influence among individuals and the environment.
- Encouraging the formation of social networks among similar institutions and groups.
- Taking participation as a right, and encouraging shared decision-making and dialogue among members of the community and the professionals that are involved in the community project.
- Recouping and giving new value to the community's traditions.
- Working on possible discrimination against different members of the community.
- Working on the gender dimension in order to promote egalitarian relations between men and women.
- Developing the capacity for self-expression – talking and being listened to.
- Monitoring the existence of practices in educational and health establishments that might violate the rights of children and young people.
- Working on the capacity for self-protection in the face of practices that violate the rights of children and young people, such as mistreatment, sexual abuse, sexual exploitation, exploitation on the job, and the sale and supplying of drugs.
- Raising the self-esteem of children and young people by recognizing their resources, capacities, potential and strengths.
- Developing the capacity in children and young people to work in a team.
- Opening up channels of communication among generations, based on mutual respect.

7.1. Evaluation of community interventions

Research on community participation may be used to describe the community, assess its problems and needs, find and select best practices related to the goals that the community proposes for itself, and/or to evaluate the interventions or projects that have been carried out.

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

7.2. Participatory evaluation

Participatory evaluation involves all those with an interest in the project – those directly affected by it, or those who participate in carrying it out –, in understanding it and in applying that understanding to improving the work.

The real purpose of an evaluation is not only to find out what happened, but also to use that information to improve the project.

The evaluation should begin at the start of the project. In a participatory evaluation, the interested parties should be involved in:

- Identifying and defining the problem or goal to be addressed.
- Developing a plan (practice theory, logic model) for how to achieve success.
- Identifying the questions about the project that should be raised and the best ways of asking them. These questions will identify what the project seeks to do and therefore what should be evaluated.

Participatory evaluation has certain advantages, principally the following:

1. It provides a better picture of the initial needs of the project beneficiaries and of the final outcome of the project.

2. It may provide information that could not otherwise be obtained.

3. It indicates what worked and what did not work, from the standpoint of the persons most directly involved in the project, i.e., the beneficiaries and the project personnel.

4. It may indicate why something worked or not.

5. It produces a more effective project.

6. It empowers the participants from the community.

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

8. It provides training in skills that can be used in other areas of life, since it stimulates critical thinking, cooperation, problem resolution, independent action, and keeping within time limitations.

9. It increases the participants' self-confidence and self-esteem.

10. It encourages the participants to be involved in the project.

11. It stimulates participants' creativity.

12. It fosters collaborative work.

Participatory evaluation also involves some negatives, the most significant of which are:

1. It requires more time than a conventional evaluation.

2. It requires that trust be established among all participants in the evaluation process, which may be difficult to achieve in some cases.

3. It requires that participants be trained to understand evaluation and how the participatory process works; it also requires training in basic research skills.

4. Funders and policy-makers may neither understand nor believe in participatory evaluation.

Some of these disadvantages may also be viewed as advantages: the training that people receive is a part of building skills, which can then be transferred to other areas of life.

7.3. Types of evaluation

Three types of evaluation may be distinguished:

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

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

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

Some of the criteria most used in project evaluation are:

Population or beneficiaries:

Refers to the number of people who to some extent participate in, or benefit from, the project. It is recommended that the number of persons or organizations participating be stated, or, if these were created by the project, also indicate their degree of participation in project implementation, in the evaluation itself, and in the continuation of the actions. This criterion is related to coverage and focus of the project.

Sustainability:

Sustainability refers to the projection of project outcomes over time once all the agreed-upon activities have been completed.

Generally, it is decided that an institution or organization will take on the task of ensuring the work of continuity once the project is over. If this is the case, it is necessary to document this commitment.

Efficacy:

Refers to the degree of compliance with proposed objectives, that is, an evaluation is done of the extent to which programmed objectives were reached.

Efficiency or cost-benefit analysis

This relates the outcomes to the resources invested. In other words, it refers to the optimizing of allocated resources as a function of efficiency in achieving the objectives.

Quality:

Quality refers to intermediate or final outcomes, and is applied to the goods, products and services provided; it relates the extent to which these goods or services meet or do not meet the needs, and describes their attributes.

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