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Social reintegration in the European Union and Norway

By Annette Verster and Ulrik Solberg

Introduction 2

Executive summary 5

Belgium 7

Denmark 13

Germany 16

Greece 24

Spain 26

France 31

Ireland 38

Italy 42

Luxembourg 52

Netherlands 55

Austria 62

Portugal 65

Finland 68

Sweden 72

United Kingdom 76

Norway 83

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Social reintegration in the European Union and Norway

By Annette Verster and Ulrik Solberg[1]

INTRODUCTION

The issue of social rehabilitation and reintegration (hereafter social reintegration2) is mentioned under the third strategy target of the EU Action Plan 2000–2004. The third EU strategy target is to 'substantially increase the number of successfully treated addicts', and point 3.1.3.4 instructs that 'Member States [are] to ensure that adequate attention is paid to social and professional rehabilitation and reintegration of former addicts'.

However, social reintegration is also linked to social exclusion, which is mentioned in chapter 2 of the EU Action Plan, where it is stated that 'the EMCDDA [is] to develop indicators on drug-related crime, the availability of illicit drugs (including at street level) and drug-related social exclusion'. For the EMCDDA, social reintegration comes under strategy target four – that is, as a response to social exclusion – however, target two is clearly also relevant. Social exclusion is often perceived as a cause of problem drug use, although many see it as a consequence of problem drug use. We will not elaborate on this further here, except to note that social exclusion and problem drug use are two phenomena that are very closely interlinked and that social reintegration is a possible response to both.

The EMCDDA Programme 2, 'Analysis of responses', set out to identify how social reintegration is understood in each Member State and to map the availability of social reintegration facilities in Member States according to these national perceptions. It became evident at an early stage that this would be a complex task, involving extensive data collection, as national reports generally provided insufficient data on this specific subject.

Consequently, the EMCDDA invested in additional research and, with its existing staff, studied the following Member States: Denmark, Greece, Ireland, Luxembourg, Austria, Portugal, Sweden and Norway. However, the remaining eight countries turned out to be difficult to map and so, in February 2002, the EMCDDA launched a call for tender for a project, 'Mapping social reintegration services in EU countries'.[3] The aim of this project was to describe the state of the art of social reintegration in the following eight countries: Belgium, Germany, Spain, France, Italy, the Netherlands, Finland and the UK. The independent researcher Annette Verster was the selected contractor.

The research specifications, to investigate 'the state of the art of social reintegration', suggested that the following should be identified for each of the eight countries:

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[1] Other contributors will be mentioned in the respective chapters.

2 Our country studies so far have shown that the term 'rehabilitation' is used ambiguously across Europe – from low-threshold refuges, to normal treatment, to actual reintegration into society. For this reason, we shall use the term 'social reintegration' in this report, as this is used much more consistently across Europe and is, therefore, less likely to cause confusion.

[3] Call for tender CT.01.P2.28.

- the national policy definitions of social reintegration services in addiction treatment;
- the type of interventions classified as part of social reintegration;
- the number of services, the clientele and (if possible) the number of slots available; and
- the projects and services available in each particular country.

The following information sources were explored for relevant data:

- bibliographical lists;
- websites;
- national country reports; and
- the EMCDDA network of national experts.

After collection and analysis of the information gathered from documents, grey literature and personal communications, a draft chapter was written for each Member State. These drafts were sent back to the contacts in each country and their comments were included in the final report.

Initially the idea was to describe interventions only if they were designed specifically for drug users and if they were a last step in the treatment process. After a first analysis of the material, it became clear that the information gathered would be very limited if this inflexible approach were adopted, and that social reintegration was not necessarily perceived as being the last step of the treatment process. It was decided, therefore, that all projects that could be described as social reintegration should be included, regardless of whether they were specifically targeted at drug users or which phase in the treatment process was involved.

Unlike treatment, social reintegration does not necessarily include a psychosocial or medical component. 'Subsidised employment', which is a way of rehabilitating/reintegrating (former) drug users, is an example.

Keeping these considerations in mind, we have defined social reintegration in the following way:

- *Any attempt to integrate drug users into the community*

The term 'social' originates from the EU action plan, but it now seems evident that the majority of Member States involved with the EMCDDA do not use this term.4 Consequently, 'reintegration' and 'social reintegration' will be used synonymously here. Also, self-help groups – like Narcotics Anonymous (NA) – will be included as an example of a social reintegration intervention (although NA of course serves other purposes as well). By definition, data on client contact is not available from NA, but information was sought regarding the number of NA contact groups. Lastly, note that the definition of social reintegration used here also includes interventions targeted at former drug-using prisoners, since these take place in the community.

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4 Member States normally use the term 'reintegration', although the UK often refers to it as 'regeneration'.

The next step was to define which concepts would be used for classifying social reintegration interventions. When the study was launched, three hypothetical ‘work concepts’ were adopted, and it turned out that most countries did actually classify their reintegration interventions according to these concepts. The three work concepts were:

- training, education and development of skills;
- employment; and
- housing.

The country reports will be presented in protocol order and each report is organised according to the following headings:

- introduction
- definition
- concepts
- organisation
- funding
- discussion
- summary
- sources
- acknowledgements

Some reports will have additional headings, according to their specific national situation.

EXECUTIVE SUMMARY

This report aims to identify to what extent Member States provide services for the social reintegration of former drug addicts. It recognises that most Member States stress the importance of social reintegration as part of their drug policy and national drug treatment system and that most have a variety of interventions that can be considered as social reintegration interventions. However, although most countries do not employ an explicit definition or description of social reintegration per se, they generally use the terms and concepts that we have mentioned here. In addition to these, some countries also offer debt counselling and supported living.

In some cases, social reintegration is the last stage of the treatment process but in others it is a post-treatment intervention carried out by non-treatment services. However, as a general observation, social reintegration is not necessarily perceived as either the last step in the treatment process or as a post-treatment intervention, but rather as a separate and independent intervention, with its own goals and means, which can be offered for both former and current problem drug users. This indicates that social reintegration does not necessarily have to take place after treatment but that it can take place irrespective of prior treatment. A second, but equally important, implication of social reintegration for both current and former drug users is the fact that it is an intervention for the whole spectrum of clients as a target group, ranging from well-functioning 'clean' former addicts to very deprived street addicts.

Many of the social reintegration interventions do not specifically target former or current drug users but are general interventions and services, which are available to the general population. Sometimes they are even part of a prevention policy for avoiding the onset of drug use. This complexity has meant that, for many countries, it has been impossible to provide reliable quantitative data on social reintegration services and interventions, and consequently we cannot provide a quantitative pan-European overview of the availability of such services.

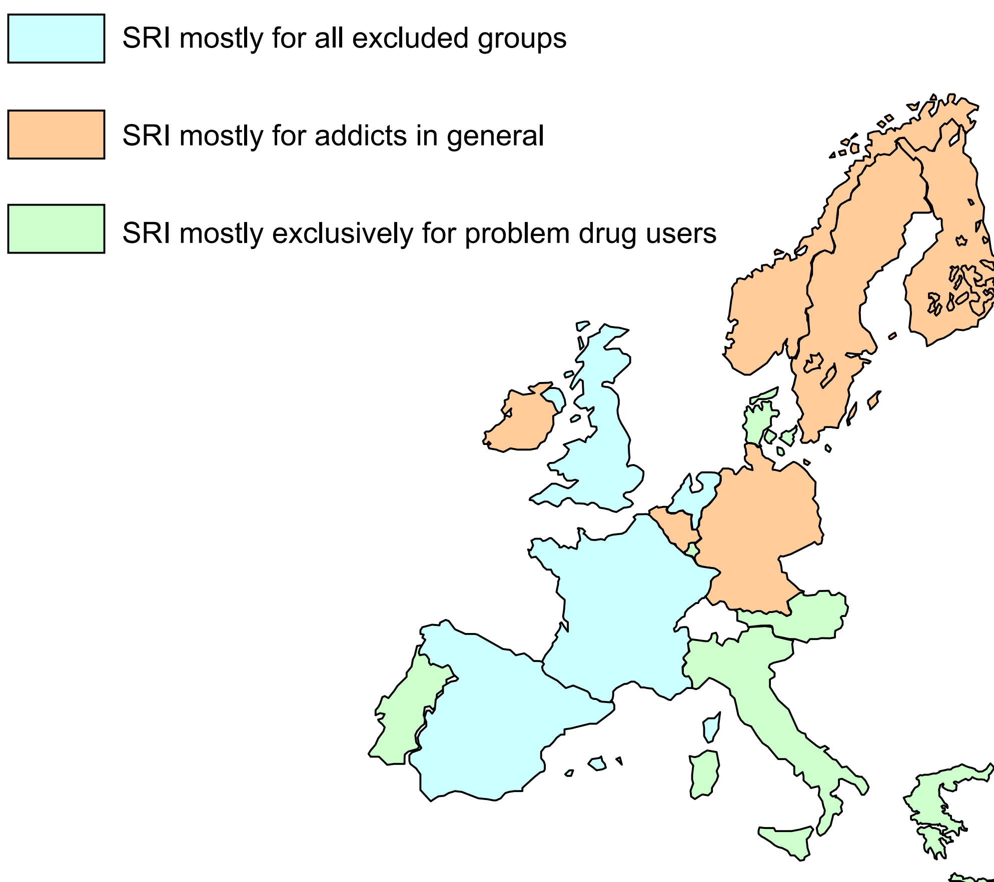
However, quantitative data on social reintegration are available for a few countries and these suggest that this kind of intervention has a much more limited coverage than treatment interventions. One example is Germany, where 7 380 slots are available for social reintegration (of which around 4 000 are not exclusively for drug addicts) compared to around 55 000 for medically assisted treatment.

Another finding that has emerged during this study is that social reintegration for problem drug users generally take place through one of the following three channels:

- social reintegration for excluded groups, with or without addiction problems;
- social reintegration for persons with addiction problems in general; and
- social reintegration explicitly and exclusively for problem drug users.

There are many countries that provide social reintegration services through more than one of the 'channels' above, but there is a tendency for one channel to dominate. The following map illustrates which of these three channels provide the majority of slots for problem drug users. As we do not have hard-core figures/data, the following map is a qualitative estimate based on the literature and country overviews.

Figure 1: Qualitative overview of social reintegration (SRI) for problem drug users in the EU and Norway



Interestingly, there seems to be no differentiation between north and south, or between countries with a more or less lenient drug policy. The only obvious parallel to be drawn with earlier findings is that, in countries that typically distinguish between treatment for addicts in general and treatment for problem drug users, a distinction is also made between social reintegration for problem drug users and other kinds of addicts. This is true for Denmark, Greece, Italy, Austria and Portugal.

In summary, national and European drug strategies recognise that social reintegration is an important part of the overall range of responses to drug use, but the actual availability of social reintegration services is limited. This point is even more apparent when we consider that many interventions are not only for former and current drug users but for a wide variety of clients. However, as drug users may also attend social reintegration services that are not specifically targeted at this group, the real impact will remain unclear.

Another point that has emerged is that many evaluations assess the many social reintegration interventions according to indicators such as level of drug use and consumption patterns, as well as improvement of physical and mental health. However, despite the obvious importance of such improvements for the user's eventual reintegration into society, the final objective – integration of the former drug user into society – often is not achieved.

CLASSIFICATION AND AVAILABILITY OF SOCIAL REINTEGRATION IN BELGIUM

Introduction

Belgium has a federal constitution and activities in the field of drug treatment are generally organised at regional level. The Belgian national focal point collates information from four sub-focal points, one each in the Flemish-, French- and German-speaking communities and one in Brussels (the capital region).

In 2001, the Federal Drug Policy Note (2001) recommended the creation of an overall national drug policy in order to address the problem of diversification within the different regions. A 'general drug policy cell' is planned for the end of 2002. This will bring together all ministers with responsibility in the drug field (38), in order to formulate a consistent drug policy. This report on social reintegration is based on the situation in 2002 and will be divided into two parts: information from Flanders, and from the French- and German-speaking communities.

In general, social reintegration is considered to be an integral part of addiction treatment. Furthermore, several interventions are available to anyone, and not specifically (ex-) drug users. Hence, it is difficult to map social reintegration interventions separately. Outlined below are interventions with aspects of social reintegration, whether in housing, education or employment, which are (also) available to drug users in Flanders and in the French- and German-speaking communities.

Flemish community

Definition

The terms used in Flanders are based on a referral guide (*Doorverwijs gid*s) issued by the Flemish sub-focal point, which contains a list of treatment facilities for alcohol and drug addiction. The guide only includes VAD centres (Vereniging voor Alcohol- en andere Drugproblemen). The VAD is the regional umbrella organisation for alcohol and drug problems and is recognised by the Flemish government.

Various terms are used to describe reintegration interventions in the Flemish community, including: 'nazorg' (aftercare), 'resocialisatie' (re-socialisation), 'herintegratie' and 'reintegratie' (both reintegration), and 'sociale werkplaats' (social workplaces).

Description of the interventions

In Flanders, social reintegration interventions include:

- sheltered housing/accommodation (*beschut* or *begeleid wonen*);
- guidance in finding employment;
- social workplaces;
- education guidance;
- support and guidance upon leaving prison;
- advice to older drug users and their families;

- debts advice *(schuldbeheer)* and loan advice *(loonbeheer*); and
- case management.

Organisation

Although therapeutic communities have halfway houses, outpatient treatment centres in liaison with general services provide the majority of the interventions.

De Sleutel is the biggest drug-related service in Flanders and provides social workplaces for drug users. This is part of a general project for longterm unemployed people. A case management project was established in collaboration with De Sleutel and the University of Antwerp. Social workplaces offer education and training to ex-drug users. More than half the people who avail of this service find a job afterwards.

Recently De Sleutel started a project called 'Perspectief', in collaboration with the public welfare service of Ghent. The aim of this project is to help drug users find a job. Other topics that will be discussed are amongst others, case management, comprehensive approach, needs assessment etc.

The centres known as Medisch-Sociale Opvang Centra (MSOCs) have the following responsibilities:

1. Medical: to improve the quality of life of the drug user by taking care of treatment needs, which will reduce behaviour that puts health at risk

2. Social: to reintegrate the drug user into society through housing, social welfare and employment guidance

3. Motivational: to encourage the drug user to participate in programmes that are focused on achieving a drug-free lifestyle

Wouter Vanderplasschen et al. conducted an evaluation study in Belgium on continuity of care. Several concerns regarding cooperation, communication and coordination have been reported in most European countries. This evaluation studied different aspects of coordination and continuity (e.g. first contact, intake, referral, follow-up). The data illustrate that relatively little information is available concerning the course of the treatment process and that only 10% of all client files contain a treatment plan.

Following this study, a project called 'Case management in East-Flemish substance abuse treatment' started in October 1988. For the implementation of this trial, a scenario was developed by the Department of Ortho-pedagogics at Ghent University (Vanderplasschen & Broekaert, 1999). The objectives of this project are:

- preventing or reducing relapse and, if necessary, facilitating a smooth re-admission process;
- individualised care and guaranteed continuity of care;
- promoting the social functioning of the client (this intensive form of care is restricted to a small number of clients, helping them to implement more fundamental life changes);

- improving coordination of care and ensuring its suitability for people addicted to illegal drugs; and

- improving communication between the services involved with care.

Another project is the development of an integrated addiction treatment system in the province of East-Flanders. It is generally agreed that there is a gap in the provision of aftercare.

French- and German-speaking communities

Definition

The inventory *'A qui s'adresser?'* lists treatment centres (*centres de cure*) in Brussels, the French- and the German-speaking communities. In the French community and Brussels, many different terms are used, some of which are seemingly interchangeable. Examples of concepts and terms include *réinsertion sociale* (the last phase of residential treatment before leaving the therapeutic community), *réseau de familles d'accueil pour toxicomanes* (family networks for drug addicts), *centre d'accueil pour toxicomanes et parents de toxicomanes* (reception centres for drug addicts and parents), *groupes 'parents-solidarité'* (parent support groups), *centre de post-cure pour toxicomanes* (aftercare treatment centres for drug addicts), *réinsertion* (reintegration), *travailler avec les familles* (work with families) and *centre thérapeutique de post-cure* (therapeutic aftercare centre). Because no definition is provided for any of these terms, we can only list the interventions and describe them where possible.

Concepts

- Sheltered housing

- Help with finding accommodation

- Guidance with administrative issues

- Guidance with vocational training

- Guidance in finding employment

- Family networks

- Support and guidance upon leaving prison

Organisation

Aftercare and/or social and professional reintegration interventions take place in various outpatient and inpatient facilities. Aftercare may consist of individual follow-up treatment at an outpatient centre or may come in the form of group work and mutual support within a department that is either actively involved in drug rehabilitation or part of a residential programme or rehabilitation centre. Specific departments include ‘habitations protégées’ (sheltered housing).

<u>*After treatment*</u>: Reintegration occurs with the help of social workers, who handle the administrative tasks related to seeking jobs and accommodation. They also offer assistance with straightening out the patient's administrative situation. This is

complementary to the rehabilitation treatment available at the various outpatient centres. The large therapeutic community in Wallonie, 'Trempoline', provides a '*phase de réinsertion sociale'* for people preparing to leave a therapeutic unit and re-enter society. This phase offers support and guidance over a period of six months in a semi-residential situation and six months as an outpatient.

After prison: A number of people in outpatient centres prepare ex-convicts for their release from prison and help them carry out the necessary administrative tasks.

Other situations: For people who have been institutionalised for a long period of time, aftercare is offered through 'habitations protégées' (sheltered housing). Support and psychiatric care are also provided. This type of aftercare is provided by SIAJeF (Liège). Other institutions (Odyssée or the CHU, in Liège) also provide assistance with social reintegration, specifically through sheltered accommodation.

Education and training

A number of specific training programmes are available, including the SIAJeF programme (Liège), which offers professional instructors (construction, secretarial services, the catering industry), the Essor programme, an on-the-job training company in Thuin, and l'Espérance (Thuin), a specific programme for alcoholics.

Employment

Facilitating reintegration into the workforce is the specific goal of some departments. Patients are offered several types of assistance: organising their administrative affairs, finding accommodation, accessing training, specific job-seeking skills (looking for job offers at the employment centre, help with drafting a CV, etc.)

Housing

Many departments provide assistance in finding accommodation, but initiatives that specifically target drug users are rare. However an initiative called 'appartements encadrés' (supervised apartments) is one such.

The Hestia project (Projet Lama, Brussels) is a programme that offers six apartments. Hestia is the main tenant and has the right to sublet these apartments. Finding new accommodation can be an arduous task and the results of this initiative are encouraging. The programme is an important factor in successful social reintegration (it enables the client to sever connections with the drug-using environment) and is a first step towards greater autonomy (when the patient eventually finds his or her own apartment).

Funding

The BACOB Bank and Arco Group have given a total of €495.787 to ten projects in Belgium that support drug addicts in starting a new life. De Social workplace of De Sleutel is one of these projects and has a budget of € 6.197.

Discussion

Although it is not possible to give a quantitative overview of reintegration activities in Belgium, it should be mentioned that several treatment centres report interventions with aspects of social reintegration. However, there is no information regarding the timing of these interventions or whether they occur as the last step in the treatment process or not. Social reintegration seems to be a part of treatment and, in many cases, interventions are a collaboration between specific drug services and general health centres.

The federal drug policy recommends good organisation of aftercare. The care system plays an important role in social integration (and, as a consequence, prevention of relapse). The federal government demands that services or organisations funded by the government pay more attention to aftercare and allocate more money for it.

The different initiatives focused on reintegration need better coordination to work. It makes sense that these initiatives start with the communities, because these are responsible for education, job centres and welfare. The communities will be asked to develop an action plan in collaboration with the departments of Justice and of Forensic welfare for (ex-) drug users. An educational and vocational process that is linked with welfare gives the best guarantee for longterm integration into society.

Considerable efforts will be made to ensure that past judicial sentences do not hinder the reintegration process. The Minister of Social Integration is responsible for this and he will liase with the communities and regions and communicates with the ministers of Social Affairs, of Employment, of Justice, of Public Health, of Internal Affairs and of Big Cities Policy.

Numerous reintegration activities take place within or upon leaving prison. There are many treatment facilities, particularly in the French-speaking part of Belgium, that offer support both inside prisons and immediately after prisoners have been released.

Summary

- In Belgium, the two guides, *'A qui s'adresser?*' and *'Doorverwijsgid*s', contain information about various interventions, including some relating to social reintegration. The description of the different interventions is, however, more qualitative in nature, as quantitative information is difficult to obtain.

- There are big differences in the terms and concepts used in the regions, due to language differences and the federal structure.

- The national drug policy is in the process of changing, and the situation may already be different to that described here.

- Although there are regional differences, several reintegration interventions take place in a national context.

- Services may be offered by specific centres for addiction treatment or in collaboration with services that are available to the public in general.

- These interventions do not necessarily occur as a last step in the treatment process, but can occur at any time during treatment (or detention).

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CLASSIFICATION AND AVAILABILITY OF SOCIAL REINTEGRATION IN DENMARK

National context

The 1994 ‘Government drug-policy statement paper’ (‘Regeringens narkotikapolitiske redegørelse’) does not refer explicitly to reintegration but does, however, state that treatment services should be available to as wide a range of drug addicts as possible. Reintegration facilities, especially in the form of self-help groups, have grown considerably during the past five years.

Definition and concepts

There is no standard national definition of social reintegration and the term ‘social reintegration’ does not appear in the Danish literature studied. The three most commonly used terms are ‘reintegration’ (*reintegrering*), ‘aftercare’ (*efterbehandling*) and ‘lockout’ (*udslusning*) and these terms can denote interventions that are either the last step in a treatment process or that occur after (or outside) treatment.

Some Minnesota-model treatment units use halfway houses as the last phase of the treatment process, whereas others take the word ‘halfway’ more literally and implement a reintegration phase after the midpoint (which is then in between primary treatment and reintegration). The Minnesota-model treatment units all offer follow-up treatment in their halfway houses, but this is sometimes in an outpatient setting and sometimes in an inpatient setting. Furthermore, halfway houses are the last step in the treatment process in some, whereas others offer inpatient treatment in halfway houses followed by reintegration in an outpatient setting. For this reason, a distinction will be made in this chapter between inpatient reintegration and outpatient treatment, according to where the reintegration intervention takes place.

Two other important areas in social reintegration in Denmark are:

- self-help groups; and
- drop-in centres.

Self-help groups are normally set up independently with a greater or smaller involvement of public services or treatment facilities. NA plays a very important part and is probably the greatest single player in self-help groups.

Drop-in centres are not exclusively social reintegration services but also often offer low-threshold services. Drop-in centres are sub-divided into the following four categories:

- drop-in centres for former drug addicts;
- drop-in centres for methadone clients;
- drop-in centres for mixed user groups; and
- drop-in centres for active drug users.

Current availability of drug-related social reintegration facilities in Denmark

The 'association of counties' (Amtsrådsforeningen) has published an overview of data on drug-related treatment facilities in Denmark that also includes some data on drug-related social reintegration facilities. This publication only covers halfway houses (and inpatient reintegration) and outpatient reintegration offered through the Therapeutic Communities in Denmark. The table below shows information for 1999 from this document.

Table 1: Availability of reintegration facilities in therapeutic communities in Denmark, 1999 *(number of treatment slots)*

Reintegration setting	*Minnesota-model*	*'Social-educational'*	*Christian*	*Total*
Halfway and inpatient reintegration	73	12	10	*95*
Outpatient reintegration	26	10	–	*36*
Total	*99*	*22*	*10*	*131*

Some reintegration units (which may or may not be attached to treatment units) report that there is no real maximum number for how many subjects can be included, especially in outpatient reintegration. Also, when reintegration takes place through halfway houses, it is seen as the last step in the (inpatient) treatment process and not as a 'stand-alone' intervention.

The data shown in the table above is only a small part of the total range of social reintegration services in Denmark. Self-help groups have increased dramatically during the past few years in Denmark, but there is no exact record of how many exist in total. It is estimated that there are approximately 100 NA groups scattered around Denmark, with a floating number of clients attending meetings. Of course, NA is not exclusively a social reintegration centre but can serve as such for former problem drug users who have left treatment.

The number of drop-in centres has also increased during the second half of the 1990s and there are now a total of 64 such centres in Denmark. Unfortunately, no data are available on the number of places provided, but Table 2 shows the availability of these drop-in centres.

Table 2: Availability of drop-in centres in Denmark in 2001

Kind of drop-in centre	*Number*
Drop-in centres for former drug addicts	14
Drop-in centres for methadone clients	21
Drop-in centres for mixed user groups	20
Drop-in centres for active drug users	9
Total	*64*

The primary function of these drop-in centres is not social reintegration but rather to offer low-threshold services. However, they do serve as a point of reference and contact for many problem drug users. What the drop-in centres have in common is that they offer an alternative to what is normally perceived as the 'drug treatment system'.

The names of the different kinds of drop-in centres are self-explanatory, so it will suffice to present a few additional comments. The staff at the drop-in centres for former drug addicts is themselves former drug addicts and so serve as role models for their clients. The drop-in centres for methadone clients maintain a relatively high level of rules and norms for their clients. The clients at the drop-in centres for mixed user groups are generally older than those in other drop-in centres and a considerable percentage of the staff are ex-addicts themselves (many are volunteers). The drop-in centres for active drug users focus on satisfying very basic needs, such as providing heated premises and a hot meal (and hence this specific kind of drop-in centre is more like a low-threshold service than a social reintegration facility).

Evaluated social reintegration interventions

Among current employment interventions, there is a time-limited programme called the 'Active again Project' for marginalised groups (not just problem drug users). Two other employment programmes are for methadone users and carry the names 'FRAM' and 'Spirillen'. Evaluation of the former showed that methadone users were not professionally or intellectually inferior to other groups that need support to get employment. Regarding the latter, two success criteria were set: firstly, that 50% of the participants would qualify for and begin a more targeted commercial education or employment and, secondly, that 90% of the participants would make a plan for the immediate future. However, these two success criteria were not fulfilled. The first was achieved by only 19% and the second by 50% – both considerably lower than hoped.

Summary

- Social reintegration services have expanded considerably in recent years and there is now a relatively wide range of services available.
- Many social reintegration interventions are informal interventions by self-help groups and NA groups.
- Many social reintegration services also operate as low-threshold services.
- Evaluations of social reintegration interventions are scarce, but, of those carried out, the success rate of the predefined criteria is relatively low.

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CLASSIFICATION AND AVAILABILITY OF SOCIAL REINTEGRATION IN GERMANY

Introduction

Germany is a federation of Länder (regions), each with autonomous governments and policies. Overall, there are a broad spectrum of services for addiction treatment, including advice centres and inpatient and outpatient places.

Reintegration services have developed significantly over recent years. They are no longer the last link in the chain of treatment but have to be offered at each stage of the treatment process. This means that services have to be available and accessible for drug users and people on substitution treatment, before, during and after medical rehabilitation.

Given the fact that about 80 % of drug addicts are unemployed, about 50 % do not have any professional training, about 60–70 % have inadequate school education and about 20 % do not have stable housing, there are diverse areas of activity. It has to be taken into consideration that the development of drug addiction is often accompanied by school or employment failure, so qualification in this specific area is absolutely essential in the treatment of drug addiction. As about 60 000 drug addicts are treated each year, at least 30 000 offers of reintegration assistance should be available. In reality, the existing services in the field of occupation/qualification only reach about 1 500 persons, in the field of education about 300 persons, in the field of housing about 2 000 and in the field of culture (theatre, music, arts etc.) about 200 at best (DBDD, 2001).

Definition

'Aftercare' is defined as all professional support and self-help measures which serve to prevent relapse and the reintegration of clients in terms of their social and employment situation. The main aim is for the former addict to learn to handle everyday life and unusual crises without being in danger of relapse and to secure and stabilise the success of rehabilitation (Heinrichs, 2002).

The German social law (BGS) states that the rehabilitation of a former addict is only complete when he or she is long-term employed (or when it is possible to state that the person has no chance of achieving successful employment rehabilitation). This means that it is necessary for different institutions offering medical and vocational rehabilitation to create an individual plan for the general rehabilitation of an addict. This means that the necessary finances for enforcing this plan have to be guaranteed. The next step is to develop quality standards for the enforcement of the rehabilitation process (DHS, 2001).

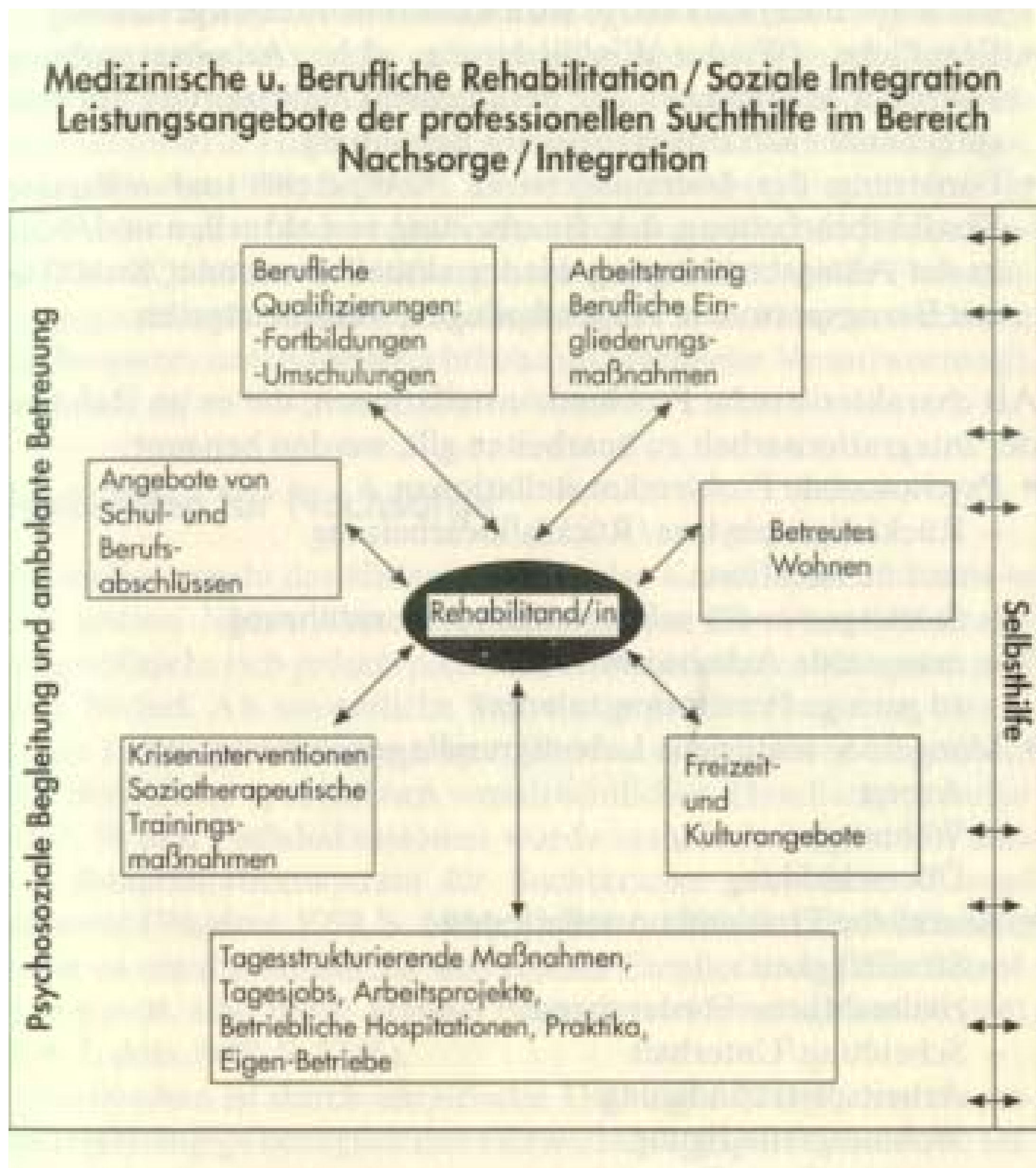
Concepts

The different aspects of reintegration can be divided into four areas:

1. Education and vocational training;
2. Employment;
3. Housing; and
4. Psychotherapy and social work.

Figure 2, 'Medical and employment rehabilitation/social integration activities in professional drug treatment regarding aftercare/integration', outlines the different

aspects of reintegration in Germany. Clockwise, these include vocational training, employment, housing, leisure and cultural activities, measures to help structure the day, crisis intervention and education. All these aspects point towards the centre, to the state of full reintegration.



Source: Frietsch, R. (2000): Nachsorge als Bestandteil des Gesamtrehabilitationsprozesses. In: DHS (Hrsg.): Jahrbuch Sucht 2001. Geesthacht: Neuland Verlag S. 187

Education and vocational training

The job situation, unemployment during the professional career, deficiencies in school education and job training are major factors in the reintegration of drug users. Training in learning key skills, such as perseverance, concentration, responsibility, etc., is offered in school and job interventions. Interventions are oriented towards the demands of the labour market, such as training in making job applications, qualifications, occupational projects and practical training in business. There is close cooperation with industry, which means that it is not necessary to have special institutions in the drug help system. Unfortunately, it is not possible to quantify these interventions (EBDD, 2001).

Vocational training has the following goals:

- development of key qualifications;
- belief in oneself;
- stabilising abstinence;
- increasing self-help potential; and
- motivating a drug-free lifestyle.

Day structuring is considered an important aspect of occupational reintegration. Such interventions include work therapy, occupational therapy and occupational projects.

Day structuring includes the following goals:

- preparing for reintegration into employment;
- stabilising abstinence;
- incentives to take responsibility;
- resolving day-to-day problems; and
- improving self esteem.

Employment

Work and occupation projects are part of the drug rehabilitation system. They offer diverse opportunities for gradually acclimatising to work and the work processes, right up to the point of full employment. These projects provide support for reintegration into the labour market or for further training or education (*Berufsorientierung, Massnamen zur Arbeitsbeschaffung, Ausbildungbegleitende Hilfen, Weiterbildung und Umschulung, Trainungsmassnahmen, berufliche Rehabilitation, Arbeitstherapie, Beschaftigungstherapie, etc*). The organisation of these projects usually takes place through liaison between the drug services and general social services. In most cases, funding comes through general services, such as social services (*Soczialgetsetzbuch SGBIII, VI, IX*), job centres (*Arbeitsamte*r) and insurance companies.

School and employment training has the following goals:

- educational diplomas;
- interview skills;
- qualifications (first aid, driver’s licence, PC qualifications, etc.);
- occupation; and,
- work experience.

A pilot project was carried out in Bavaria and other Laender in rural regions where outpatient therapy in counselling centres was combined with working on small farms. The client lives on the farm during this period. The costs of this pilot turned out to be lower and the results better when compared with regular inpatient treatment. A similar project took place in Schlesweig-Holstein, where drug users worked in small craft

companies. Results show, however, that this type of treatment is not suitable for every client (Küfner et al., 2000).

Housing

Accompanied housing is a major intervention in the field of social reintegration. It is a global term for different forms of housing support in drug care. It aims at stabilising, orientation and crisis intervention after inpatient treatment. People on substitution treatment or who are abstinent but still in need of support can be offered accompanied housing. People in accompanied housing receive regular but not permanent professional help (DBDD, 2001).

The goals of accompanied housing are:

- long-term abstinence;
- identification of personal problems;
- acknowledgement of the need to change;
- motivation and preparation for a drug-free lifestyle;
- improved self-help potential;
- improved health consciousness; and
- improved social and employment reintegration.

Debts counselling

Debts counselling, conducted with cooperation from general services, includes the following goals:

- overcoming debts and creating a stable financial basis;
- stabilisation of personal situation ;
- stabilisation of abstinence ;
- improved perspective on live; and
- facilitation of social and employment reintegration.

Leisure time

Interventions that focus on cultural and leisure activities like sport, training, nature, environment and culture have the following aims:

- encouragement of initiatives to fill leisure time;
- stimulation of talents and creativity;
- building social contacts and developing strong relationships;
- abstinence; and
- development of a healthy perspective on life.

Criminal justice system

The execution of sentences is the responsibility of the federal Laender. The respective departments of the Ministry for Justice are responsible for administering the prisons, collaborating in law-making, managing financial and staff resources, the fields of safety and building and the employment of prisoners. In Germany, a distinction is made between detention and imprisonment for punishment following a sentence. Youth custody concerns persons up to the age of 18 (up to 21, in some circumstances). Custody prior to deportation, custody for public order offences, preventive detention, coercive and enforcement custody and imprisonment instead of a fine are based on different laws and have different purposes (DBDD, 2001).

An important aspect of resocialisation as part of a sentence is the education of prisoners. According to the Ministry of Justice in Baden-Württemberg, prison inmates generally have a considerably lower level of education than non-offenders (http://www.justiz. baden-wuerttemberg.de/). Society, family, employment and leisure time are fast developing. Education is particularly offered to young offenders, in order to avoid the consolidation of criminal behaviour because of lack of education. Courses are offered at different levels, including elementary and primary school level (focusing on reading, mathematics, writing in everyday situations), as well as junior high school and professional school levels (theoretical and practical curricular units). Further education is offered for foreign prisoners in their own language, as far as possible. Courses about leisure activities focus, to some extent, on alcohol and drugs. First aid, language courses and computer training (word processing as well as IT) are also offered. Between 1998 and 2000, the Laender of Brandenburg, Bremen and Lower Saxony cooperated in setting up a distance learning network (TELIS) for computer training in prisons. This network is integrated with a European network of Spanish, Portuguese, French and English prisons at the moment (www.telis.uni-bremen.de).

Social training aims to improve competence and encourage new behaviours and attitudes towards problems with other people in the family, jobs, the authorities and leisure time. Sport activities have to be offered to prisoners, according to the laws on imprisonment, the youth courts and detention. Most of the bigger prisons have the required sports halls and facilities. The leisure activities most frequently offered in prisons (N = 33) are television (100 %), sport (96.8 %), games (75 %), creative activities (67.9 %), further education (61.5 %) and cooking (38.1 %) (Küfner et al., 2000).

Self-help

The goal of self-help groups is for the individual to discover his/her own resources and learn to use and develop them in order to achieve something. In Germany, self-help groups in the field of illegal drugs are rare. There are several local groups of 'Narcotics Anonymous' as well as groups of the self-help organisation JES (Junkies, Ex-users, Substituted). Nevertheless, there are a few very successful aftercare projects that have

been developed on the basis of self-help concepts. These projects always include professional help, to a bigger (e.g. Synanon) or smaller (e.g. Self-help Taunus) degree.

The main goals of self-help groups focus on:

- accompanying drug users and partners during and after treatment;
- reflection on the self; and
- relapse prevention.

Supply of services

According to the *Deutsche Hauptstelle gegen die Suchtgefahren E.V.* (DHS), the rehabilitation system for addicts is still inadequate, especially in terms of aftercare. Social reintegration, especially the employment of former addicts, should be part of the general rehabilitation process, but is still characterised by unclear definitions, badly arranged authority regulations and, above all, an ill-defined (almost arbitrary) method of financing (DHS, 2001). Table 3 summarises the supply of aftercare interventions in Germany in the year 2000.

Table 3: Supply of aftercare

Type of service	*Number of institutions*	*Number of beds/places*
Addiction advice centres	1 390	275 000 people/year
Housing facilities	259	3 930 (2 000 specifically for the DU)
Employment projects/Vocational training for drug addicts	91	1 450

Source: Gaßmann and Leune, 2000, p. 146.

The supply is not sufficient for the needs of the services and the measures for resocialisation and professional reintegration of the relevant people. For example, in 2000 there were 1 450 places available for the professional reintegration of drug users. There is a need for at least 10 000, considering that there are 30 000 people in treatment every year of whom at least one-third would need such places. For the year 2001, there were 150 work projects for drug users with 1 750 places available and 8 000 self-help groups with 150 000 places (Frietsch, 2000; DHS, 2002).

Most of the interventions occur in collaboration with general services, so the interventions that specifically concern drug users are difficult to quantify.

Funding

According to German law, drug users have to be offered a variety of support services for medical and vocational rehabilitation in order that a tailor-made plan can be formulated for the user's general rehabilitation. This means that the necessary finances for accomplishing this plan have to be guaranteed. Therefore, the financing authority is not only responsible for the medical welfare and rehabilitation of drug users, but also for their housing and employment (DHS, 2001).

In Germany, Laender, communities or social security only finances aftercare and reintegration interventions to a small extent. Funding is not based on the Social Law. This is why there are about 150 mainly non-profit-making organisations, with a variety of aftercare and reintegration services, depending on regional requirements and circumstances (DBDD, 2001).

In general, aftercare interventions are funded through a combination of health insurance and pension insurance funds (social insurance). The local welfare fund (Sozialhilfe) covers all other cases.

Evaluation

Evidence-based addiction treatment, where there are positive therapeutic outcomes, is the basis on which funding institutions finance treatment. Therefore, quality management and supervision of treatment in the field of detoxification and rehabilitation takes place under the control of funding organisations. The rules of public pension insurance define a treatment as successful if an insured person with a health problem does not have to stop working but is instead permanently integrated into work and society. Health insurance companies define treatment as successful when an emerging handicap or need of care can be prevented, removed or the situation improved. The aim of the social assistance system is to avoid or reduce an emerging handicap and to reintegrate the client into society.

Despite the vast range of special services for drug users, there are several weak spots in the system, including social rehabilitation (DHS, 2002).

Summary

- There is a wide range of aftercare services and interventions in Germany, including housing, vocational training, employment and psychosocial counselling.
- The situation regarding social reintegration interventions can differ across the country, the Laender and smaller regions.
- Drug treatment centres generally take care of the social reintegration of their clients.
- This can happen in collaboration with general social services (which are accessible to anybody) as well as through specific projects for drug users.
- These interventions are generally financed through insurance or through special projects funded by the Ministries of Health, Social Welfare and Justice.
- Social reintegration interventions do not just occur at the end of addiction treatment but are spread throughout the treatment process.
- Although there are many projects addressing the social reintegration issue, there are still not enough. They are also not well-defined or properly organised at national level.

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CLASSIFICATION AND AVAILABILITY OF SOCIAL REINTEGRATION IN GREECE

National context

Unlike many other countries, the term 'social reintegration' is used with great frequency in the Greek literature studied. The term 'social' generally implies that active attempts are made to integrate the former drug addict back into society: finding a stable occupation for, and/or upgrading the educational level of the client, and/or re-establishing relations with the client's family and friends. Social reintegration is, however, relatively recent in Greece, only having emerged in the course of the last fifteen years. The terms 'reintegration' and 'rehabilitation' are seemingly used interchangeably in the Greek literature studied.

The Greek National Action Plan Against Drugs (2002–2006) highlights three mains areas of action within social reintegration: firstly, the development of an educational programme; secondly, reinforcement of vocational training programmes; and, thirdly, encouragement of drug users in treatment to become actively involved in social and cultural events.

Current classification of social reintegration in Greece

A distinction has to be made between social reintegration interventions in Greece, according to whether they are carried out in a specific physical centre ('social rehabilitation centres', as they are called in Greece) or through a 'programme', which does not necessarily involve an actual centre but can be in the form of subsidies. The former include the following kinds of centre:

- social rehabilitation centres (in some cases, this is a semi-residential setting whereby the client stays in a hostel at night but does not receive treatment);
- vocational training centres; and
- specialised educational facilities.

Specialised vocational training does not necessarily take place at the vocational training centres but can also take place at the social rehabilitation centres.

The main social reintegration programme (that is not connected to a physical setting) is subsidised employment. This is a grant for helping former drug users enter the labour market.

The four interventions (specific centres or subsidy programme) mentioned here are compatible with our three predefined areas of social reintegration: housing (in this case the social rehabilitation centres), education (the specialised educational facilities and the vocational training centres) and employment (subsidised employment).

Availability of social reintegration facilities in Greece

The first kind of social reintegration activity mentioned above is social rehabilitation centres. There were 13 social rehabilitation centres in Greece at the time of the Greek national report of 2002. These centres act both as the last stage of the treatment process and as a post-treatment intervention. KETHEA is the biggest single player in the field of social rehabilitation centres and runs 9 of these 13 centres. In the course of 2001, there were 678 users in the social rehabilitation centres.

In 1998, KETHEA was authorised to run the specialised vocational training centres for three Greek regions and OKANA opened one in 2000. These centres do not only run

vocational training programmes but also provide help finding a job and guidance on possible career paths.

There are currently three specialised educational facilities. In 2001, these three educational facilities had a total of 108 participants, who could follow a variety of topics at different levels.

The employment programme works as a subsidy that is given to the employer as well as to former drug users who wish to run their own business from the Ministry of Labour. Every year, a fixed number of subsidised jobs are targeted at specific groups. In 2001, a total of 275 ex-addicts were in employment programmes. For the year 2002, 400 employment posts are planned for ex-addicts.

Adding up the available data on the different social reintegration measures, a total of 1061 cases were in some form of social reintegration in 2001. This is a surprisingly high number, considering the relatively short time that social reintegration has been available in Greece.

Evaluation results and findings

Many studies have been carried out at local level at the social rehabilitation centres. One such centre, EXODOS, concluded that, whereas 75% of the clients had legal problems on entry into treatment, this had dropped to 35% when they reached the social reintegration stage. On a more global scale, completion rates at the social rehabilitation centres varied considerably, ranging from 8% to 73% (the second highest reported was 32%).

Summary

- Social reintegration does not necessarily have to be the last step in a treatment process but can occur at any time.
- Social reintegration is generally for both former and current drug users.
- Social reintegration is comparatively new in Greece but is, nevertheless, already well integrated into the society.
- A wide range of social reintegration interventions is available and the number of places has increased in recent years.

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CLASSIFICATION AND AVAILABILITY OF SOCIAL REINTEGRATION IN SPAIN

Background/introduction

The Government Delegation for the National Plan on Drugs (*Plan Nacional sobre Drogas*) is responsible for the global drugs strategy. The National Strategy against Drugs places special emphasis on prevention activities and programmes that promote health and welfare, including harm reduction programmes and social assistance and integration programmes. The autonomous communities, in collaboration with local administrations, are in charge of planning and carrying out appropriate policies for these issues, as well as ensuring their financial and technical support (National Report, 2001).

Definition

Social reintegration (*incorporación,* or *inserción social*) is explicitly mentioned as part of the overall drug policy and is defined as: to facilitate people becoming and staying part of the community (Alvarez, 1996).

Concepts

Programmes aimed at facilitating the social reintegration of people with a drug dependency can be classified into three categories: education and training (*formación*), employment (*incorporación laboral*) and housing (*apoyo residencial*). Furthermore, several programmes are organised in the area of criminal justice.

Organisation

Programmes targeted at drug users tend to cover all the needs they have. On the one hand they administer the health care provided by the National Health System, on the other they endeavour to improve the user's living conditions, paying special attention to training, employment and housing. The programmes and services for social reintegration that were developed by the Government Delegation for the National Plan on Drugs in the year 2000 are shown in Table 4.

Table 4: Social reintegration programmes in Spain, 2000

Type of Programme	*Number of programmes / centres*	*Number of users*
TC's with specific activities	94	
Centres with activities and/or programmes (without treatment)	71	
Residential treatment centres with programmes (TCs)	52	
Housing services	111	3055
Training programmes	499	18042
Employment integration programmes	108	4677

Source: Government Delegation for the National Plan on Drugs with data from the Autonomous Communities' Plans on Drugs; National Report 2001.

An increase has been seen in the number of Spanish programmes aimed at the social integration of drug users through education and training, employment and housing. Of these activities, training programmes continue to outnumber the rest, especially those targeted at improving job-seeking skills, from which some 10 585 persons have benefited. Furthermore, 4 600 persons have participated in employment integration programmes, which are used to provide drug users undergoing rehabilitation treatment with the opportunity to find remunerated employment (National Report, 2001).

Education

In the year 2000, over 18 000 people made use of the training programmes, compared to 12 505 in 1999. In 2000, the activities and services providing professional counselling and help finding a job have been consolidated in several autonomous communities .However, these services do not exclusively target people with an addiction problem but are accessible to anybody. More than half (58.6 %) of the total number of drug users who attended training programmes in 2000 took part in these activities (National Report, 2001).

In penal institutions, the National Employment Institute runs a whole range of academic, pre-employment and employment-training courses, and there are courses run by the Autonomous Organisation for Penitentiary Employment and workshops.

A total of 10179 prison inmates started professional training courses in the year 2000 and 1 852 inmates started social work courses in the same period. It is estimated that approximately 50 % were drug-addicted individuals, which means an increase in the number of users of 5.25 % and 8.5 % respectively, when compared to the year 1999.

Employment

The range of programmes for the reintegration of drug-addicted individuals into employment can be classified into four large groups:

- handicraft workshops
- special employment programmes, including: workshop schools (Escuelas-Taller), craft workshops (*Casas de Oficios*) and employment workshops (*Talleres de empleo*). These three types of programmes combine training and employment and a salary is paid to the individuals (for six months or a year). The programmes are managed by the National Employment Institute. Municipal employment programmes and initiatives offered by the European Social Fund are also available. This was the category most often used. More than 2 000 drug-addicted individuals obtained a job out of a total of 4 677.
- contracts subsidised by private companies
- self-employment (freelance and cooperative work)

In July 2001, the Ministry of the Interior and the Ministry of Work and Social Affairs signed a joint collaboration statement for promoting employment and social reintegration of drug-addicted individuals undergoing rehabilitation programmes. The National Employment Institute now integrates (ex-) drug users undergoing rehabilitation into their Training and Professional Reintegration programmes (*Escuelas Taller; Casas de Oficios y Tallleres de Empleo*).

Housing

The organisations responsible for housing are always NGOs. The regional (autonomous communities) and local administrations finance the NGOs' services. In 2000, 3 055 individuals were lodged in supported apartments or lodgings.

Criminal justice

A wide variety of programmes designed to assist people with legal and criminal problems have been established by the Prison Institution Administration, the Government Delegation for the National Plan on Drugs and the autonomous communities' Plans on Drugs, with the participation of NGOs. These programmes provide various types of action, depending on where the person concerned is located: police headquarters and courts, prisons and programmes offering alternatives to imprisonment.

According to data provided by the 32 Assistance Services for Arrested Individuals or Points for the Attention of Drug-Addicted Arrested Individuals working at different Spanish courts at the end of 1999, as well as other data provided by Penitentiary Social Services, a large number of people who benefited from diversion of sentence were cases relating to drug addiction.

The information obtained from the different Regional Plans on Drugs indicates that 832 individuals were diverted to treatment by the courts in 1999 and 1 884 additional cases were diverted from the penitentiary centres themselves. The number of individuals who were receiving compulsory treatment (as an alternative to imprisonment) at autonomous community centres was 2325. 160 of these in assistance outlets, 18 in apartments, 63 in therapeutic communities and 79 in medical and/or similar centres (Spanish National Report, 2000).

The legal framework for these actions is defined in the Spanish Constitution, which establishes that prison sentences and security measures must aim at the re-education and social reintegration of individuals and at protecting their health. This constitutional mandate has been developed by means of the Penal Code (Organic Act 10/1995, 23 November) and the Penitentiary Regulatory Norm, which ensures that penitentiaries will receive adequate assistance for addiction prevention, treatment and reintegration of drug-addicted inmates. In this way, the main guidelines established by the National Plan on Drugs are guaranteed.

The drugs strategy establishes a close collaboration between the Government Delegation for the National Plan on Drugs, the General Directorate for Penitentiary Administration, the regional and local Plans on Drugs, the national and regional plans against AIDS, the health departments of the autonomous communities and the NGOs (these obtain funds from the national, regional and local Plans against Drugs and from the Ministry of Labour and Social Affairs).

This type of organisational structure establishes links between prisons and the community, and ensures continuity of treatment both for individuals entering prison and those who are leaving a penitentiary centre.

The general objectives of these programmes are: to provide assistance for addicted individuals with legal problems; optimising coordination between the different administrative bodies and agents involved; offering advice and legal guidance on the personal, family and social situation of the individual arrested.

Data provided by the different autonomous communities to the Spanish Monitoring Centre for Drugs' indicator of individuals starting treatment show that this population has low levels of education and a high rate of unemployment.

The ultimate objective of interventions for drug-addicted inmates is social reintegration.

Therefore, any action in this area must aim to prevent harm associated with consumption of drugs and to facilitate the normalisation and social reintegration of drug-addicted individuals. Any therapeutic alternative should not, therefore, be isolated as a separate treatment programme but should be integrated with a range of actions to provide training and education.

Funding

The national report (2001) outlines how the different central government departments with responsibility for drug-related matters manage the drug budget. In 2000, this budget was around 10000 million pesetas (€62 million). In addition, the Government Delegation for the National Plan on Drugs, with a total budget of 5598 million pesetas (around €33million), allocated 3766 million pesetas to the Regional Plans on Drugs. In 2000, the autonomous communities, through these plans, invested 25 684 million pesetas from their own budgets (compared with 22 696 million pesetas invested in 1999) (National Report, 2001).

The distribution of expenditure in 1999 by the autonomous communities and cities is summarised in Table 5 by area of intervention (including the amount allocated by the Delegation).

Table 5: Distribution of expenditure per type of intervention, 1999 (in million of Euro)

Areas of intervention	*Amount (Euro)*	*Percentages*
Prevention	28.21	15.94 %
Care and rehabilitation	132.67	74.96 %
Research, documentation and publications	2.60	1.47 %
Institutional coordination and cooperation with private initiatives	13.52	7.63 %
	177.00	**100 %**

Source: Spanish National Report, 2000.

In 1995, a fund was created (Law 36/1995) from goods confiscated in relation to drug trafficking and related offences. This fund will be used for prevention, treatment and social rehabilitation of drug users as well as to address drug-related crime and enhance international cooperation in these areas. In 2000, the budget of the Government Delegation for the National Plan on Drugs included 4.5 million euro from this fund, and this was used to finance drug prevention programmes and the fight against drug trafficking.

Summary

- Spain has formally defined the concept of social reintegration.
- Spanish interventions for social reintegration focus on education, housing and employment.
- In addition, there are several interventions in the criminal justice system.
- In general, most interventions come under general services and are accessible to anyone.
- No specific information is recorded on the number of drug users reached by such interventions.
- Funding of services is organised at national level and at the regional level of the autonomous communities.
- Interventions that can be classified as social reintegration do not necessarily occur at the last stage in the treatment process but at any time throughout the process.

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CLASSIFICATION AND AVAILABILITY OF SOCIAL REINTEGRATION IN FRANCE

Introduction

Until May 2002, the Ministry of Health was part of the Ministry of Employment and Solidarity and had a Minister of State (or undersecretary) for Health. Today, there is a Ministry of Social Affairs, Employment and Solidarity and a Ministry of Health, Family and Disabled People.

The social reintegration facilities specifically targeted at drug users are primarily financed by the Ministry of Employment and Solidarity and partially by the French government drug action coordination unit (MILDT). Interventions not specifically targeted at drug users (but accessible to them) are generally part of the Ministry of Employment and Solidarity and of 'The fight against social exclusion' (Loi de prevention et de Lutte contre les exclusions).

Definition

The term that comes closest to social reintegration in the French literature is 'insertion'. Insertion is defined as 'the process that guides a person to find a place in society' ('l'insertion est défini comme un processus qui conduit une personne à trouver une place reconnue dans la société').

Concepts

The concepts used for describing social reintegration interventions (for drug users) in France can be divided into four groups:

1. housing (hébergement social);
2. education (suivi socio-éducatif);
3. employment (insertion par le travail); and
4. legal aid (aide juridique).

As mentioned in the introduction regarding all EU countries, the distinction between social reintegration and treatment is not always clear in France. Units offering specific services to drug users may offer, among other things, social reintegration interventions. This makes it difficult to give examples of facilities specifically oriented towards social reintegration.

Examples of housing facilities are:

- therapeutic apartments (appartements thérapeutiques);
- transitional or emergency housing (structures d'hébergements de transition ou d'urgence); and
- host families (familles d'accueil).

Examples of services by means of which education, employment and legal assistance can be provided are:

- reintegration services (ateliers d'aide à l'insertion);

- reintegration services in prisons (unités pour sortants);
- low-threshold services (structures dites de bas seuil); and
- mobile street units (équipes mobiles de proximité).

Description of interventions

Therapeutic apartments (TAs) are designed to help drug users regain their independence. They are currently reserved for individuals who are experiencing serious health and social difficulties. These apartments may also be used as emergency or transitional housing, where treatment can be provided, enabling users to have a break, to stabilise detoxification or substitution treatment, or to wait for more permanent housing. This housing is also available to drug users who have recently left prison, or to those who have been given an alternative to imprisonment. Overall, there were 86 TA networks, with a total of 422 accommodation places, in 2001.

Transitional or emergency housing allows for a short stay of one to four weeks depending on the medical and social needs of the person. This is usually accompanied by socio-educational and/or medical support. This type of housing is especially useful for people suffering from significant marginalisation, such as a person leaving prison or where sentencing has involved an alternative to prison. In 2001, there were 147 such places available in 18 facilities.

Reintegration through host families is an intervention that dates back to the late 1970s. The target of these interventions varies (people who are single, with children, separated, in substitution treatment, on trial, etc.) and so too does the duration of stay (from a weekend up to nine months). In 2001, there were 20 host family networks (Annual report, 2001).

Table 6: Number of social rehabilitation housing units in France, 1999

Type of intervention	*Number of reintegration units*	*Number of places*
Therapeutic apartments	86	422
Transitional or emergency housing	18	134 (147 in 2001)
Host families	20	116
Total	*124*	*672*

(Source: MILDT, 2001)

The goal of the reintegration services offered in prisons is to ensure continuity of care for users who are under police arrest or in prison. The aim is to improve the provision of care for individuals in custody (30% of whom are drug addicts) and to prepare them more effectively for their release (routine involvement of specialised drug treatment centres in prisons, prisoner release preparation teams, etc). Particular efforts are made to provide care to those in custody who are suffering from alcohol problems (approximately 30% of the intake).

In general, the policy is to ensure that drug users have access to existing social reintegration schemes, notably those provided under the social exclusion law, such as reception in lodgings and social reintegration centres, access to social reintegration

schemes under the programmes for countering and preventing all forms of social exclusion.

Organisation

Aftercare and resocialisation programmes are mostly integrated into the general system of specialised care for drug treatment, the CSSTs (centres spécialisés de soins aux toxicomanes). In 2001, there were 263 CSSTs, 201 outpatient centres, 46 residential therapeutic centres and 16 centres inside the prison sector. These organisations were funded until 2001 directly from the state budget, within the framework of several years of contracts between the local state representative and the CSST. This ensures the quality of the services provided and their compatibility with public drug policy. In the near future, these organisations will be funded by the national social insurance system.

Several other organisations run social reintegration interventions such as storefront facilities, legal help, employment reintegration programmes, etc. Even if most of these organisations are subsidised by central or local authorities, the quality of service is less certain than for the CSSTs.

Since 1999, reintegration has received increasing political attention from the French Directorate-General of Health. Social reintegration interventions that are part of the Ministry of Employment and Solidarity's 'Fight against social exclusion' (Loi de prevention et de lutte contre les exclusions) can take three different forms:

1. professional reintegration, to reinstate contact with the labour market;
2. social reintegration or social care; and
3. grouped social reintegration activities, focusing on employment, care, housing, culture and education.

None of these facilities, however, are specifically for drug users. They are for the general population as a whole, and those at risk of exclusion in particular. There is no mention of the words 'drugs', 'drug user' or 'addiction', but in theory these facilities are also accessible to (ex-) drug users. The drug services liaise between their clients and the general interventions to fight social exclusion that are available to everybody. Quantifying the slots and interventions for drug users is therefore impossible.

In general, the policy is not to create new responses and specific programmes of social reintegration to supplement those services that already exist, but to utilise the existing programmes in a better way.

Some of the general projects of the Ministry of Employment and Solidarity's 'Plan national de lutte contre les exclusions' include the following:

- CMU (Couverture maladie universelle), which makes social security available to everyone, facilitates access to those most in need of extra cover with no increase in medical fees (4.2 million people were availing of this at the end of July 2000).
- PRAPS (Programmes régionaux d'accès à la prévention et aux soins; the regions run this programme) is a programme that protects those who live in precarious circumstances and who may have difficulty accessing the social and medical services.
- PASS (Permanences d'accès aux soins de santé) comprises both the private and public hospital services, and these are obliged to treat anyone, including people with

special needs. They offer curative and palliative care and maintain the continuity of care. On 30 April 2000:

- 237 hospitals were receiving funding for PASS
- 138 PASS had personnel
- 183 PASS had a control body
- 135 PASS had protocols

- RMI (Revenu minimum d'insertion) is a minimum welfare payment given to those who are not entitled to unemployment benefit.
- CHRS (Centre d'hébergement et de réinsertion sociale) is a centre for emergency housing and social reintegration.
- PDALPD (Plans départementaux d'action pour le logement des personnes défavorisées) is a departmental action plan for housing people who are ostracised from society.
- FSL (Fonds de solidarité pour le logement) has the goal of helping people to retain their accommodation when they have problems paying the rent or helping them find new accommodation by giving loans, subsidies or a guarantee when required.
- ANAH (L'Agence nationale pour l'amélioration de l'habitat) is a national agency which aims to improve people's environment.
- There are a number of different services for young people, such as PAIO (Permanence d'accueil, d'information et orientation) and FAJ (Fonds d'aide aux jeunes).
- ASI (Accompagnement social individualisé), CES (Contrats emploi solidarité), CEC (Contrats emploi-consolidé) and the TRACE (Trajet d'accès à l'emploi) programme have the goal of helping to find work for young people between 16 and 26 who have problems or who are at risk of becoming excluded from employment because of their addiction. In the first 18 months of the TRACE programme, 65 000 young people were seen and 80% of them found work or education after 15 months in the programme (source: bilan de lutte contre les exclusions or 'construire une place pour tous', pp. 21 and 22).

The aim is to focus on including people with addiction problems, especially in CHRS and the TRACE project (and subsequently CES and CEC).

Policy recommendations

The 1999–2002 national drug plan states that specialised services for drug treatment have until now focused mostly on a psychological and medical approach, often neglecting the social and professional aspects. It is generally recognised that it is also necessary to offer services that cover the family and social problems (accommodation, finances, work, etc.) of drug users. Although several aftercare centres have included professional reintegration services in order to deal with social problems, these are often cut off from reality and do not necessarily help to reintegrate drug users into real life. The national drug plan makes the following recommendations regarding social reintegration:

1. It is necessary to ensure a better integration of risk reduction policy in all specialised and non-specialised facilities, so that those users suffering most from social exclusion can be dealt with more effectively in all large towns and cities (boutique solidarité, CHRS, établissements de santé). The number of services will be increased over a period of three years to include: 3 sleep-in centres, 20 storefront facilities, 30 syringe exchange programmes, 30 mobile teams in problem areas and 50 automatic syringe dispensers.

2. Welfare services will be improved for individuals undergoing drug substitution treatment supervised by general medicine centres (support for GP networks, contractual agreements with healthcare centres and accommodation or social rehabilitation facilities).

3. Continuity of care for users under police arrest and in prison must be ensured. It is necessary to improve the provision of care for individuals in custody (30% of whom are drug addicts) and to prepare them more effectively for their release (more systematic involvement of specialised drug treatment centres in prisons; prisoner release preparation teams). Particular emphasis will be placed on the provision of care to those in custody suffering from alcohol problems (approximately 30% of the intake).

4. Drug users must be assisted in accessing existing social integration schemes, notably those provided under the social exclusion law (reception in lodgings and social reintegration centres; access to social integration schemes under the programme for combating and preventing all forms of social exclusion).

Availability of services

In total there are 387 centres specialised in drug addiction (out of a total of 1345)[5] that offer integration and reintegration services (this is usually not the only activity but is in addition to therapeutic housing, prevention and care). Overall, there are 690 centres offering care, 969 drug services offering prevention and 187 offering therapeutic housing. Of the 387 centres specialised in drug addiction, 40 provide legal help, 26 provide emergency housing, 38 have a programme of reintegration through employment, 22 offer hostel accommodation and 354 run a social and education programme (DATIS; Lopez, 2002)[6].

The figures for all the other services that are part of the Ministry of Employment and Solidarity's 'Plan against social exclusion' includes all services to all people and therefore no specific information is available for (ex-) drug users.

Funding

The majority of the financing for the fight against drugs comes from the Ministry of Employment and Solidarity's budget. Some is part of the budget specifically allocated for AIDS prevention, partly corresponding to harm reduction policies (chapter 47-18: AIDS prevention programme). Regarding specific funding, the budget of the Ministry includes two chapters on the fight against drugs (chapter 47-15: programme of the fight against

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[5] This figure comes from the DATIS database on drug facilities, which includes all types of organisations, whether state approved and funded or not. A single specialised centre (such as a CSST, mentioned above) may be represented in the database by several units.

[6] This number does not add up as some centres provide more than one kind of intervention.

addictive practices as part of the health policy; and chapter 47-16: inter-ministerial action in the fight against drug addiction).

Table 7: Funds allocated from the health budget for social reintegration for drug addicts between 1998 and 2000 *(in million of Euros)*

Action	*1998*	*1999*	*2000*
Reintegration services (ateliers d'aide à l'insertion)	1.77	1.81	1.83
Reintegration services in prisons (unités pour sortants)	0.76	0.76	0.79
Low threshold services (structures dites de bas seuil)	2.36	3.02	3.16
Mobile street units (équipes mobiles de proximité)	0.00	0.23	5.03
Transitional or emergency housing (Hébergement d'urgence pour usagers de drogues en situation de grande précarité)	0.00	0.00	3.16
Total	4.89	5.82	13.96

Source: MILDT, 2001

Summary

- There are many social reintegration interventions operating in France.
- Housing facilities are mostly financed by the Ministry of Health. However, it is not easy to distinguish whether they are based on social reintegration or treatment objectives in general.
- A large number of other projects that focus on education and employment are accessible to drug users. However, they are designed for the general population and are funded by the project 'Lutte contre les exclusions'. Quantitative data for social reintegration interventions specifically for drug users are therefore not available.
- These reintegration interventions are not confined to any particular phase of the treatment process. As far as it is possible to identify, they can take place during, at the end of or even before treatment. In particular, the services available to the general population can be part of a strategy to prevent social exclusion and can even take place outside of any type of treatment.

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CLASSIFICATION AND AVAILABILITY OF SOCIAL REINTEGRATION IN IRELAND

Introduction

The aim of this report is to briefly sketch the conceptualisation and provision of social reintegration interventions in Ireland, as they relate to former drug users. The coverage of this report is designed to be consistent with the initial aim of the EMCDDA, which was to describe interventions that were designed specifically for drug users. However, the report departs from the secondary aim, which was to map interventions that were a last step in the treatment process. In this regard, the interventions referred to in this report, are not contingent on a particular phase of treatment for drug misuse/addiciton, but generally are targeting individuals that are not actively using 'street drugs' and/or are post-treatment or in the latter stages of treatment or in some cases have had no contact with treatment. However, it must be noted that this material is not representative of an exhaustive coverage of all social reintegration interventions for former drug users in Ireland.

The objectives of the report are to:

- Identify National policy regarding the social reintegration of former drug users
- Identify the classification of interventions as part of the social reintegration process
- Describe the interventions
- Highlight some outcomes from evaluation of interventions

National context

The Irish 'National Drug Strategy 2001-2008' addresses the issue of rehabilitation / reintegration in three foreseen actions mentioned in the strategy. Action 48 advises that each Health Board area should have in place, a range of treatment and rehabilitation options for each drug misuser, by end of 2002. This approach should assist in their re-integration back into society. Action 74 has as goal to 'increase the number of training and employment opportunities for drug misusers by 30% by end of 2004' whereas Action 75 states that the potentials of reintegrating drug misusers through Social Economy Projects and vocational training should be explored. So far there are no clear figures on how many former or current drug users who have been activated or reintegrated through the earlier mentioned actions in the National Drug Strategy.

Another important policy paper is the National Development Plan from year 2000 that in chapter 10 under various headings addresses the issue of reintegration of socially excluded people. The heading 'Promoting social inclusion' promises to provide work and skills training as well as work placement (employment measure) and personal development services to alcohol and drug abusers in order to reintegrate them into the community. Under the heading 'Youth services' the intention is to provide facilities and special projects for youths either 'at risk of drug abuse' or who already experience 'significant drug problems'.

Current definition and classification of social reintegration in Ireland

It can be said that the term social reintegration, as it relates to former drug users in Ireland, has been historically utilised interchangeably with such terms as rehabilitation and social exclusion/inclusion. However, it can be recognised that as attempts are made to move from the realm of conceptualising social reintegration to the concrete provision of providing reintegration services, such a move is predominantly characterised by focusing on service provision that 'prepares' former drug users for active participation in the labour market.

Interventions premised on the social reintegration of former drug users are predominantly classified under the headings of education, training and employment initiatives. Such initiatives are broadly designed to enhance and/or develop the skills-base of individuals in pursuit of labour-market opportunities. It must be noted that the term former drug users implies that the target groups for such initiatives are no longer users of 'street drugs'. Herein lies the assumption that individuals are either a) post-treatment or b) in the latter stages of treatment.

Additionally, it must be noted that although the broad understanding of social reintegration interventions as the relate to former drug users tends to emphasise the educational, training and employment elements, in some cases service provision also combines a focus on individual personal development and vocational pursuits. For example, the Northern Area Health Board (NAHB) has developed a specific Rehabilitation/Reintegration Service (RIS) targeting former drug users. Within this context, the NAHB utilises a definition of 'rehabilitation/reintegration that centralises the belief that "…The aim of the [reintegration] process is to empower people to access the social, economic and cultural benefits of life in line with their aspirations…"(NAHB 2002).7 This empowerment can be achieved by focusing on both personal development such as maintaining relapse prevention skills while also providing/facilitating to education, training and employment opportunities.

Availability of social reintegration facilities in Ireland

The development of social reintegration facilities for former drug users in Ireland has primarily taken place within the eastern region of the country. In particular, within the Greater Dublin area, reintegration responses have been developed against a background of high levels of drug use, primarily heroin use. Such responses have tended to be located within the areas served by the Eastern Regional Health Authority (ERHA) and 12 of the Local Drug Task Forces.

For instance, the Northside Partnership (2001)8 identified former drug users as one of eleven specific priority groups to be targeted through its Social Inclusion Initiative. The Northside Partnership operates on the Northside of Dublin City, an area comprising over 100,000 people. The partnership recognised an estimated 4,000 drug misusers were resident in the area. In response, a series of measures were devised by the partnership to assist former drug users in the process of social reintegration. For example, the Labour-Market Inclusive Project (LIP) supports former drug users in securing and maintaining employment opportunities. In addition, the partnership has developed a

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[7] Northern Area Health Board (2002) From Treatment to Rehabilitation – progression within a continuum. (Personal Communication)

[8] Northside Partnership (2001) New Frontiers: Confronting the toughest challenges of social inclusion. Northside Partnership, Dublin

Targeted Outreach Initiative to contact former drug users, not in contact with mainstream services.

Provision has also been made available to facilitate drug users that are currently attending treatment facilities, and who wish to access interventions that will assist them in the reintegrative process. In this regard, drug users availing of methadone treatment can also access a state-subsidised 'Community Employment Scheme for Drug Users' operated by the state vocational training agency FAS. This scheme facilitates individuals in the learning of new 'marketable skills' that is designed to assist in accessing employment opportunities.

Merchant's Quay Ireland (MQI) in its capacity as a drug service provider, identified a gap in service provision for a programme that would assist former drug users, that had completed residential treatment to access opportunities in the mainstream employment market. In response, MQI established the social reintegration programme called 'From Residential Drug Treatment to Employment'.9

In addition, a range of projects operating under the auspices of the Local Drug Task Forces are primarily aimed at providing a service that will serve the social rehabilitation/reintegration needs of former drug users. Examples of such projects include:

The Soilse Project, the HYPER project, the Pathways Project, the Tower Project, the Fettercairn Drug Rehabilitation Project, the STAR Women's Rehabilitation project and the Ringsend and District Response to Drugs. 10

Research and evaluations

The evaluation of the Merchant's Quay reintegration programme had 49 clients admitted to the programme in the two-year period from early 1998 to end of 1999. 65% of the admitted clients in the two-year period completed the programme. For the clients admitted in 1999, 89% agreed that the reintegration programme provided the necessary skills to avoid relapse. 83% secured full-time employment whereas 13% pursued full-time educational opportunities.

The earlier mentioned programme HYPER had a core group of six participants in their programme for between five and eleven months. One year after discharge five of the six were still drug free and stable whereas the sixth had relapsed and had returned to the programme.

Summary

- Social reintegration has enjoyed radically increased political attention with the launch of the new Irish Drug Strategy.
- The majority of social reintegration <u>facilities</u> are for addicts in general and only a few are specifically for former or current drug users.
- The exact coverage of social reintegration <u>programmes</u> is not known but must be believed to expand in the course of the next few years.

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[9] See the EDDRA database for a comprehensive overview of this intervention

[10] These seven projects have been evaluated and inserted onto the EDDRA database

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CLASSIFICATION AND AVAILABILITY OF SOCIAL REINTEGRATION IN ITALY[11]

Introduction

In Italy, there has been a continuing devolution of responsibilities to the regions and a consequent reduction in the direct operational responsibilities of the national government. Some specific areas have remained the responsibility of the central administration, such as prisons and the criminal justice system, whilst others have been largely transferred to the regions, such as the planning and delivery of health services. Social reintegration targeted at drug users, therefore, involves an interface between different levels of operational responsibility: national, regional and local.

At national level, strategic planning and guidance is provided through national plans developed by different Ministries. Both the National Health Plan[12] and the National Employment Plan[13] are important contributors to the overall strategy for social reintegration. In addition, in November 2001 the National Department for Anti-Drug Policies was established, based within the Office of the Prime Minister, and an Extraordinary Commissioner was appointed with responsibility for overall coordination of drugs policy and strategy and the development and implementation of a National Drugs Plan.[14]

The National Plan was approved in February 2002. Amongst its priorities were the expansion of socio-rehabilitative services and an increased focus on social reintegration, including education, vocational training and employment interventions. The Directorate General for Employment of the Ministry of Labour and Social Policy has responsibility for the employment service, for the promotion of equal opportunities and for activities aimed at reducing social exclusion, insofar as it is manifested through unemployment; in particular, the Directorate is responsible for management of funding from the European Union and the National Employment Fund. The Directorate General for Drug and Alcohol Dependence, which is based in the same Ministry, has technical competence for the collection, coordination and evaluation of data provided by different ministries. This department also prepares the annual report to Parliament on the state of the drug problem in Italy, acts as the national focal point to the EMCDDA and manages the National Drugs Fund. The Ministry of the Interior, through specialist drug teams (NOT) that assist the Prefect in assessing and referring people found in unlawful possession of drugs, and the Ministry of Justice, through the adult and juvenile justice systems, also have important roles in the drugs field and are directed at national level but managed and implemented at the regional and provincial levels.

The planning and delivery of local health care services is the responsibility of the regions. This allows a degree of flexibility to reflect local needs within the framework of

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[11] The Directorate General for Drug Dependency, Ministry of Welfare, prepared this chapter.

[12] Ministero della Salute. *Piano Sanitario 2002–2004*.

[13] Ministero del Lavoro e delle Politiche Sociali (2002). *Piano Nazionale d'Azione per l'Occupazione*.

[14] Programma triennale del Governo per la lotta alla produzione, al traffico, allo spaccio ed al consumo di sostanze stupefacenti e psicotrope (Anni 2002–2004). Presidenza del Consiglio dei Ministri, Ufficio del Commissario Straordinario di Governo per il Coordinamento delle Politiche Antidroga.

national guidelines. The provincial or sub-provincial levels of the local health authority (Azienda Sanitaria Locale) run these services. Social services operate at regional level, but there has also been some devolution of functions to the communes and municipalities. The regions maintain registers of organisations approved for providing social services, including both socio-rehabilitative organisations and social cooperatives. The regions also manage the National Funds, which are allocated pro-rata to the regions, and the resources for training and social employment.

Definitions

There is no standard definition of social exclusion in Italy[15] and different structures and individuals operate to different definitions. Broadly speaking, there is a view of social exclusion as a social situation that can lead to marginalisation. Although the precise nature of such a social situation is not commonly agreed, it appears to have shared economic, social, policy and legislative features. It is probably easier to refer to the groups of people who are viewed as socially excluded rather than to select a single definition. The longterm unemployed, illegal immigrants, the Romany population, people with severe dependency problems, prisoners and ex-prisoners and people without stable accommodation are most commonly designated as marginalised or socially excluded.

As well as there being no standard definition of social exclusion/inclusion, there has been little debate on the terminology used for social reintegration or social exclusion/inclusion as it applies to drug users. A variety of definitions have been used, from different perspectives. A National Drugs Conference in Genoa (November 2000) ran two sessions to address this area: ‘Social inclusion is possible’ and ‘Social insertion and entry into employment with a specific focus on problems arising from disadvantaged circumstances’[16]. In general, reintegration is taken to mean the phase of a treatment programme when clients are assisted to regain their social and economic independence having successfully completed the intensive phase of treatment. This most commonly occurs as the last phase of a residential treatment programme. There are, however, many examples of the ‘Ser.T’ (drug treatment services managed by the local health authority) running reintegration programmes. Increasingly, two kinds of reintegration are seen. The first is the process of assisting an individual who has been in an institution (residential rehabilitation, prison, etc.) for an extended period to re-enter society. The second is the provision of services and interventions to assist socially excluded people to reintegrate. Drug users and former drug users can be included in either or both of these categories.

Concepts

Drug use or dependency does not necessarily equate with social exclusion. Rather, it is where there is a combination of circumstances usually associated with chronic dependency, such as longterm unemployment, insecure accommodation and a current or recent prison sentence, that marginalisation seems to occur. In situations where a person with a dependency is able to return to his or her previous employment or to

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[15] Leone, L. (Ed.) (2001). *Valutare le Politiche per l’Inclusione Sociale: Rapporto di ricerca per il VIDES*. Roma, Internazionale Studio CeVAS Consulenza e Valutazione nel Sociale.

[16] Dipartimento per gli Affari Sociali (2001). *Atti della Terza Conferenza Nazionale sui Problemi Connessi con la Diffusione delle Sostanze Stupefacenti e Psicotrope*, Genova, 28–30 Novembre, 2000. Roma, Presidenza degli Consigli dei Ministri, Dipartimento degli Affari Sociali.

education on completion of treatment, the legislative framework in Italy is designed to limit the likelihood of marginalisation.

There are, therefore, several different possible objectives for reintegration:

- A common objective is to assist a return to, or entry into, the employment market. This may involve providing education, vocational training and employment counselling and guidance.

- Another objective may be to assist a successful return to previous employment or to provide treatment without loss of employment.

- There has been increasing provision of direct employment through social cooperatives which are part of the overall structure of treatment services. This kind of employment is generally in the non-profit sector, but is separate from the treatment service itself.

- There are some examples of collaboration between the Ser.T and independent social cooperatives whereby the local health authority provides insurance cover whilst the cooperative provides vocational training and employment.

- Vocational training and employment are both provided within the prison system. These are available to convicted prisoners and aim to provide skills and work experience in preparation for release and reintegration into society.

- In general, supported accommodation is not provided. For those in residential treatment, the 're-entry' phase often consists of a period of continued residence whilst starting work, training or education, followed by a non-residential but supported transition period to full independence. The available data on the accommodation status of drug users in treatment suggests that homelessness is a relatively rare condition and that treatment services assist clients to secure accommodation on completion of the residential treatment period.

- There appears to be very little provision of legal aid or advice, either for those with a drug problem or for those with legal problems.

Organisation

Italy puts considerable emphasis on avoiding social exclusion and promoting social inclusion. Both national resources and funding from European Commission programmes have been used to this end. The General Directorate for Employment in the Ministry of Labour published a document on returning current and former drug dependents to employment.[17] This document examines the situation as it was in the mid 1990s, the policies that were aimed at promoting employment and reintegration and ways in which these might be expanded. It mentions the importance of employment as a means of allowing the drug user to maintain contact with 'normal' social behaviour and also notes that unemployment prolongs drug dependency. Above all, it states that an inferior level of education and vocational training can result in low-level jobs or unemployment and that tackling these factors, along with reintegration into work, is fundamental to achieving full rehabilitation and personal independence.

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17 Ministero del Lavoro (2001). *Inserimento Lavorativo di Tossicodipendenti ed ex-Tossicodiendenti*. Roma, Ministero del Lavoro e della Previdenza Sociale, Direzione Generale per l'Impiego.

The National Drugs Conference held in Genoa in November 2000[18] included a section that specifically addressed the difficulties encountered in returning to employment and social life. A number of proposals for changes or improvements emerged from this session. Amongst these suggestions were:

- To develop guidelines to encourage regional and local authorities to implement fully the section in the Agreement between the State, the Regions and the Autonomous Provinces (1999) on training programmes to aid a return to employment;
- To promote a system for return to employment that is flexible and recognises degrees of disadvantage;
- To increase the participation of social cooperatives and businesses that employ disadvantaged people as providers of services to local public bodies; and
- To amend the legislation to include drug addicts in the category of disadvantaged people, thus allowing them to benefit from access to employment in category B social enterprises.

The National Drugs Plan has proposed that this amendment be made as soon as possible and has included increased activity in vocational training and return to work as one of its key action areas. In relation to (ex-) drug users, the General Directorate for Employment in the Ministry of Welfare has included the following in it priorities:

- Planning and coordination at central and regional levels to ensure that the Employment Service is actively involved in reintegration projects for drug users;
- Harmonisation of the activities of the Employment Service, public and private drug treatment services, the system of social cooperatives, trade unions and businesses in order to promote integration/reintegration programmes; and
- Promotion and orientation of policies for employment and placement of drug addicts and integration of these policies into the strategic plan for the development of employment services, with the aim of achieving a new accord between the state, the regions and the autonomous provinces.

With the objective of avoiding social exclusion and encouraging an employed person with a drug problem to seek treatment, arrangements are in place which allow an employee to be guaranteed to return to work on completion of treatment. These arrangements are as follows:

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18 Dipartimento per gli Affari Sociali (2001). *Atti della Terza Conferenza Nazionale sui Problemi Connessi con la Diffusione delle Sostanze Stupefacenti e Psicotrope*, Genova, 28–30 November, 2000. Roma, Presidenza degli Consigli dei Ministri, Dipartimento degli Affari Sociali.

- Where an employee is shown to be drug dependent and enters a therapeutic programme, his/her return to work is guaranteed for a maximum period of three years from ceasing work to completion of treatment (or longer if their specific contract permits).

- Confirmation of drug dependence must be provided by a public health service, defined in the guidelines as the Ser.T.

- The treatment programme may be provided in separate blocks, if this is appropriate, provided the absence from work does not exceed three years.

- The law on maintenance of employment for drug dependents is thus designed to aid reintegration and is more appropriate than the law relating to maintenance of employment for employees who are ill or have had an accident. In 1984, the National Institute of Social Security decided that Law 833 of 1978 (indemnity for illness) also applies to illness as a result of drug dependence. In combination with the special contractual arrangements described above, this provides a wide range of options for treating drug dependents who are in employment.

- All the collective contracts which were examined took into account the requirements of the law concerning maintenance of employment, although the majority simply applied the letter of the law and no more.

There is limited data available on the operation of these arrangements in practice. However, the Ministry of Welfare has submitted a project – Dal Welfare al Work Fare – for funding through the National Drugs Fund aimed at developing improved instruments for achieving a return to work of disadvantaged people and at providing more adequate monitoring and evaluation.

A particular difficulty is that social reintegration is primarily conducted as part of the therapeutic process, usually by residential rehabilitation services. There is no national or regional data available on reintegration activities and only a small number of reports are available through the websites of individual organisations or in hard copy. More data is available on projects financed through EU programmes (European Social Fund, Integra, Adapt, Equal) or through the National Drugs Fund.

Under the Integra programme for the period 1997 to 1999, 54 projects that included drug users and former drug users as their target group (exclusively or with other target groups) were financed. In total, some 11 200 drug/ex-drug users were involved, along with 2 245 'change agents' (social workers). The total cost of these projects, involving around 400 local partners and 177 international partners, was €23 394 974.

The available data for projects financed through the National Drugs Fund from the allocation available to regions for the 1997–1999 period shows that a minimum of 282 projects in 10 regions and one autonomous province were specifically concerned with social reintegration. It is probable that there were more, but the information given about many of the projects was not always sufficiently clear about their objectives. Furthermore, there were social reintegration projects funded in the other regions where no data was available. These were projects managed by communes, social cooperatives, the Ser.T, local health authorities and NGOs and involved a range of other organisations, including training bodies, educational institutes, trade associations and trade unions.

Although there is evidence, therefore, of substantial activity in the field of social reintegration, the supporting documentation remains sparse. The major focus of these projects consists of:

- Vocational and professional training in specific areas, such as gardening, building maintenance, typography and graphic design and computer programming;

- Placement in supported employment, usually through social cooperatives;

- Support and guidance for ex-drug users in the early stages of their return to employment; and

- Employment counselling and guidance to assist in identifying suitable work and developing personal skills.

There is no universal model for the organisations working in this area. However, it is clear that most of the projects are collaborative efforts involving public bodies, NGOs, social cooperatives, employers and employee associations.

The Ministry of Labour and Social Security reported on research undertaken by ISFOL to examine activities undertaken by specialist drug services[19] to promote reintegration into work. Thirty-nine services (17 Ser.T, 13 first intervention centres and 9 therapeutic communities) were involved in this study. This offered a reasonable sample, although slightly more weighted towards the Ser.T (which have less involvement in this area) than towards the therapeutic communities (which have a significant focus on this area). Of the total respondents, 90% indicated that they run an active programme of support and social reintegration, especially in the area of employment, focused on clients who had either completed or were in the final phase of a residential programme. Between 1993 and 1997, 2 122 people (1 697 male, 425 female) were assisted. The annual number helped had risen each year, almost doubling between 1993 and 1997. Around 20% of those benefiting from these interventions attended the Ser.T and around 80% attended first intervention centres and therapeutic communities. Almost one in three organisations stated that the activity was carried out within their own service and about the same percentage worked with type B social cooperatives, private firms, local producers (mainly in handicrafts, commerce, building and nursery gardens) and local authorities.

There was a clear synergy between the services and the external world in the realisation of these programmes. The plans were often developed with external support for activities conducted within the service. A second element was providing training to clients to develop skills that would be of value in obtaining employment. In 44% of cases, the training was conducted by the service itself with the support of external organisations such as professional training centres, local authorities and local businesses. In 24% of cases, the services were largely self-sufficient and in 32% of cases the services were entirely dependent upon external organisations. In terms of the employment provided, in 72% of cases it was with organisations employing up to 20 people and in 18% of cases with organisations employing between 20 and 200 people. In no instance was employment found with an organisation employing more than 200 people.

The most common employment settings for these programmes were social cooperatives, followed by handicraft businesses and private companies. In 28% of cases, the contract offered was time-limited for between 3 and 12 months and, in 23% of

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19 Ministero del Lavoro (2000). *Inserimento Lavorativo di Tossicodipendenti ed ex-Tossicodiendenti*. Roma, Ministero del Lavoro e della Previdenza Sociale, Direzione Generale per l'Impiego.

cases, it was a trainee contract for 6–12 months. In only 8% of cases was a permanent contract offered. Surprisingly, the opportunity to use part-time and flexible time working was scarcely used. Around one quarter of the firms studied lacked any practical understanding of the particular needs of employees who had had drug problems. In 74% of cases, a member of staff of the drug service acted as a mediator to support re-entry into employment. In some services, a social worker monitored individual clients. The role of the mediator was largely psychosocial (support, advice, motivation), helping with adjusting to work, supporting the client in searching for employment, etc. Around 35% of clients relapsed, around 15% were absent from work and around 10% were considered insufficiently productive. The National Report on the Drug Situation in Italy 2001[20] provides further information on some social reintegration programmes in this area.

Finally, there are some 60 Narcotics Anonymous groups operating in Italy with an estimated 600 members. These are concentrated in a small number of regions, predominantly in the north. Day centres have also been established to provide a drug-free social setting for those who have completed treatment or are in treatment. Very little data is available on the number of such services or their utilisation.

Funding

There is no clear basis for the funding of social reintegration activities. Insofar as they are part of the regular activities of treatment services, they are considered part of the overall therapeutic programme. This applies to the residential or semi-residential phase of a socio-rehabilitative programme. In such cases, funding is part of the regular budget, financed by the local health authority (ASL) or the Ministry of Justice (where treatment is part of an alternative to custody).

The majority of reintegration programmes, however, are financed through project funding, most commonly through the National Drugs Fund but also through EU programmes and project funding from local authorities (in the regions, provinces and communes) targeting a range of issues, such as economic development and tackling social exclusion. There is no specific budget for reintegration interventions, nor is there a means at present of calculating how much is expended on such interventions for drug users.

As noted above, in the period 1997 to 1999, the Integra programme allocated €23.394.974 to projects which included drug and ex-drug users in their target group. For the same period, in 10 regions and one autonomous province, a total of €30.276.928 was allocated to some 282 projects concerned with social reintegration. Data is not available at present on social reintegration projects and expenditure for 2000 and 2001. It would be surprising, however, if there was not a continued focus on this area, especially as guidelines for the allocation of funds specifically referred to social reintegration, and the National Drugs Plan places considerable emphasis on activities aimed at achieving and sustaining entry into the labour market.

Complementing the many local projects, the General Directorate for Employment in the Ministry of Welfare has promoted a series of projects financed through the National Drugs Fund. Between 1999 and 2001, a total of €9 841 241 was allocated to 16 projects promoted by the Ministry of Labour (now the Ministry of Welfare). This is equivalent to

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[9] Ministero del Lavoro e delle Politiche Sociali, Direzione Generale per le Tossicodipendenze (2003). *Report to the EMCDDA by the Reitox National Focal Point: Italy's Drug Situation 2001*. Roma, Ministero del Welfare.

€1 968 248 per annum over a five-year period. In 2001, four projects aimed at promoting social inclusion and entry into the job market were financed. 'Progetto Koinè' is an experimental project to develop a model for the support of drug users from treatment into employment. By linking treatment services, businesses, social cooperatives and institutions, it aims to build work opportunities and support the target group in seeking and retaining employment. 'Drug use, prison and psychiatry' is a project that aims to carry out interventions to achieve recovery and entry into employment for drug users with psychiatric problems. It has developed a method for 'tracking analysis' and uses an intranet system to network between the different people involved in monitoring progress and evaluation. 'From centres to services for employment' aims to establish a dynamic project for the placement of drug users into employment. Focusing on the employment services, it aims to build up effective links with EU initiatives in order to develop and carry out training and awareness programmes and to train staff in these services to offer specific advice and support to drug users returning to or starting work. 'Integration is possible' is an innovative experimental programme aimed at developing courses for immigrants with drug problems. The project is conducting an initial analysis of the relationship between immigration and drug use and will evaluate this in terms of social exclusion and entry into the job market. It is using a range of activities to implement the project within a common systematic approach. These national projects aim to improve knowledge about the processes of social reintegration and returning to work and to offer models for adaptation at local level.

Discussion

Although there has been little debate on the topic and there is no nationally agreed definition of social exclusion, social inclusion or social reintegration, there does seem to be a broad consensus between the different actors in the field based on the types of project that have been promoted and funded.

Social reintegration can be broadly described as the desired goal of a therapeutic intervention aimed at providing the drug/ex-drug user with the tools to achieve independence, both economic and social, and at providing guidance and support through the transition from therapy into independent life.

Most social reintegration activities for drug users fall into one of two categories: part of standard therapeutic activity in which vocational skills are identified and developed; and special projects financed from a variety of sources, with a focus on education, vocational training and/or employment. For the first category, there is little systematic monitoring of these activities and few published reports. For the second category, most project funders require monitoring, some require external evaluation and all require the submission of final reports. However, there is no common monitoring or evaluation system in use. Moreover, the reports which are prepared often do not appear in the public sphere or are not readily accessible. In consequence, there appears to be a high level of activity with a low level of data.

In light of the priorities within the National Drugs Plan for an extension of social reintegration projects, expansion of residential treatment programmes and development of programmes that prepare drug-using prisoners for entry into a therapeutic programme, there is now the opportunity to promote a common basis for monitoring and reporting on initiatives, especially those financed through the National Drugs Fund. Such an approach is fully in line with the drugs plan, which foresees measuring the quantity and quality of responses, with the aim of supporting the most effective actions and avoiding wasted effort.

Summary

- The availability of dedicated social reintegration activities in Italy varies according to the geographic area, the availability of resources to support such activities and local and regional priorities.

- There has been little discussion on the meaning of the term ‘social reintegration’, or on the purpose and content of activities in this area.

- Social reintegration is broadly seen as including preparation for re-entering society undertaken as part of the residential/semi-residential therapeutic programme and as specific projects with defined objectives. It is assumed from the limited documentation available that there is intended to be a seamless link between the therapeutic programme and reintegration projects.

- In practice, most activities are focused on developing the client’s capacity to enter and remain in employment. This may involve a return to full-time education, vocational/professional training, employment in a supportive environment or counselling, guidance and support to enter into the commercial employment market.

- Funding comes from a wide range of sources: a relatively small amount comes from income for regular activities and the larger part comes from project funding at commune, provincial, regional, national and European levels.

- Project funding presents a dilemma for therapeutic services, because such funding is time-limited, but regular funding is not available to incorporate social reintegration into the overall therapeutic programme.

- The general practice is for social reintegration projects to be designed specifically for drug/ex-drug users. However, the increasing involvement of social cooperatives as agents providing vocational training and employment means that, whilst the project may be client-specific, the location is not.

- There is limited quantitative and qualitative data available, although there has been an increase in the number of reports dealing with the topic.

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CLASSIFICATION AND AVAILABILITY OF SOCIAL REINTEGRATION IN LUXEMBOURG

National context

Although there is currently no commonly accepted political definition of social exclusion, this issue plus social reintegration have gained increased political interest at the beginning of the new millennium.

The four-year Luxembourg action plan for drugs ('Plan d'action 2000–2004 en matière de drogues et de toxicomanies') refers for the first time to the reintegration of drug addicts ('Structures post-thérapeutiques/Réinsertion socioprofessionelle'). Reintegration measures did exist prior to the action plan but most are of relatively recent origin and the reintegration interventions on offer so far are few. Rehabilitation/reintegration activities come under the Ministry of Health.

Another important policy document is the so-called National Action Plan on Social Inclusion (hereafter PAN), which came about in the wake of the European Council meeting in Nice in December 2000. At this meeting, Member States adopted goals for combating poverty and social exclusion and agreed to provide national action plans by June 2001 – which Luxembourg then did.

Social reintegration measures in Luxembourg often start when the treatment intervention is over, but this is not always the case and social reintegration can even take place independently of the treatment intervention.

Current classification of social reintegration in Luxembourg

Social reintegration activities in Luxembourg are compatible with the categories that have been defined in the introduction, namely:

- education;
- employment; and
- housing.

A pronounced national feature for Luxembourg is the concept of ethno-specific care. Non-natives, especially of Portuguese origin, are over-represented in the problem drug-using population and recent research has stressed the importance of tailor-made interventions for this non-national group. So far, drug agencies have been encouraged to include Portuguese-speaking members on their teams in order to better meet the needs of Portuguese-speaking problem drug users.

Availability of social reintegration facilities in Luxembourg

The main social reintegration interventions in Luxembourg are outlined below. Besides these specific social reintegration services, there are other services that mainly operate other kinds of interventions but that also run some kind of social reintegration project.

The oldest of the social reintegration facilities dates back to 1995 and is normally referred to as the national aftercare centre (Nachsorgehaus Neudorf/Maison de réinsertion Neudorf). The population of this centre mainly comprises patients who have successfully completed a therapeutic programme at the Syrdall Schlass therapeutic centre. The aftercare centre has six treatment slots and offers accommodation plus

psychosocial support for six to twelve months. The aftercare centre is an integral part of the socio-professional reintegration strategy.

More recently, another housing project was set up in September 2000, and implemented in 2001. The project is financed by JDH (Fondation Jugend- an DrogenHëllef) and offers accommodation facilities for ten former drug users.

Furthermore, the Mondorf Group (a cross-border ministerial group created in 1992 between the German-speaking community of Belgium, Luxembourg, Saarland and Rheinland-Pfalz in Germany and also the Moselle region in France), jointly with CePT (Centre de Prévention des Toxicomanies) and SNJ (Service National de la Jeunesse), organises activities which include training for young people. They also plan to establish a job opportunity network for former or current drug addicts.

Regarding ‘ethno-specific care’, the idea is to adapt the existing services to the needs of the users, for instance by hiring Portuguese-speaking staff rather than creating specific services for this particular group. However, for other specific target groups, like pregnant women and drug-addicted couples, so-called ‘modular therapeutic annexes’ have been created. These have been operational since December 2002 and are intended to take advantage of existing social reintegration and training facilities offered by the Manternach Therapeutic Community (Centre Thérapeutique de Manternach).

Self-help groups (Groupes d’entraide/Selbsthilfegruppen) are also important players in the field of social reintegration in Luxembourg. For problem drug users, the main options are 12-step models such as AA or NA.

There is also a social reintegration project for released prisoners with or without an addiction problem. This project is called ‘Defi’ (challenge) and provides, among other things, training and socio-professional reintegration during the period of release from prison.

Finally, it should be noted that many of the social reintegration services in Luxembourg are, at one and the same time, low-threshold services. This is, for example, the case for the JDH, which also runs syringe exchange and outreach programmes.

Summary

- The importance of social reintegration interventions has been stressed over the past few years.

- The range of interventions has widened and availability has risen considerably since the mid-90s.

- Social reintegration and low-threshold services are often under the same roof.

- Rather than creating new services, social reintegration projects have been set up in existing treatment centres.

- There are both specific and general social reintegration services available for problem drug users.

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CLASSIFICATION AND AVAILABILITY OF SOCIAL REINTEGRATION IN THE NETHERLANDS

Introduction

In the Netherlands, the government is responsible for coordinating the development, implementation and evaluation of addiction care. Dutch addiction care is oriented towards public health and based on demand and harm reduction. The institutions of the addiction care system initiate, develop and guide addiction care (drug prevention, treatment, outreach work, aftercare and reintegration) at local and regional levels.

The Ministry of Health, Welfare and Sport subsidises a quality and care innovation programme for addiction care, which is scheduled to run until 2003. As part of this programme, three development centres have been established:

- quality and innovation of care – part of this centre's responsibilities is to develop protocols
- prevention – this centre began by publishing a review of the literature to identify and implement promising prevention strategies
- social addiction care – this centre is responsible for developing modules of case management and stepped care for people with multiple problems (social, health-related, psychological) and chronic addiction.

The results of this programme will probably be available in 2004.

Definition

Although social reintegration is part of the national drug policy and is explicitly designated as part of Dutch addiction care, it is not clear what is considered to be social reintegration, what interventions this should consist of, what the goals are and what specific activities should be undertaken.

Concepts

The range of concepts used for describing social reintegration interventions in the Netherlands include aftercare, support, social rehabilitation and integration. Bless and Freeman (1996) developed an overview of the categories of interventions used in drug prevention and addiction care in terms of available 'product groups' and 'products', the respective 'target groups' and the 'targets' set by each product group. The part relevant to social reintegration is shown in Table 9. This table illustrates that interventions under the product group 'support', 'aftercare' and 'social rehabilitation' contain elements that fit the overall definition of social reintegration, such as probation services, supported employment, supported housing and educational–work projects.

Table 9: Categories of interventions

Product group	*Products*	*Target group*	*Target*
Support	Outpatient support and programmes, rehabilitation support, probation services	Addicts	Support for social skills or life skills
After care	After care contacts	(Ex-) addicts	Relapse prevention
Rehabilitation	Training and courses, supported housing, supported employment, employment assistance, educational working projects	(Ex-) addicts	Societal participation

(Source: Bless en Freeman, 1996)

Obviously, this overview simplifies the situation, as there are many diverse products available in addiction care across the country and even within regions. In general, the diversity is greater in outpatient than in inpatient addiction care. Within the categories described, there is room for differentiation and specification.

Overall, the intervention areas (type of intervention or product group) are generally known, but there is no nationwide record of the addiction care products supplied (National Report, 2001).

Organisation

The Netherlands has a long history of employing a pragmatic approach to drug policy. Over the years, several factors have received special attention. In the seventies, it was the concept of harm reduction, in the eighties and part of the nineties it was prevention of HIV/AIDS and in the past decade the focus has been on prevention of nuisance (overlast) caused by the addict population to the community. Specific funding was made available for programmes that would target reducing drug-related nuisance for the community.

These nuisance projects can have a variety of social reintegration components, including educational, work and/or housing and judicial ones. The fact that these different elements can occur concurrently makes it difficult to classify them. Several of these projects were described in the National Report of the Dutch focal point and will be summarised here.

De Omslag (Stichting ter Bevordering van de Ontmoeting tussen Landbouw, Ambacht en Gezondheidszorg) runs a project, ‘agriculture and care against drug nuisance’, under the jurisdiction of the Ministry of Health, Welfare and Sport. The goal of this project is to reduce nuisance and train people to work in agriculture (caring for animals, woods, etc.). The farmer gives support to the participants. The drug services are responsible for the

placement of the drug user and ongoing therapeutic support and act as a safety net in case of emergency. De Omslag will publish its final report in November 2002.

Criminal justice system

Probation and resettlement or rehabilitation have a long history in the Netherlands and are meant as an adjunct to or substitute for imprisonment. The police, public prosecutors or judges can refer drug users to an outpatient addiction care organisation. Social workers work closely with the probation service (Reclassering). There is also a variety of education and work programmes for drug addicts inside prisons (National Report, 2001).

Addiction Guidance Departments (Drug-Free Departments)

Of the 13 000 Dutch prisoners or detainees, 35–50 % have addiction problems. In 1997, there were 20 Addiction Guidance Departments (VerslavingsBegeleidingsAfdelingen; VBAs) with a total of 446 places/cells, half in remand houses and half in prisons. In 1999, one-third of the available cells stayed empty. Detainees in VBAs are supported to work on their addiction. The mean length of stay in 1999 was 13 weeks. It is possible for VBA detainees to be referred to regular addiction care. In 1999, 60 % of the VBA participants received aftercare (inpatient and outpatient).

Strafrechtelijke Opvang Verslaafden/SOV (Penal Placement of Addicts in a Penitentiary Treatment Institution)

In recent years, compulsory outpatient addiction treatment for a maximum of two years has been available. This compulsory period offers a programme of treatment and rehabilitation activities. More freedom of choice is progressively offered over the period and the explicit aim is reintegration into society (having a job, housing, no debts and able to pursue leisure activities). All addicted offenders with an extensive history of drug-related crime who have served at least one prison sentence for such crimes may be subject to this new measure.

Other examples of coercive treatment with some social reintegration interventions are found in forensic addiction clinics and in the experimental project Triple-Ex, in The Hague.

Forensic addiction care

A forensic addiction clinic for imprisoned drug-using recidivists resisting regular care and treatment was opened in 1998 (IVON, 1998). The treatment programme envisages three consecutive stages: an intramural, a semimural and a resocialisation stage. The last stage is similar to ‘supported living’: clients are supported in learning to live independently again after release from prison. Work projects form the most important element of this long-term programme. The objective is to offer an appropriate mix of therapies, practical and social skills training, education and reorientation to the labour market situation. Only convicted addicts who are not allowed to enter other (regular) treatment programmes are allowed to enter this special programme, because of their severe addiction problems, previous failure to complete treatment and/or their judicial history. For the first four years, this new intramural facility will operate as a scientific experiment. The Trimbos Institute is currently evaluating the project.

Treatment for local criminal addicts (Triple-Ex)

This experimental four-year project also includes detoxification and several types of aftercare (treatment of psychosocial problems, social relations, daily work). The project is restricted to the city of The Hague. Evaluation of this programme shows that some 40 % of ex-clients do not use drugs during the following two years (Addiction Severity Index). The others started to use drugs again, three-quarters of them for longer than six months. However, more than half of these relapsed clients did not use drugs in the month before follow-up. In the same month, clients had worked for a mean of 25 days. More than 90 % entered another treatment programme after finishing Triple-Ex. During follow-up, most of them were arrested at least once for criminal acts, more than one-third more than once. A longer duration of treatment was related to a reduction in relapse rates. Satisfaction was not related to any outcome (Vermeulen et al., 1999).

Education and training, employment, housing

In Amsterdam, the Jellinek Centre has a special department, Werk en Scholing (work and education), which offers a variety of projects to anyone with an addiction problem in the region. Three different target groups are identified: support clients (active substance misuse), care clients (controlled substance use) and resocialisation and employment projects (past substance use). Activities for the support clients include: art, creative activities, sport, music, eating together. The activities for care clients include games, reading, ping-pong, television and video, computer, hairdresser, ironing, cooking and washing, as well as the activities on offer to the support clients. The aim of these activities is to acclimatise to working, have the opportunity to benefit from vocational training and experience, develop social skills, etc. The projects for resocialisation and employment include bicycle repairing, joinery, work for the environment, postal work, catering, shop work, working as a printer, etc. The aim of these projects is to support people finding employment and a place in society. Collaboration takes place with the social services, social welfare, job centres and specific work projects. Aftercare is provided for three months following placement. In the planning for 2003, 70 people will be placed (Robert Berkhout, 2002).

The Jellinek Centre also offers accompanied housing as an intermediary six-month phase between residential treatment and living alone. Social workers support residents.

In general, however, it is difficult to identify specific projects that offer education, vocational training or housing to drug users in Holland. The main reason for this is that general policy is to include every problem, or every person, in the general support and care system. The Dutch welfare system is very well organised and is accessible to anyone. It is the responsibility of the municipal and regional social services to support and assist people (including drug users), for instance in competing for jobs. The drug services generally liaise with mainstream services, such as social welfare, job centres, the Housing Department, etc., in order to support their clients in finding housing, clearing debts, applying for vocational education, etc.

There are several projects of social reintegration or aftercare that are part of the general mental health system but do not distinguish between drug users and other clients. One such project focuses on finding employment for people with psychiatric problems. As the report does not make specific mention of the words drugs or addiction, no relevant data can be obtained from this source (van Weeghel, 2001).

One project which does focus specifically on drug users, however, is Baanberekenend. The aim of this programme is to support and place former drug addicts in a competitive job within three years, through individual support, education, training and teaching social skills. Between July 1995 and July 1999, 72 participants (the anticipated outcome was

78) have left the programme and 31 (43 %, while 36, or 48 %, was expected) have found a paid job (two-thirds competitive and one-third subsidised). The project costs Euro 108.900 per year and is funded by money allocated for nuisance prevention (Michon et al., 2000).

Maatschappelijk Herstel Voorziening/MHV (Social reintegration service)

The MHV was set up in 1992 and was another example of a programme that was specifically aimed at drug users. The general objective was to coordinate between the existing care system, social services (Sociale Dienst), job centres (Arbeidsburo) and addiction care, in order to offer the client one route from addiction care to a job. The MHV no longer exists today.

Drugs in the workplace

At the other end of the spectrum, there are a number of interventions that focus on drug prevention in the workplace, with particular emphasis on prevention rather than reintegration. These programmes consist of Employee Assistance (EA) activities (information, education or training combined with printed material) explaining company policy, the risks of alcohol or drug use and rehabilitation possibilities. There are no further quantifiable data available on these programmes.

A living unit for older addicts

A large proportion of the addicted population is getting older and these people may find themselves confronted with several problems. Some of the problems are comparable to those of the elderly in general, but some are related to drug addiction. Ageing drug users are less able to access their daily drug needs and they are at risk of personal neglect. They need some type of supported living to maintain the minimum standard of living.

The Municipal Health Service of Rotterdam funded an experimental living unit for seven methadone- and cocaine-using 'seniors' (older than 55). The unit opened in 1999 and was evaluated a year later (Heijman & Verveen, 2000). The relationship between professionals and neighbours was good and no public nuisance was detected during the year that was evaluated. Clients were satisfied with this type of supported accommodation, could manage financially and were able to keep their cocaine use within acceptable limits due to the support of the professionals.

Others

There are also self-help groups such as Narcotics Anonymous (6) and Companion Contacts (Lotgenoten-contacten). The main targets of self-help groups are to prevent future use, encourage contact with companions and enable the user to start a new life with the help of the group.

Finally, several projects were identified that focused on prevention of social exclusion. These are mostly organised at local level. Because the main target is prevention, they are not included in this overview.

Availability

The provision of aftercare and social reintegration services is diverse and institution-specific. Some interventions are undertaken by drug services, others are part of the general social welfare system and are accessible to anyone. Reliable data on specific reintegration interventions are therefore not available. In general, there are few waiting lists in the Netherlands and services are easily accessible.

Funding

Overall, the drug-specific services are funded by a combination of the Ministries of Health and Justice, local government and the insurance companies.

No specific information is available on the costs of social reintegration projects in the Netherlands. The National Steering Committee on Nuisance Reduction (Stuurgroep Vermindering Overlast) spent 96 million euro on drug-related nuisance projects between 1994 and 1998.

Summary

- Social reintegration is part of Dutch policy.
- Specific supportive social reintegration interventions for people with addiction problems do exist but are still incidental.
- Most of these interventions are not specific for people with addiction problems and occur through collaboration between services.
- Quantitative information is not available, because the interventions are not specifically for drug users and so are not monitored explicitly.
- Most interventions do not solely occur at the end of treatment but take place throughout the process.

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Classification and availability of social reintegration in Austria

National context

Austria's 2002 national report notes that social reintegration is not merely a post-treatment intervention for former problem drug users but that it is equally important for people with any addiction problem. In fact, social reintegration measures have increasingly been targeted at current problem drug users rather than as follow-up to treatment that is targeted exclusively at former problem drug users. Current problem drug users may or may not receive other forms of help, such as methadone treatment, and the social reintegration intervention does not necessarily have an abstinence-oriented goal.

Current classification of social reintegration in Austria

The main source for this classification is the maps provided by the national focal point (NFP) for the national report. The terms used for these maps to classify reintegration interventions are as follows (these were originally in English, hence there has been no translation):

- housing for former drug addicts;
- housing for (current) drug addicts;
- occupation projects for former drug addicts; and
- occupation projects for (current) drug addicts.

However, as our definition of social reintegration allows for both former and current drug addicts (or problem drug users), we can group them into the following two headings:

- housing (for both former and current drug addicts); and
- employment (for both former and current drug addicts).

Education and training are often provided by inpatient treatment facilities. However, specific programmes exclusively dedicated to the education and training of (former) drug addicts are less conspicuous, but they do also exist. Styria will be running training programmes at job training centres and the Vienna Social Fund is part of the EU programme, Equal. The latter covers training as well as employment.

Availability of (social) reintegration facilities in Austria

According to the maps mentioned above, the number of units carrying out the reintegration of former drug addicts in Austria can be calculated as shown in Table 10.

Table 10: Availability of reintegration facilities in Austria (number of units)

Type of reintegration intervention	*Units*
Housing	15
Employment	6
Total	*21*

The Viennese employment project 'Fix und Fertig' was subject to higher demands than expected and so, in 2001, it was restructured to offer a total of 19 per-day jobs. However, demand was still higher than supply and an average of 15 candidates a day had to be turned down.

Other than the above-mentioned reintegration facilities, there are also reintegration services that have no fixed setting. In Austria, the process of 'reintegration in the job market' is generally comprised of three stages. The first stage deals with job orientation plus initial training and upgrading of skills. This is followed by the second stage, whereby the client takes part in an occupation project. The third and last stage is a process of supporting the client to actually integrate in to the labour market.

Finally, the NA also plays a role in reintegration in Austria, although the actual extent of this work is not known at present.

Evaluations and evaluation findings

Some of Austria's reintegration programmes have been evaluated. The Vienna employment exchange provides services aimed at the occupational rehabilitation and reintegration of people with a history of addiction (including alcohol). During 1999, approximately 1 000 clients applied to the Vienna employment exchange for assistance and the evaluation showed that it was possible to refer about one-third of these to a job or training course.

The 'Assisted Housing' (Betreutes Wohnen) project in Vienna provides temporary accommodation accompanied by outpatient psychosocial care. An evaluation of this project showed that, between 1996 and 2000, 39 clients received counselling. Half of these completed the counselling process successfully, 13% left prematurely but with a positive prognosis and the remainder left prematurely, with a negative prognosis. In short, 62% of the clients who benefited from this project had a positive outcome from their stay in assisted housing.

Another evaluation of activities supporting the 'reintegration into the job market' showed that clients that had completed the first two stages (training and taking part in an occupational project) stayed in employment 20% longer than those who had only completed the training stage.

There are social reintegration interventions both inside and outside of criminal justice settings. At least one expert (Schinnerl) has pointed out that imprisonment has the unfortunate effect of making the individual more likely to integrate into a criminal environment.

Summary

- Social reintegration does not necessarily focus on the post-treatment stage or on former drug users.

- Of the three main kinds of social reintegration, housing, employment and education, Austria puts most emphasis on the first two.

- Evaluation shows that social reintegration measures can work but that supply is still lower than demand.

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CLASSIFICATION AND AVAILABILITY OF SOCIAL REINTEGRATION IN PORTUGAL

National context

The Portuguese National Action Plan on Drugs set two objectives that are to be accomplished by 2004: firstly, to reinforce the employment programme 'Vida-Emprego', the main social reintegration programme in Portugal, and to increase its capacity by 50%; secondly, to increase the number of reintegration apartments (housing) to 100% compared to the level at the beginning of the action plan. For both kinds of intervention, the target group is current as well as former drug addicts. The term 'social' (reintegration) has been noted in the Portuguese literature, but usually no clear distinction is made between social reintegration interventions and simple reintegration interventions. Generally speaking, the term used to denote interventions aimed at reintegrating former drug users into society is 'reinsertion' (reinserção).

Current classification of social reintegration in Portugal

The 2002 national report of the Portuguese national focal point lists as many as 15 different kinds of social reintegration measures, whereas the Portuguese Agency on Prevention and Treatment of Drug Addiction (Serviço de Prevenção e Tratamento da Toxicodependência) identifies four kinds of reintegration (reinsertion). The latter refers only to the reintegration activities carried out at the outpatient treatment centres (Centro de Atendimento a Toxicodependentes or CATs):

- day centres (centros de dia);
- networking (participacao em Redes);
- job-club (clube de emprego); and
- the Life Programme (Programma Vida-Emprego).

The last two could be joined together under 'employment', but, as the intention here is to map what exists in Member States, according to the Portuguese national concepts and definitions we shall stick to the distinctions above.

Availability of (social) reintegration facilities in Portugal

Objectives and goals for reintegration are also mentioned in the above-mentioned Portuguese drug policy paper, *30 objectives in the fight against drugs and drug addiction*. The 22nd objective states that the Life Programme (Programma Vida Emprego) should be strengthened and that its capacity should be increased by 50%. The 23rd objective (the second of the two on reintegration) states that reintegration in the form of housing should be increased by 100% compared with current capacity. As with treatment, the aim here is not to assess these objectives or their feasibility but to highlight the political attention that has been paid to drug treatment and to the assessment of these goals.

Current availability of (social) reintegration facilities in Portugal

The following overview of reinsertion/reintegration interventions in Portugal in the outpatient treatment centres (CATs) at the end of 2000 (Table 11) is based on the activity report of the SPTT.

Table 11: Reinsertion/reintegration facilities in Portugal[21]

Type of reinsertion/reintegration	*Number of units*
Day centres (centros de dia)	9
Networking (participação em redes)	24
Job-club (clube de emprego)	19
Life Programme (Programma Vida Emprego)	45
Total	*97*

Of the nine day centres mentioned here, four are public and five are private. Day centres are designed as the reinsertion/reintegration units in which the (former) drug user learns to regain his former, pre-addiction, lifestyle.

In addition to what is listed in the above table, Vida-Emprego is not only an activity carried out in the outpatient treatment centres but also finances initiatives outside this setting. In 2001, 1693 initiatives were financed and an external evaluation is planned for the end of 2002.

Training and reintegration activities are also available outside the outpatient treatment centres; 172 individuals were involved in this kind of social reintegration in 2001. In terms of housing, there were 19 apartments available in 2000, which were used by 352 residents in the reintegration process. Lastly, the Ministry of Justice offers reintegration services to former drug users who have been released from prison.

Summary

- Social reintegration is a topic that enjoys considerable political attention and explicit goals have been set for this kind of activity.
- Social reintegration has expanded considerably over recent years.
- There is a fairly wide range of social reintegration measures available in Portugal, but their actual extent is not at all clear.
- Systematic research with clear findings on the effects of different kinds of social reintegration interventions are still scarce, but some evaluations are currently in the pipeline.

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[21] These reinsertion/reintegration facilities are part of the treatment system in Portugal.

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CLASSIFICATION AND AVAILABILITY OF SOCIAL REINTEGRATION IN FINLAND

Introduction

Opiate addiction is a relatively new phenomenon in Finland. A drug policy strategy was proposed by the Government in 1997 and accepted in 1998 and a Drug Policy Committee and Research Working Group were established. The drug policy includes action from the ministries of Justice, Interior, Finance, Education, Social Affairs and Health. In 2001, €10 million was allocated for combating the drug problem.

Because of a longer history and larger prevalence of alcohol abuse, the policies for and terminology on substance abuse are based on an alcohol-oriented culture.

The national report of the Finnish focal point mentions that problem drug users tend to become socially excluded and more marginalised than other substance abusers or criminals. With the development of drug services, the needs of drug users will be taken into consideration. Day activities, housing and supportive services for the excluded will be established and expanded. Drug rehabilitation in prisons will be increased to reintegrate prisoners into society and to reduce recidivism. Cooperation with local authorities will be enhanced in order to ensure the continuity of rehabilitation and support for a drug-free lifestyle after prison (National Report, 2001).

Definition

There is no specific definition for ‘social reintegration’. When referring to social reintegration, the term ‘rehabilitation’ is commonly used in Finnish, which implicitly includes actions targeting social reintegration. Furthermore, drug treatment can also include activities targeting social reintegration.

Concepts

Concepts of social reintegration in Finland include a follow-up stage after residential treatment, rehabilitation, support services for employment, education and housing.

Organisation

As we have seen in other countries, social reintegration is considered to be a reintegration phase into society after long-term residential treatment. During 1999, an aftercare stage was developed and incorporated into some rehabilitation projects, including housing services, training and employment measures. For instance, for people released from prison, there are the VP services of the Kalliola Clinic, or, for young people, there is the Back to the Future project of the Deaconess Institute.

In general, interventions are collaborations between drug services and general services, such as Social Welfare, Social Insurance, the municipal authorities and schools. This means that most of the social reintegration interventions are not specific projects for drug users but are existing programmes, which aim to reintegrate people who have been excluded from society. Distinguishing ‘housing’ from ‘education’ is difficult, because several aims are included concurrently. Quantitative data are not available.

Education and training

Although planning education and vocational guidance form an integral part of the treatment process, opportunities are not always available or in the interest of the client. Alternatives to vocational training are an apprenticeship contract, isolated training opportunities offered by the employment authorities and the rehabilitation allowance of the Social Insurance Institution. However, it is difficult to find employers willing to enter into apprenticeship contracts with ex-drug users.

In Finland, students receive study loans, study grants and housing benefit. Although everybody is entitled to a study loan, the banks often refuse loans to drug users if they are not creditworthy due to previous money problems. On the other hand, it is not possible to receive a Social Insurance Institution rehabilitation allowance based solely on a drug addiction diagnosis, as a secondary diagnosis is also required, such as an impairment, disability or disease (National Report, 2001).

Between 1998 and 1999, a broad-scale project of the Deaconess Institute, Back to the Future, was introduced providing education and vocational training for young substance abusers in Greater Helsinki. This project was funded by the Integra programme of the EU Social Fund. Several structural problems affecting the training choices of the target group emerged during the project. The project found that the actions available to social and health services are inadequate to resolve multiple welfare problems. Individual measures are required, with a tailor-made approach that transcends administrative boundaries.

Employment

Young people's workshops (such as apprenticeships for people under the age of 25) constitute one example of interventions in employment. However, people over 25 who need to improve life skills or labour market skills, etc., can also sometimes participate in the workshops. Depending on the municipality and workshop, there are a variety of different work areas. A person is employed in a workshop for five to six months, and standard wages are paid for their work. Other workshop activities also include offering support for young people's life-management skills and devising tailor-made educational or career paths.

The majority of the workshops are organised by the municipalities, but some are also organised by NGOs, associations and foundations. Funding for young people's workshops is mainly project funding, which lasts one to two years at a time. It comes from various sources: the Ministry of Labour, Ministry of Education, European Social Fund, Finnish Slot Machine Association and the municipalities. It is estimated that the gross amount expended on these workshops is around €50.5 million and the net amount is around €16.8 million annually. The Ministry of Labour pays about 40 % of this amount, the municipalities about 30 %, the Ministry of Education 5 %, the workshops themselves about 15 % and other project funding covers the remaining 10 %. Based on SYTa research, it is esimated that about 10 000 young people work in these workshops annually.

Prison

Prisons have engaged in substance abuse rehabilitation for about 10 years. In 2001, the committee for prison sentence reform proposed revising the objectives of imprisonment. The main goal of a prison sentence is to enhance the prisoner's ability to lead a crime-free life by promoting life management skills and integration into society.

In 1996, the Ministry of Social Affairs and Health, the prison administration and four major organisations in the substance abuse field developed the 'substance abuse rehabilitation project' (VP). The main aim of the project was to assist with finding employment, after release from prison, for people who had abused substances. It was established that people who had used drugs had difficulty finding jobs and were faced with prejudice and other obstacles. The methods used in client work turned out to be inadequate in a situation where jobs are not available. The project outcomes show that a tailor-made approach is successful in employing drug users.

The project was evaluated in 1999. The key elements of the project were turned into ten services (six rehabilitation programmes and training packages) for prison use.

Housing services

In Finland, general social services provide financially supported housing options, and these are also available for drug users. Furthermore, there are specific housing service units for alcohol and drug abusers who need daily support. Some of these units also provide rehabilitation and some act as therapeutic communities, offering the opportunity for excluded people to regain control over their lives. In 1999 (2000), the number of residents in these specific housing services was 4 300 (4 900). However, the majority of the residents were alcohol abusers. Only one out of eight residents used narcotics and almost one out of four medicines (National Report, 2001).

Self-help

In Greater Helsinki, there are Narcotics Anonymous groups for people who want to stop drug use. These include a closed group for drug-dependent persons, a women's group and an open group for any interested persons. Some other major cities also have such groups, often working in collaboration with the local treatment programmes.

Funding

Funding for social reintegration activities actually comes from numerous sources (as with the 'workshops', where the Ministry of Labour, Ministry of Education, EU funding and other project funding is used). It is not possible to outline in detail the many sources of funding that maintain the whole range of social reintegration activities.

Discussion

Drug policy and practice are relatively new phenomena in Finland and evaluation has not been a major objective of the national drug policy. Consequently, the outcomes of evaluation tend to be process-oriented, retrospective or descriptive rather than systematic or theoretical in nature.

A development project on preparing quality criteria for substance abusers' treatment services has been initiated. This project relies on a review of alcohol and drug treatment methods used in Finland. Based on a survey conducted in all outpatient and inpatient units, the most important treatment methods include – in broad terms – supportive therapy, prevention of recidivism and learning social skills.

Summary

- Opiate addiction is a relatively small and new phenomenon in Finland compared to alcohol addiction.
- Finnish drug policy and treatment are largely focused on alcohol addiction.
- There are several social reintegration interventions for substance abusers.
- Most interventions are part of the general social welfare system and not specifically for drug users.
- Quantitative data are not available.
- Social reintegration activities occur at any phase of the treatment process and are aimed at the (re-) integration of socially excluded drug users or drug users at severe risk of social exclusion.

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Classification and availability of social reintegration in Sweden[22]

National context

In the organisation of drug abuse treatment, Sweden differs from many other countries by having the social services and health service share responsibility for interventions. In principal, social services are responsible for long-term rehabilitation and other interventions providing support and help, while the health service is responsible for detoxification and treatment of the psychological side effects of substance misuse. The private sector, self-help groups and voluntary organisations that are often partly financed by state funding also carry out social reintegration interventions and drug abuse treatment. Such interventions can, for example, include basic and therapeutic counselling, different kinds of sheltered accommodation, work-related interventions, etc.

Recent decades have seen several changes in the way social services are organised. Today, work is carried out in the field of drug abuse by the community social welfare departments, usually with specific groups of misusers, at day centres or field stations or through more structured outpatient treatment programmes.

The aims of the state in this area include reducing the long-term need for social welfare allowance, liberating people with abuse problems from their addiction by means of rehabilitation interventions, enabling the homeless to obtain secure accommodation and helping to ensure that children do not grow up socially excluded. Since people's overall social situation is influenced by numerous different factors, interventions in other areas, such as public health, families, the labour market and housing, are the key means of preventing social exclusion. Under the Social Services Act, the municipalities have responsibility for offering the necessary support and help to the socially excluded. The government formulates policy targets and implements them through legislation and by means of supervision, monitoring and evaluation.

Social reintegration is generally a part of the drug abuse treatment, and is often not dealt with as an intervention alone in the public sector. Complementary, prevention of misuse and social exclusion is a separate and important area of intervention today. The ministry of health and social affairs has for example developed an action plan against narcotics, alcohol respectively poverty and social exclusion. One of the purposes of these action plans is to improve upon the structures and organisation of the social work. The work of social reintegration is also carried out by voluntary organisations often in terms of rehabilitation and self-help groups.

Social reintegration as part of the drug abuse treatment

The social services provide five main types of treatment programme: housing assistance, individually means-tested outpatient care, care in private homes, voluntary institutional care and compulsory care. These services generally include social reintegration interventions for rehabilitation, such as training apartments, work training, 'motivational homes' and social support.

[22] This chapter has been prepared by the Swedish National Institute of Public Health.

Outpatient care interventions

Outpatient care can be seen as a first step in promoting social reintegration, although the structured outpatient care[23] is generally more focused on treatment than reintegration. Examples of interventions that are closer to the concept of reintegration are assistance with housing (Table 12) and other outpatient interventions such as contact visits at an outpatient clinic or being allocated a contact person. The data on social reintegration include individuals with any addiction problem and not just problem drug users (these cannot be extracted from the existing data).

Table 12: Outpatient interventions for adults with a substance abuse problem, 1998

Type of intervention	*Average no. of days per patient*	*No. of people benefiting from the intervention (at some point in 1998)*
Structured outpatient care	97	6 688
Assistance with housing	179	9 455
Other outpatient care		13 613

Source: National Board of Health and Welfare (social services statistics)

It is important to point out that one and the same person may receive a number of types of care and treatment at the same time, such as outpatient care and voluntary institutional care or outpatient care and housing assistance.

Of the people aged 21 or more who were receiving assistance on 1 November 2001 due to abuse of alcohol, drugs, pharmaceutical preparations and/or solvents, more than 5 600 were receiving housing assistance (a reduction of more than two per cent compared to 2000) and just under 10 300 were receiving individually means-tested outpatient care (a reduction of more than 10% compared to 2000). Around 3 800 people were receiving round-the-clock care (about the same number as the previous year). More than 90% of these people were placed in voluntary institutional care, while the rest (eight per cent) were placed in compulsory care. Compared with 2000, the number of people in voluntary institutional care (Social Services Act) fell by around two per cent, while the number of people in care in private homes (Social Services Act and the Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents [Special Provisions] Act) rose by around six per cent. There were 43 more people in compulsory institutional care (Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents [Special Provisions] Act), an increase of 18%.

Voluntary institutional care

Within the scope of interventions based on voluntary admittance there are a range of interventions aimed at reintegration. Voluntary institutional care includes care, treatment,

[23] Structured outpatient care implies that the client follows rule-regulated treatment for a bigger part of the day – typically a total of more than nine hours a week.

employment, work experience, etc., combined with round-the clock residence in various kinds of homes, treatment centres and collectives.

According to the National Board of Health and Welfare, in 1999 there were roughly 5 500 slots in homes for care or residence run by county councils, municipalities, the state, individuals, associations and foundations.

Voluntary organisations

In 2002, the National Board of Health and Welfare distributed funds to 35 voluntary organisations that work in the field of drug abuse.

Below are some examples of organisations actively involved in rehabilitation interventions:

- Sällskapen länkarnas riksförbund (national league of associations which help people who abuse drugs to return to a drug-free life through support, fellowship and a ‘seven-point programme’)

- Verdandi (works for social justice in the field of drug abuse and social exclusion through local support activities)

- ALNA riks (focuses on rehabilitation activities and counteracting drug abuse in working life)

- DIANOVA (international self-help organisation for rehabilitating people abusing narcotics)

- KRIS (organised by former criminals and drug-dependent people with the main aim of helping people who are leaving institutions to re-enter society)

- Länkens kamratförbund (a national organisation for 50 associations that offer support, counselling and other activities for people abusing drugs)

- Rainbow Sweden (an umbrella group of self-help organisations that offer rehabilitation interventions such as work cooperatives, leisure activities, companionship and supported living)

- KSAN (an umbrella group of associations that are working to counteract drugs, with a focus on young women and girls, including interventions such as boosting self-esteem)

- Kvinnoforum (organises projects for girls who are at risk)

- De fria sällskapen länkarnas samorgan (offers support to drug addicts who want to quit drug abuse)

Summary

- There is no distinction made between drug treatment and social reintegration.

- The interventions that could be described as social reintegration are usually not exclusively for problem drug users but for addicts in general.

- A mixture of public and private players provide the social reintegration interventions for addicts.

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CLASSIFICATION AND AVAILABILITY OF SOCIAL REINTEGRATION IN THE UNITED KINGDOM

Introduction/Background

In the UK, drug policy and treatment is coordinated at national level by the Home Office. In 2000, a new unit was created: the Drugs Prevention Advisory Service (DPAS), which provides support to all Drug Action Teams (DATs). However, with the recent devolvement of some powers to Wales and Scotland, these countries are developing their own structures and services.

For example, Wales has its own eight-year drugs strategy, 'Tackling Substance Misuse in Wales: A Partnership Approach', which was launched in May 2000. It embraces the main aims and objectives of the national government's ten-year drugs strategy, 'Tackling Drugs to Build a Better Britain', but the Welsh strategy is implemented by the five Drug and Alcohol Action Teams (DAATs) in Wales. The Welsh Drug and Alcohol Unit advises on the implementation of the Welsh strategy and on other issues relating to substance misuse. In light of this devolution, it should be acknowledged that this report outlines drug use and social reintegration in England.

In Scotland too, the devolution process has resulted in the separate development of drug policy and strategy. Oversight of the national strategy for drugs is the responsibility of the Scottish Advisory Committee on Drug Misuse, chaired by the Deputy Justice Minister. A similar arrangement exists for alcohol misuse issues, but, in this case, responsibility lies with the Health Department. Responsibility for the commissioning of research and dissemination of good practice lies with the Effective Interventions Unit, whilst the Information and Statistics Division (ISD) of the National Health Service in Scotland (NHSiS) is responsible for collation and dissemination of drug misuse information. The Scottish strategy, 'Tackling Drugs in Scotland', also follows the main aims and objectives of the UK strategy as a whole, but, in the case of Scotland, this is complemented by a parallel National Plan on Alcohol Misuse.

In Northern Ireland, as a result of devolution in 1999, responsibility for drugs transferred to the Department of Health and Social Services and Public Safety (DHSSPS). In 2001, the first regional Drug Strategy Coordinator was appointed to head up a dedicated team with responsibility for the Northern Ireland Drug Strategy (1996) and the Strategy for Reducing Alcohol-Related Harm (2000). Both strategies are being implemented together. Four Drug and Alcohol Coordination Teams support the implementation, which are similar to the DATs in England and DAATs in Wales.

Definition

An agreed definition of social reintegration has not been found, nor is it a term widely used in the UK.

Concepts

Concepts more often used in the UK are: social regeneration, combating social exclusion, community building, etc.

In the UK, there are not many interventions specifically aimed at reintegrating individual (ex-) drug addicts into society, but there are large-scale initiatives at national level to fight community and social exclusion in order to prevent the onset of problematic drug use. These initiatives target improving employment levels, educational attainment, health and housing and reducing crime in the most deprived neighbourhoods, and they

are backed up by mainstream funding. The concept of social exclusion is well researched in the UK and there is considerable evidence to suggest that drug misuse is related to social exclusion. In the 1980s, a wealth of research in the UK identified drugs as a key issue associated with community decline. The experience of drug services, backed by research, continually shows that the poorest communities are often the main places where problem drug use occurs (Burgess, 2001). In 1998, a report produced by the Advisory Council on the Misuse of Drugs, which looked at environmental factors and drug misuse, found that any statistical relationship between drug use and deprivation seemed to apply more to problematic drug use. Whether problem drug use leads to social exclusion or whether social exclusion leads to problem drug use is not properly understood (Annual Report, 2001), although it is likely to be both rather than either/or.

The Social Exclusion Unit was set up by the Prime Minister in 1997 to help improve government action to reduce social exclusion by producing 'joined-up solutions to joined-up problems'. ‘Social exclusion’ is a term that embraces poverty and deprivation but also incorporates an understanding of how individual and structural marginalisation makes it difficult for people to move out of their disadvantaged position. The activities outlined in the government’s anti-drug strategy to tackle social exclusion will, amongst others:

- support problem drug misusers in reviewing their behaviour and moving towards more positive lifestyles, linking up where appropriate with accommodation, education and employment services; and

- ensure that throughcare and aftercare arrangements for drug-using prisoners are coherent, focused and linked to community provision.

Organisation

Social exclusion, social regeneration

Regeneration programmes have often excluded drug users in the past or have been unable to cope with the challenges posed by drug users. Today, many initiatives have sought to incorporate drug users into mainstream regeneration projects. There is a growing number of projects designed specifically to assist problem drug users to socially reintegrate, such as Transit in Liverpool.

A preliminary governmental report ‘Bringing Britain Together’ in 1998 gave a detailed picture of the concentration of interlinked problems in deprived neighbourhoods: poor health and housing, high unemployment and crime. It announced that 18 Policy Action Teams would be set up to work on solutions, bringing together government officials with front-line practitioners, residents of neighbourhoods and others. Their recommendations were distilled into a second report. A major programme of consultation was carried out on its proposals, and the results of this process were drawn together into ‘A New Commitment to Neighbourhood Renewal: National Strategy Action Plan’, published in 2001. The goals of the Action Plan will be delivered through new ways of working at local level. Local Strategic Partnerships will use the 900 million pound sterling Neighbourhood Renewal Fund to tackle deprivation and improve local services. At grass roots level, Neighbourhood Management will be piloted, giving residents a single person or team responsible for beginning to tackle persistent problems, of which problem drug use will be a common concern for most of these communities.

The strategy includes a range of additional funds to empower communities: a £50 (Euro 77) million Community Chest to provide direct funding for small-scale community projects; a £35 (Euro 52,5) million Community Empowerment Fund to help communities play their part in Local Strategic Partnerships and £45 (Euro 67.5) million for at least two rounds of Neighbourhood Management pilots.

A cross-cutting Neighbourhood Renewal Unit (NRU), based in the Department of the Environment, Transport and the Regions (DETR), is responsible for driving forward the implementation of the National Strategy for Neighbourhood Renewal.

Employment

'New Deal' is a UK-wide government initiative aimed at getting long-term unemployed people into work. It is part of the government's Welfare to Work strategy to help unemployed people into work by closing the gap between the skills employers want and the skills people can offer. It seeks to give people an opportunity to get off state benefits and into employment. Those involved in the programme take account of the effect of drug misuse on the long-term unemployed and assist them in accessing treatment to facilitate employment opportunities. However, as this is not a drug-specific project, data on numbers of drug-using clients are not available.

In London (covering 12 boroughs), a Home Office supported initiative, Dependency to Work, supports offending youth and young adults (aged 14–24) who have entered the criminal justice system to find employment. This target group's offending will be drug-, alcohol- and mental health-related, and specific needs related to education, training and employment will also be targeted. This is not a drug-specific project, although 70 % of clients do have drug dependency issues. The programme is funded by the London Development Agency under the Single Regeneration Budget programme. The life-span of the programme is five years (1999–2004) and the total budget is £25 (Euro 37.5) million.

In Liverpool, 'Transit', a Structured Day Programme, runs a four-day week programme of activities; training, education and support to help recovering drug users find a training or education place. Sessions on offer range from Computers and Desk-Top Publishing to Creative Writing, Drama and Aromatherapy, and there is the opportunity to gain nationally recognised qualifications.

Education

The School Exclusion Report of 1988 showed that large numbers of children either play truant or are excluded from school. The report set out an action plan to deliver a one-third reduction in truancy and exclusion levels by 2002. The number of pupils permanently excluded from school fell from 10 400 in 1998/99 to an estimated 8 600 in 1999/2000. This represents an 18 % decrease and is nearly a third less than the peak of 12 700 in 1996/97. The government's target for 2002 is 8 400. The Children and Young People's Unit (CYPU), which is based within the Department for Education and Skills, now coordinates follow-up action to this report. Education and skills training is supported through 'connections' or personal advisers. Again, this is not a drug-specific programme and quantitative data are therefore not available.

Housing

Research found that around 50 % of people sleeping rough (homeless) have a serious alcohol problem and about 20 % misuse drugs. Drug problems are more common amongst the younger homeless. Research carried out in 1996 found that 39 % of people sleeping rough under the age of 26 had a drug problem. The 1997 London Street Monitor estimated that about one-third of people sleeping rough in central London had multiple problems, most commonly substance abuse combined with mental health problems (Annual Report, 2001).

The rapid rise in numbers of people sleeping rough in the early 1990s was concentrated in London and exacerbated by the difficulty of coordinating action across boroughs and other agency boundaries. As a response, the Rough Sleepers Unit (RSU) was set up as part of the Social Exclusion Unit at the Department for Transport, Local Government and the Regions, and this coordinates action to tackle the problem of people sleeping rough nationally. A reduction of one-third was achieved between June 1998 and June 2000.

It is difficult for drug users to access tenancy agreements with many local authorities, but there are a growing number of initiatives around the country that seek to address this problem. Some housing associations have housing support workers to help vulnerable people, including drug users, to maintain their tenancies.

In most cities, people sleeping rough will turn for help to hostels run by a diverse range of voluntary organisations or, in some cases, local authorities. People will be directed to these hostels by local advice services such as those run by the Citizens' Advice Bureaux and Shelter. All local housing authorities are now required to ensure that there is an advice service in their area concerned with homelessness and how to prevent it. Shelter is currently expanding its free-phone emergency service in London to become a national 24-hour service.

The Edinburgh hostel situation was highlighted in an article in the Guardian Unlimited (2001), which reported on a study carried out by the Edinburgh Streetwork Project. This article stated that, despite the Rough Sleepers Initiative monies, the number of beds in the city's hostels had decreased by approximately 130 since 1997. It was reported that only 14 % of referrals from the Edinburgh Streetwork Project were able to find a hostel bed. The challenge of dealing with clients with drug problems was also highlighted in relationship to the hostels' policies. As a result of these policies, the most vulnerable clients with drug or mental health problems may be the very ones left on the streets, because of their use of drugs while in hostel accommodation. The need to look at equipping hostels to better help people with drug problems was highlighted (Guardian Unlimited, 2001).

Contact and Assessment Teams (CATs) were funded across England to deliver housing and drug treatment to homeless people. DrugScope has been commissioned to produce a series of guidance documents to assist homeless agencies working with drug users. The RSU has funded pilot tailor-made drug treatment programmes for homeless drug users across England, and this will be evaluated. Unfortunately, the results are not available at the time of writing this report. The data of the RSU are not specific for drug users and cannot therefore be used.

Prison

In 1998 the Parliamentary All-Party Drugs Misuse Group described the throughcare and aftercare of drug misusers as appalling and stated that: 'Releasing drug offenders undergoing treatment, without appropriate aftercare (which should include accommodation, training and employment), is not cost effective' (Burrows et al., 2001). Following the national ten-year strategy for drug misuse entitled 'Tackling Drugs to Build a Better Britain', a revised prison service drug strategy was launched in that same year: 'Tackling Drugs in Prison'. It was announced that the prison service was to set up its own Drug Strategy Unit (SDU) to oversee the implementation of the new strategy. Funding was then secured under the Comprehensive Spending Review to provide treatment and aftercare for drug users in prison.

Today, all prisons now provide counselling, assessment, referral, advice and throughcare (CARAT) services. 'Throughcare' refers to the treatment and support

offered to prisoners making the transition from prison to the community. A range of different agencies and organisations share the responsibility for organising and delivering drug throughcare services, including Prison and Probation Services, Health Authorities, Social Service Departments, Drug Action Teams as well as drug statutory and independent agencies (Burrows et al., 2001). Again, these services are not drug-specific and quantitative data are not available.

Furthermore, the so-called Drug Treatment and Testing Orders (DTTOs) were made available in courts in England and Wales as an alternative to custody in order to combat drug-driven crime. DTTOs provide a means for those passing sentence to direct drug-using offenders into drug treatment. It is a key government initiative to combat drug-driven crime. The DTTO is recommended for high tariff offenders who have a propensity to misuse drugs. It requires these offenders to undergo frequent mandatory drug tests, regular court reviews and compulsory treatment.

Community initiatives

There are a large number of community groups working locally to address drug issues and they can be divided into:

- generic community groups that provide advice and support to the community on a range of issues, including drugs; and

- drug-specific groups that focus on providing support for those affected by drug misuse and deliver drug education and prevention, amongst other activities.

These initiatives, however, do not seem to be part of social reintegration interventions but are more broadly focused on drug treatment and prevention.

Residential rehabilitation

Residential rehabilitation was originally based around lengthy periods of stay of between 9 and 18 months. However, since the early 1990s, it has become more flexible and many such services now offer short-term residential rehabilitation programmes. Residential rehabilitation provides a structured programme with the following basic features: maintenance of abstinence from illicit drugs in a controlled or semi-controlled therapeutic environment; communal living with other users in recovery; emphasis on shared responsibility among peers and group counselling; relapse prevention-orientated counselling and support; individual support and promotion of education, training and vocational experience; improved life skills; housing advice and resettlement; and aftercare and support (Annual Report, 2001).

Funding

In general, the mainstream services are responsible for helping with drugs and alcohol problems, primary health care, employment, education and training, and benefit delivery. Most interventions of social reintegration are funded initially through State funding mechanisms. This funding often goes to governmental departments to deliver services, but increasingly departments must award this money to non-government organisations (NGOs).

Since 1999, the Confiscated Assets Fund has enabled some £15 (Euro 22,5) million seized from drug traffickers to be channelled back into prevention, treatment and

enforcement activities in support of the national anti-drug strategy, including the ‘rough sleepers’ initiative, ‘positive futures’, etc.

Discussion

More research has been done in the UK on the issue of social exclusion, homelessness, social regeneration and social reintegration than most other countries. Based on qualitative research with recovering problem drug users in Liverpool, Buchanan highlights the additional challenges that problem drug users face:

‘The reintegration phase is the period when the dependent drug users begin to participate and join in mainstream activities. Due to negative experiences, many drug users feel anxious and afraid of judgmental attitudes from the non-drug using population, and understandably tend to lack confidence. Normal day to day activities such as engaging in further education, doing voluntary work, attending school meetings, doing a vocational adult education course, joining the local gym can be intimidating, as they have for so long been disconnected and out of touch from mainstream activities. They face a dilemma of whether to disclose their drug history, knowing that, ironically, honesty is likely to lead to distrust and possible discrimination. This phase of reintegration is crucial if the drug user is to successfully make the transition and participate in the social and economic life of her/his local community.

‘The emphasis on individually pathologising the drug problem through physiological approaches enforced through drug testing, or cognitive behavioural programmes as a condition of Probation Orders needs resisting. These approaches have some merit, but the structural dimension to drug dependence must be communicated if genuine progress is to be achieved. The Steps to Reintegration offers an alternative paradigm that conceptualises the notion of discrimination and exclusion.’ (Buchanan, 2000)

Summary

- There is a wide range of social reintegration interventions in the UK.
- However, they are mostly part of general interventions fighting social exclusion that are accessible to anyone and are not drug-specific.
- Drug users often find it difficult to access mainstream services, due to fear, prejudice and discrimination.
- Quantitative data for drug users accessing mainstream social reintegration interventions are not available.
- The main focus of the social reintegration interventions is the prevention of problematic drug use, dependency and combating social exclusion.
- Most interventions, therefore, are not a last phase in the treatment process but can occur at any time.

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CLASSIFICATION AND AVAILABILITY OF SOCIAL REINTEGRATION IN NORWAY

National context

Reintegration (more often called 'rehabilitation' in Norway) was first referred to in policy papers in a parliamentary communication, 'melding fra Storting' (number 13, 1985–1986). In this document, the rehabilitation of drug addicts was mentioned for the first time, stating that it should contribute to the ultimate goal of Norwegian drug policy, namely accomplishing a 'drug-free society' (this was subsequently changed to 'a society free of drug abuse'). Reintegration (the term 'aftercare' is widely used in this context) is the responsibility of the municipalities in Norway and the terms and conditions of reintegration are described in the law on social services. However, as many of the problem drug users are referred after psychiatric diagnosis, even the Mental Health Act can form the legal basis for reintegration interventions. Although several institutions run their own aftercare programme, the Norwegian national report of 2002 stated that there are not enough routine reintegration services in Norway.

Current classification of rehabilitation/reintegration in Norway

There are two important concerns to bear in mind regarding the issue of classifying rehabilitation/reintegration in Norway: firstly, there is no such thing as a standard definition of what rehabilitation/reintegration really means in the Norwegian context; secondly, the term is often used for measures/interventions that, in other European countries, would be considered as low-threshold services. The term 'rehabilitation/reintegration' is often used in Norway to denote refuges and drop-in centres, as well as for the last phase of the treatment process. It is also used to refer to what is normally simply called treatment! However, the common thread through all this is that reintegration interventions lead to a reduction in marginality and aim at some kind of rehabilitation of socially excluded individuals. In this sense, treatment (including medically assisted treatment) and low-threshold services can also be considered as social reintegration in Norway.

This does of course pose a problem, as the definition of social reintegration should not overlap with that of treatment but should indicate an intervention that is quite distinct from treatment. However, the task here is to identify the terms used and the classification applied in the respective Member States, in this case Norway, and then to map the availability of social reintegration according to the national classification. However, as we have a minimum definition of social reintegration, which reads 'Any integrative efforts for (former) drug users in the community', the intervention in question will have to be compatible with this definition as well. In summary, an intervention such as medically assisted treatment can be considered as social reintegration if the intervention includes a component such as employment, housing or education and thereby lives up to Norway's definition of social reintegration.

Current availability of social rehabilitation/reintegration in Norway

Bearing in mind that many rehabilitation/reintegration services are not only part of the last stage of the treatment process but can also operate in the first stage, it is a very complex matter to try to identify how many reintegration units exist and what their capacity is in terms of treatment slots.

As with treatment facilities in Norway, rehabilitation/reintegration services are very often targeted at abusers in general, and only a few are exclusively for drug abusers.

The Norwegian focal point has announced that a new and structured database for treatment and care facilities (www.rustiltak.no) is currently being developed. This will probably provide more specific tools for extracting data (number of slots, etc.) regarding the various interventions, including rehabilitation.

As was mentioned in the section 'Current classification of social reintegration', methadone substitution treatment is considered to be a social reintegration intervention in Norway. As medically assisted treatment in Norway must include a social (re)integration component, such as housing, education or employment, it will be included here as a social reintegration intervention, as it is compatible with the Norwegian definition of social reintegration. The number of patients admitted to medically assisted treatment has grown from 204 at the end of 1998 to 1 909 at the end of 2002. This is a significant increase, but there are still some 600 individuals on waiting lists.

Research and evaluation findings

The Norwegian Institute for Alcohol and Drug Research, SIRUS, is implementing an outcome evaluation (2000–2003) that focuses on the costs and benefits of treatment and social reintegration interventions. The sample includes clients from both drug-free treatment and medically assisted treatment and the evaluation is being conducted as a longitudinal study with an assessment at the beginning of the intervention and a subsequent follow-up. The follow-up generally shows that there is both a rapid onset of positive effects of the interventions in terms of reduction of drugs and alcohol consumption and that this reduction lasts throughout the period of the intervention. There is also a marked improvement in mental health. Less encouraging are the results relating to the social reintegration intervention itself. One indicator used to measure the level of success was the number of days in legitimate employment, and this does not increase between recruitment and the time of the follow-up.

Similar results can be seen in an evaluation by 'Rogaland research', namely that consumption levels and patterns as well as various indicators to measure quality of life increase significantly, but that the results in terms of actual social reintegration are poor. The evaluation points out that one reason for this could be a lack of overall perspectives on reintegration and that a drug-free lifestyle for former problem drug users could lead to further social isolation, as they become excluded from their former drug-using social circles.

Summary

- There is no clear-cut definition of the concept of social reintegration in Norway.
- Social reintegration can occur at any time during the treatment process.
- General treatment is often considered to be part of social reintegration.

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