

Aus der Klinik für Psychiatrie und Psychotherapie
des Zentrums für Psychosoziale Medizin
des Universitätsklinikums Hamburg-Eppendorf

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Evaluation of addiction services in Cyprus

Dissertation

zur Erlangung des Grades eines Doktors der Medizin
der Medizinischen Fakultät der Universität Hamburg vorgelegt

von

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aus Cholargos, Athen, Griechenland

Hamburg 2010

Angenommen von der Medizinischen Fakultät

der Universität Hamburg am: 09.09.2010

Veröffentlicht mit Genehmigung der Medizinischen

Fakultät der Universität Hamburg

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Abbreviations

CAC	Cyprus Anti-Drugs Council
CYP	Cypriot Pounds
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESPAD	European School Survey Project on Alcohol and Other Drugs
EU	European Union
GP	General practitioner
ICE	Institute for Continuing Education of Kenthea
MHS	Mental Health Services
NAADAC	The Association for Addiction Professionals (United States)
NFP	National Focal Point
NGO	Non-governmental organisation
NTA	National Treatment Agency for Substance Abuse
PDU	Problematic drug user
TC	Therapeutic Community
TDI	Treatment demand indicator
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation

Synopsis

In April 2007 a European twinning project started between Cyprus and Germany, in order to assist Cyprus in the implementation of adequate drug services and harmonisation with the European Community's legislation. The overall objective of the twinning project was to enhance the capacity of the Mental Health Services (MHS), a body of the Ministry of Health, as regards the implementation of a continuum of care for drug addicts. Hereby, the evaluation of the governmental and non-governmental drug services in Cyprus and their coordination, as well the improvement of existing and the introduction of new drug treatment services were main targets. The evaluation of this process was undertaken by a team of German experts.

A field investigation studied parameters as population in need, treatment demand and coverage, showing an individual place of Cyprus in the international drug ranking, with cannabis being the most widespread illicit substance used by adults (last-month prevalence). However, the life-time prevalence for cannabis use was among the lowest compared to other European countries. But while the life-time prevalence of illicit drug use among the general population in Cyprus is comparable low, the last month prevalence is relatively high, especially for amphetamines, cocaine and ecstasy. In particular the last month use of ecstasy (0.8%) among young population was on top in Europe. The last month prevalence is one indicator for current drug use, therefore showing the extent of treatment needs within a community. Considering the high last month prevalence, it can be assumed that current users might develop a problematic drug use and are consequently a target group for drug services. Nevertheless heroin remains the primary drug of abuse in persons seeking treatment, although Cyprus was until 2008 the only country of the European Union without a substitution treatment. In comparison with other European countries, current heroin injecting is on the highest level along with countries such as Czech Republic, Latvia, Lithuania and Bulgaria.

In 2007 there were 20 treatment units located mainly in the capital Nicosia but also in Limassol, Larnaka and Pafos. In relation to the estimated total number of problem drug users, the treatment coverage in Cyprus accounts for 59%. In 2006, 560 drug users made use of one of the six governmental drug services. The clients were on average 28 years old and 87% of them were male. For 41% of the clients it was the first contact with addiction services. In the last years the number of new clients increased, implying that the total

number of drug users in Cyprus may have increased as well. Among all clients, heroin users were the main group (55%) requesting treatment. Cannabis users were the second main client group accounting for one fourth of all clients, followed by cocaine users, representing 15% of all clients in treatment. Within the period from 2001 to 2006 the number of new clients with primary use of cannabis increased from 30% to 43%, a high number when compared with other European countries. In the same period the number of new clients with primary use of cocaine tripled up to 18%. The proportion of new clients with heroin use decreased from almost 53% to 35%.

The coverage and gaps in the Cyprus treatment system were evaluated with special attention drawn to the concordance with standards for drug treatment services within the European Union. The evaluation of the current situation as to health policy tasks, coverage and functioning of the current drug treatment services, and the assessment of the existing drug services as regards European standards resulted in the elaboration of recommendations, which describe future demands for an improvement of the drug treatment policy in Cyprus.

Cyprus belongs to the EU countries where the provision and financing of drug treatment services is provided by both public agencies and NGOs. With the introduction of high-dosage buprenorphine maintenance treatment in Cyprus in 2007, substitution treatment is now available in all Member States. Nevertheless, Cyprus shows a poor diversification of treatment provision and services in comparison to other EU Member States. Thus, suggestions were aimed at more harm reduction measures, including maintenance treatment with other substances, and a good balance between multifunctional services with a low threshold and specific treatment options. In addition, Cyprus does not manage to keep up with international standards concerning specific target group specialised treatment options: Gender specific programmes for women, special migrant programmes, prison-based substitution treatment and other harm reduction programmes are lacking. There is also a lack of communication between the involved public bodies, which limits an effective planning and coordination of drug treatment. Finally, there is no clear structure for the distribution of the budget, while the strategic planning of the national drug policy remains unclear.

The Cypriot addiction services offer the presuppositions for an efficient and good functioning drug care system in the future. As drug services in Cyprus are still adapting to the increasing special needs of the population, an evaluation can guide needed reforms to achieve a more efficient system. Some crucial changes with respect to the structure and coordination of the facilities, in combination with a redefinition of several objectives, in

order to cover existing gaps in the treatment offer, can guarantee the continuity of care within a drug treatment conformed to the international state of the art.

1. Hypothesis

Cyprus is since May 2004 a full Member State of the European Union (EU). In the process towards a full integration, the implementation of and harmonisation with the European Community's legislation is essential. In this context, Twinning projects were launched, as an initiative of the European Commission to assist future Member States, by strengthening their administrative and judicial capacity through specific targeted co-operation. One area of Twinning projects has been the area of drug treatment.

This evaluation began as part of a Twinning project between Cyprus and Germany, started in April 2007 and focusing on Cyprus governmental drug services, and was complemented by the further evaluation of the Cyprus non-governmental drug services, prevention network and prison addiction services. A field investigation studied parameters as population in need, treatment demand and coverage, as well as high risk patterns and their trend over the last years, showing an individual place of Cyprus in the international drug ranking. Although in Cyprus the life-time prevalence of illicit drug use among the general population is comparable low, there is a significant trend over the last years showing a relatively high last month prevalence in comparison to other European countries. This fact, as well as the current political and geographical conditions on the island, point out the essentiality of a detailed epidemiological analysis and evaluation, in order to formulate recommendations guarantying the quality and efficiency of the drug treatment system.

Accordingly, the main objective of this evaluation will be the delivery of a clear and coherent basis regarding the Cyprus addiction services, in order to assist the implementation of changes needed for the establishment of a therapeutic continuum for drug addicts. The results of this evaluation analyse in detail the current availability of the governmental and non-governmental drug facilities, their structure and coordination, as well as the legal framework in which they operate, formulating recommendations for the improvement and the introduction of new drug treatment services in Cyprus.

2. Introduction

2.1. Background

The strength of the EU in the promotion of peace, prosperity, liberty and democracy lies in its enlargement policy. All the Member States of the EU have a body of common rights and obligations which is reflected in the Community's "acquis communautaire" [1]. The "acquis communautaire" of the EU is constantly evolving and incorporates the content, principles, political objectives and legislation adopted by the Treaties, the declarations and resolutions of the EU, as well as measures relating to the common foreign and security policy, to justice and home affairs and finally to the international agreements concluded by the Member States in the field of the Union's activities. The Union is bound to maintain the Community's "acquis communautaire" in its entirety and develop it further. All countries which apply for an entry in the EU have to accept the Community's "acquis communautaire" and will have to integrate it into their national legislation and implement it from the moment of their entry. Deviations of the "acquis communautaire" are granted only in exceptional circumstances.

In this context, Twinning projects were launched first-time in 1998 [2]. Twinning is an initiative of the European Commission to assist Candidate Countries in the implementation of the Community's legislation as future Member States, by strengthening their administrative and judicial capacity through specific and targeted co-operation. Twinning Projects' objectives promote priority areas of the Union's "acquis communautaire" and are derived from the European Commission towards the countries concerned, which must agree in advance on a detailed work plan to meet. These projects, built on the Union's basic policy priorities, assure the exchange of best practices and experiences and promote the establishment of networks based on various partnerships. A Twinning project is yet not a one-way technical assistance from a Member State to a Beneficiary Country with the aim of replicating an existing particular administrative system. Much more, it is a project of bidirectional co-operation in a specific field that must generate mandatory results and help introduce EU-wide best practices in connection with the Community legislation.

Twining projects are focusing on limited, clear and well-defined institutional targets and are set out to deliver specific and guaranteed results in this particular field, with

constant progress reports and monitoring exercises. The Commission acts as a mediator, facilitator and guardian of equitable, transparent and continuous application of the Twinning rules, by establishing a central co-ordination and setting the legal, financial, and procedural framework of the project. Only in 2005, the EU invested over € 1 billion in more than 1000 Twinning projects in 25 countries. One area of Twinning projects has been the area of drug treatment.

If the Twinning subject addressed is of limited extend and the structures needed to be adapted to the “acquis communautaire” are not complex or need little adjustment, a "Twinning Light" project can be applied. The financial frame of “Twinning Light” projects has been set at € 150.000 and the duration limited to a maximum of 8 months. "Twinning Light" generally involves one or more short missions by selected officials (civil servants experts) and can also include additional services such as: appraisal of regulatory texts, supply of documentation, workshops, seminars, visits, as well as interpretation and translation in relation to the subject.

2. 2. Drug Treatment

Over 205 million people in the world use illicit drugs, of which approx. 25 million develop a drug dependence [3]. Drug dependence is a multi-factorial health disorder, often following a course of multiple relapses or/and ending in a chronic disease and requires a multidisciplinary approach of treatment, prevention and research. This forms a persisting multisectional challenge in the areas of public health, socio-economic development and security, for both industrialized and developing countries.

Although recent surveys indicate that cannabis and ecstasy are the most consumed illegal substances in Europe, for the most counties of Europe and Asia opiates (principally heroin) remain the main problem drug. In South America that is the case for cocaine and in Africa for cannabis [4].

2. 2. 1. Understanding of drug treatment

Working towards a strategic policy of treatment, a clear conceptualisation and definition of treatment itself is essential. Treatment can be defined in general terms as the provision of one or more structured interventions designed to improve and maximise personal and social functioning, as well to manage health and other problems as a consequence of drug abuse. According to the World Health Organization (WHO) Expert Committee on Drug Dependence, the term “treatment” refers to “the process that begins when psychoactive substance abusers come into contact with a health provider or any other community service and may continue through a succession of specific interventions until the highest attainable level of health and well-being is reached“ [5]. In addition, treatment aims at reducing the dependence on psychoactive substances, as well as the negative health and social consequences caused by, or associated with, the use of such substances [6].

A drug treatment system is a group of interrelated or interdependent treatment and rehabilitative elements that form a combined response to substance abuse problems in a defined region or country. Those interventions are not static and are subject to various political, cultural, religious and economic factors that influence how they are organized and delivered and how they evolve over time. The nature of treatment interventions, including medical, psychosocial, traditional healing and other rehabilitative services, may therefore have a different form across different countries. Nevertheless, drug dependence treatment

should be still guided by evidence-based interventions and investments, with the applied high quality of standards required for approval of pharmacological or psychosocial interventions in all the other medical disciplines.

2. 2. 2. Continuity of care

Drug abusers could be classified into six subgroups, including non-dependent drug abusers, dependent drug abusers, injecting drug abusers, acutely intoxicated drug abusers, drug abusers in withdrawal and drug abusers in recovery [6]. Each client's drug treatment journey is different and depends on a range of factors including health status, relationships, nature of the drug problem and quality of the drug treatment they receive. Many individuals may require the provision of several different types of treatment service over time (continuum of care). Therefore, drug abuse treatment should include multi-step, well-integrated care pathways such as screening, comprehensive assessment, intake and treatment planning, stabilization, monitoring, medically supervised withdrawal, departure planning, community-based support or residential rehabilitation programmes, periodic follow-up, etc. These elements are important components in any effective package of treatment care services.

Experience and research shows that drug treatment is not an event, but a process usually involving engagement with different drug treatment services, perhaps over many years [7]. In order for a generalised long-term benefit to be reached, a partnership between the treatment provider and the client or service user is needed, with both working towards common explicit goals. However, drug treatment use is often episodic, with service users "dipping" in and out of the treatment structure over time. Evidence suggests that the average time in treatment for a person with a heroin, crack or cocaine dependence problem averages between five and seven years, with some heroin users requiring indefinite maintenance on substitute opioids. Evidence also underlines that service users gain cumulative benefit from a series of treatment episodes and that optimised treatment usually involves retaining clients in drug treatment for a minimum of three months. This is the point at which treatment begins to have generalised long-term benefit, by engaging the service user sufficiently in a therapeutic relationship to enable positive changes to occur. However, the biggest improvements in client outcomes are likely to be made in the first six years of treatment [8].

2. 2. 3. Effectiveness of treatment

In order for the best results in the treatment of drug dependency to be reached, there are many factors, which must be considered conformed and applied by the treatment system, such as legal framework, affordability, responsiveness to multiple needs and diversification of services, geographical accessibility, distribution and linkages, availability of low threshold services, cultural relevance and user friendliness, gender-sensitiveness of services, timeliness and flexibility of opening hours, criminal justice system responses, etc. The services' policies, programmes, procedures and coordination mechanisms should be predefined and planned with respect to needs assessment and clarified in advance to all therapeutic team members, administration, and target population. Monitoring systems, communication and coordinating structures, networking, updating services, treatment protocols, supervision and qualified staff, as well as regular evaluation could guarantee the clinical governance of the treatment services and a better service supply. In addition, a variety of individualized services, as well as guidelines for the selection of appropriate services are essential [3, 9]. Finally, the drug treatment should also be flexible and adaptable in order to be able to respond to the complex changing conditions concerning drug abuse nationally and in local communities (i.e. new drugs, illegal distribution channels, rise of prevalence, new consumption methods, etc.).

Within the larger population of individuals affected by drug use disorders, there are several subgroups which require special consideration and often specialized care. These groups with specific needs include children, adolescents, women, pregnant women, people with medical and/or psychiatric co-morbidities, sex workers, ethnic minorities, socially marginalized individuals, as well as patients in the Criminal Justice System. The appropriate treatment of these patients requires targeted and differentiated approaches and interventions with a better respond to the needs of these groups (contacting services, clinical interventions, treatment setting and service organization).

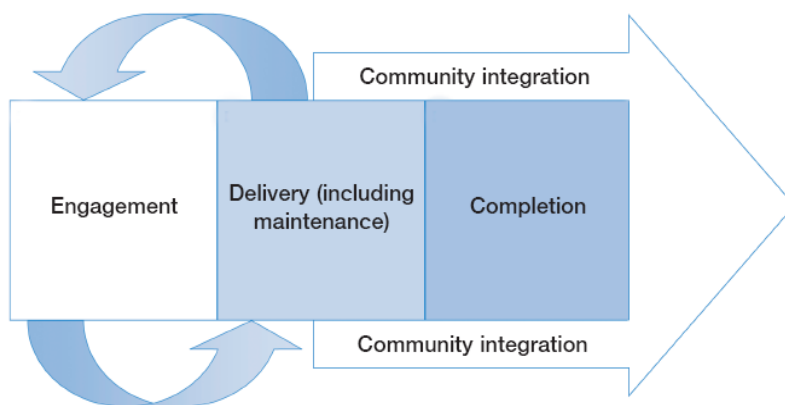
Although there are many articles on prevention, treatment and rehabilitation, only 0,7% of the papers refer to low- and middle-income countries, unanimously showing that poor accessibility and delayed onset of treatment persist in many countries and that political and cultural factors still play a crucial role in provision of services needed [10].

2. 2. 4. Component parts of the treatment journey

To improve the drug treatment effectiveness, the National Treatment Agency for Substance Abuse (NTA) described the clients' journeys through drug treatment [7]. Based on effectiveness studies the treatment journey is conceptualised into four overlapping segments, each with key objectives [11]. These are illustrated in figure1 and comprise:

- treatment engagement
- treatment delivery
- community integration (which underpins both delivery and treatment completion)
- treatment completion (for clients choosing to be drug free and who can benefit)

Figure 1. The client's journey [7].



- a. Treatment engagement :

The treatment system needs to be able to engage people rapidly and retain them once they have entered treatment. Two issues important to improving treatment engagement are the timely access to treatment and the focus on supporting retention for at least three months in structured treatment for adults with dependent drug misuse (particularly heroin, crack/cocaine, polydrug and alcohol). Each drug treatment system will be assessed on its ability to engage service users on these two issues.

- b. Drug treatment delivery

Drug treatment providers need to deliver effective and evidence-based drug treatment interventions, working through the active fostering of positive therapeutic relationships

with service users and encouraging their full participation in delivering their care plans. Good quality drug treatment should improve an individual's health, social functioning and reduce public health and offending risks they pose to others. During this phase, other options should commence to meet the service users' wider needs in the community. This community reintegration could include for example points towards the improvement of the general health and housing status, as well as the resumption of work or education activities.

- c. Improving community integration for maintenance and treatment completion

Few service users who enter drug treatment think that they will be in specialist drug treatment indefinitely. For those who wish to be drug free, commissioners and providers need to create better pathways and exits from specialist drug treatment including improved social support, housing, education and employment opportunities to maximise treatment gains. Drug-related aftercare support, such as support groups or individualised sessions or alternatively from mutual aid groups run by Narcotics Anonymous (or equivalent), has been demonstrated to sustain abstinence. Service users who are stable but who wish to be maintained on substitute opioid medication should also have opportunities to receive social support, education and employment where appropriate. For stable individuals who do not need to continue in specialised drug treatment services, there should be clear exit pathways into maintenance and monitoring in primary care settings with ongoing community integration and support. However, it is vital that such service users have explicit accessible pathways back into specialised structured drug treatment services if needed (e.g. in case of relapse).

This approach will require treatment systems to be configured both to create effective exit routes out of specialised drug treatment and to be well integrated with primary care and other systems of support and care for those in maintenance treatment and for those who wish to be drug free.

2. 3. The different types of drug treatment services

The treatment system of drug dependence should be characterised by proactive outreach and low threshold with socio-cultural relevance, integrating evidence-based pharmacological and psychosocial interventions with sufficient duration applied by multidisciplinary teams. Early identification, protection from potential sanctions and functional referral, facilitating a continuum of care, in combination with a wide range of psychological and social interventions, as well as self-help support groups are additional key components, which should be made available for every single patient. [11, 12]. A treatment system with the following components should ensure routes of treatment and coordination for continuity of care [6, 7, 13, 14]. In general there are five categories of treatment services, which of course are only a part of the whole system.

2. 3. 1. “Open access” services

a. Advice and information

Advice and information is provided by non-specialists such as general practitioners (GPs), specialist physicians and emergency departments. This should include:

- information about drugs and alcohol, and their effects.
- advice on reducing and giving up drugs and alcohol.
- information on reducing the potential harm from drug misuse, such as injecting more safely and preventing overdose.
- how to get help for drug problems and for other problems, such as housing and sexual health.

b. Harm reduction

Most harm reduction is about preventing diseases passed on by contaminated blood (particularly HIV and hepatitis infections), and preventing overdose and drug-related deaths. All drug treatment services, whether residential or community-based, should provide this as a core service. Important examples of harm reduction are:

- needle exchange services, which distribute and dispose of needles, syringes and other injecting equipment (such as spoons, filters and citric acid).

- advice and support on injecting more safely, injecting less and preventing other people from starting to inject.
- advice and information on preventing infections associated with drug misuse, particularly hepatitis A, B and C, and HIV (blood-borne viruses).
- testing, vaccination, advice, information and counselling around hepatitis and HIV.
- access to treatment for hepatitis B, C and HIV infection.
- assessing clients and referring them to other treatment services if necessary.

2.3.2. “Structured” services

a. Community-based psychosocial counselling and relapse prevention

- Counselling and psychological support

Counselling is not to be confused with basic advice and informal support. It should be carried out by a trained and competent professional and be included in a client’s care plan. Counselling needs to be formal, structured – with clearly defined treatment plans and goals – and regularly reviewed. Psychological therapies can include cognitive behaviour therapy (CBT), coping skills, relapse prevention therapy, motivational interventions and family therapies.

- Structured day programmes

Structured day programmes usually run a set series of activities for a fixed period of time (for example 12 weeks). Clients attend these services according to a set attendance level (usually 3-5 days a week), as set out in their care plans. There is a timetable of activities which will either be the same for everyone, or be set individually for clients according to their needs. Programmes often include group work, counselling, education and life skills, as well as creative activities.

b. Prescribing interventions (inpatient and outpatient/community settings)

- Medical community based prescribing:

Community prescribing is specialised drug treatment in the context of a care plan. It is provided as part of primary care, by a GP with an interest in drug misuse or a doctor in a specialist drug treatment service. Where clients receive treatment may depend on the seriousness of their problems, the duration of the past treatment and their stability. Community prescribing includes:

- Stabilisation of a client on substitute drugs.
- Prescription of substitute drugs, such as methadone and buprenorphine, for a sustained period (maintenance prescribing)
- Prescription for withdrawal (community detoxification)
- Prescription for relapse prevention.

- Detoxification (inpatient):

Detoxification consists in a medically assisted withdrawal and involves an inpatient hospital stay. During detoxification most prescribed medication targets the suppression of withdrawal symptoms. The inpatient treatment can also include stabilisation on substitute medication, emergency medical care for drug users in crisis and in some cases treatment for stimulant users. In addition, other services may be available, such as preparation for entering inpatient treatment, counselling, help with alcohol problems, harm reduction and treatment for blood-borne viruses.

c. Rehabilitation

Residential rehabilitation usually involves clients staying in a facility for weeks or months and a complete break from their current circumstances. As with inpatient treatment, clients generally access rehabilitation through community services. People entering rehab usually have undergone detoxification before entering. Rehabilitation services normally offer a mixture of group work, counselling and other practical and vocational activities. There are several types of facilities:

- traditional rehabilitation units, with programmes to suit the needs of different service users.

- crisis intervention units (usually in urban areas), offering generally shorter stays for clients in drug-related crisis.
- "second stage" or "move-on" supported accommodation, offering additional assistance after rehabilitation
- other supported accommodation, with rehabilitation interventions (therapeutic drug-related and non-drug-related interventions) provided at a different nearby site(s).

d. Aftercare:

Aftercare services offer client support after the completion of structured treatment. Their main objective is the maintenance of the clients' positive developments reached in previous treatment and their assistance in every-day difficulties and problems. Examples include assistance in house keeping, education, employment, general health care and relapse prevention.

2. 4. Evaluation of treatment

Evaluation is a method for the assessment of costs, effectiveness or impact of a treatment or treatment system, which provides feedback to key audiences. A routine collection and dissemination of such information promotes a healthy culture towards evaluation and improvement of services. Before an evaluation study begins, there are many fields which have to be examined, discussed and defined through a communication of all interested parties (i.e. previous research results, specific short-term and long-term objectives, setting and size of the study, human resources needed, skills needed, financial resources, timetable, etc.) [15]. An effective response to the drug problem requires a systematic evaluation, which should be repeated periodically, involving key decision makers in the earliest discussions of evaluation and giving priority to interventions that clearly demonstrate the advantages of evidence-based treatments. The evaluation of drug services should include following steps listed below [15].

2. 4. 1. Needs assessment

An effective evaluation requires a systematic exploration of the current situation with respect to the objectives, repeated on a periodic basis. The components of a needs assessment include:

- Contextual assessment: Exploration of structural, social and cultural background, influencing the overall drug use situation.
- Drug use assessment: Description of the drug use/abuse situation and associated problems.
- Resource assessment: Identification of existing resources, such as funds, organizations and human resources.
- Intervention and policy assessment: Investigation of nature, appropriateness and adequacy of the existing interventions and policies.

2. 4. 2. Process evaluation

Process evaluations examine the operational part of a treatment; they focus on how treatment services or systems operate and the ways in which resources are used to produce

outputs. Treatment objectives, fidelity and quality of the treatment, the characteristics of clients treated, number of drop outs, qualifications of staff, as well as coordination, management and record keeping are being investigated. Thus, there is an attempt to identify those areas, where improvements can be made.

2. 4. 3. Outcome evaluations

Outcome evaluations investigate the change of clients in relation to time care received. In specific, many factors have to be analysed, such as the proportion of clients completing treatment, the proportion of clients reducing their drug use after treatment, outcome of specific treatments in relation to no treatment or other treatments, etc. A quality outcome evaluation should always be based on a good process evaluation component.

There are many different types of study designs, which can be used:

- Naturalistic/observation studies: These studies implement an assessment of clients at several points in time (usually before, during and after treatment).
- Experimental, controlled designs: They involve the apportionment of clients to one or more treatments or to a no-treatment or a waiting list (delayed treatment condition).
- Client satisfaction studies: The most common method is to use a confidential self-administered questionnaire, which also takes into account the cultural differences among clients.

2. 4. 4. Economic evaluations

Two major topics of an economic evaluation are the efficient use of resources and the average costs per client. There are three types of an economic evaluation:

- Cost analysis: A cost analysis determines the overall cost of the resources used to provide a service.
- Cost-effectiveness analysis: Cost-effectiveness analysis compares the costs and outcomes of two or more different treatments with similar objectives.
- Cost-utility and cost-benefit analysis: Cost utility analysis rates the quality of life, life expectancy and survival of clients treated as primary outcome measures and is seen lately as the most appropriate for health case evaluation.

2. 4. 5. Measures and impact of evaluation

The principal requirements of a measuring (evaluation) device are validity and reliability. The chosen measure should also be free from response bias and be non-reactive to extraneous factors, while remaining sensitive to changes of the phenomena studied.

Vested interests of treatment providers, poor quality of evaluations and the lack of clear-cut results, as well as poor communication between evaluators and decision-makers often diminish the impact of the evaluation results. Therefore, it is important to involve key decision makers in the earliest discussions of an evaluation and give priority to interventions that clearly demonstrate the advantages of evidence-based treatments.

2. 5. EU Drug Policy

2. 5. 1. Basic Principles

The EU drug policy is characterised both internally and externally by five principles of international drug policy: shared responsibility, emphasis on multilateralism, balanced approach, development mainstreaming and respect of human rights [16]. All multilateral efforts and initiatives, as well as every bilateral relation of the EU towards Member States are inspired and characterised by the shared responsibility principle [12, 17, 18].

The EU Drug Strategy concentrates on the two major dimensions of drugs policy: multidisciplinary, integrated demand reduction and supply reduction, in order to reduce the number of people addicted. This also covers a number of cross-cutting themes, such as international cooperation, research, information and evaluation, with the following main targets:

- Promotion of a high level of health protection, well-being and social cohesion through prevention and reduction of drug use, drug dependence and drug-related harms to health and society.
- Insurance of a high level of security for the general population by taking action against drugs production and cross-border trafficking of drugs.
- Intensification of preventive actions against drug-related crime through effective cooperation.
- Strengthening of the EU coordination mechanisms to ensure that regional, national and international action is complementary and contributes towards the effectiveness of the drug policy within the EU and among international partners [17].

In the field of demand reduction the main action fields consist in the improvement of the quality of treatment services, by ensuring a balanced, multidisciplinary approach, better coverage of, access to and effectiveness of services and promoted research in the drug field. In addition, a further development and improvement of selective prevention and new outreaching methods contribute also towards demand reduction.

In the last years, the field of harm or risk reduction has also gained in importance and has been promoted by the EU policy. The reduction of drug related deaths, by improving availability and access to harm reduction services and promoting early detection of risk factors, as well as early intervention and prevention of the spread of HIV/AIDS, hepatitis C

and other blood born infections and diseases, has become a major point of the anti-drugs policy.

There have been five multi-annual plans for European action against drugs: two adopted by the CELAD (European Committee to Combat Drugs) (1990 and 1992), and three adopted under the Union Treaties (1994-1999, 2000-2004 and 2005-2008). The latest EU planned actions, implementing the international principles of anti-drug policy, are embodied in the EU Action Plan on Drugs for 2005-08. Additional focus points were the systematic incorporation of major drugs policy targets into relations and agreements with relevant third countries and the intensification of the law enforcement cooperation between Member States and Europol, Eurojust, third countries and international organisations.

2. 5. 2. Standards of drug services provision in Europe

Regarding the prevention and reduction of drug-dependence-associated health-related harm, the European Council recommends the implementation of intervention services and facilities [19]. The Member States should make „services and facilities, particularly aiming at risk reduction“ available. That implies especially:

- to „provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services; (...)“;
- to „promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility“;
- to „provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser“.

In line with these recommendations the actual EU drug action plan 2005-2008 supports „the securing of the availability of and access to targeted and diversified treatment and rehabilitation programmes“ by:

- available and to treatment demand corresponding, evidence based treatment options, covering a variety of psychosocial and pharmacological approaches.
- strategies and guidelines for increasing availability of and access to services for drug users not reached by existing services.

- Improvement of access to and coverage of rehabilitation and social reintegration programmes, paying special attention to specialised (social, psychological, medical) services for young people using drugs“.

2. 5. 3. Development of legislation

The EU’s first action in the development of a legal framework in the drug field was Article 12 of the 1988 United Nations’ (UN) “Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances” [20]. However, it was actually the Maastricht Treaty in 1992 [21, 22], which first specifically referred to the drug phenomenon. In 1997, the Amsterdam Treaty represented a new step forward against the drug problem, inspiring also upcoming legal instruments, such as directives, regulations, recommendations or framework decisions, addressed to the drug problem [23].

But despite the rapid evolution in the structure and operation of the EU, there is still no legal basis for the EU to directly regulate drug use and possession. The European actions against drugs are carried out by each Member State under the supervision of the European Community and the European Community itself, represented by the Commission [17, 24]. However, in the more controversial areas of harm reduction and dealing with drug use and drug users, there are no concrete EU guidelines and so drug policy is left to the national governments’ discretion [25].

The EU does not have a separate system of classifying substances and therefore the UN system is being followed. Nevertheless, 1997 the Council of the European Union adopted a joint action concerning risk assessment, information exchange and control of new synthetic drugs, not currently listed in the 1971 UN Convention on Psychotropic Substances [26]. Recent developments in the field are also the development of a European Arrest Warrant applied to drug traffickers, harmonisation of penalties for drug trafficking, and updating of the legislation on precursors and money laundering [27].

Europe also plays a major role in the global alcohol market, being the source of a quarter of the world’s alcohol and over half of the world’s wine production. Unfortunately the ability of the Member States to implement effective alcohol policy is strongly affected by the trade law of the EU. The direct or indirect discrimination of domestic goods of Member States within the EU is prohibited by law [28].

2.5.4. National Coordination

The partnership and active cooperation between central and local governments, governmental and non-governmental agencies, service providers and the community sets the key for an effective response to the drug problem. Although drug coordination mechanisms exist at both national and regional or local level in almost every EU Member States, there are significant differences in the existing systems, primarily in the link between those levels of coordination mechanisms, reflecting major political and structural differences among the Member States [26].

The greatest differences are found in the link between coordination mechanisms at the national and those at regional or local level. In the most countries with a federal structure (e.g. Belgium, Germany), there are vertical coordination systems, which allow cooperation between the different independently acting coordination bodies. In other countries (e.g. Finland, Portugal) national coordination bodies supervise directly the coordination at regional or local level. Nevertheless, some general action routes and features can be identified. Most countries have drug coordination mechanisms at both national level and regional or local levels.

In the last years there has been a shift from a simple national planning to the implementation of two complementary instruments - a strategic framework and an action plan -, which allow a more detailed definition of objectives, actions, responsibilities and deadlines. Some countries, for example Cyprus, Latvia and Romania, have already incorporated detailed implementation processes in their drug strategies and action plans. In addition, almost every European country has an objective of evaluating their national drug strategy, in order to secure validity and effectiveness.

This diversity of different national drug strategies with common objectives and their evaluation is helping promoting a comparative analysis of different approaches and improving the overall understanding of effectiveness of assessments and strategies. In the last years, both the United Kingdom and the United Nations' Office on Drugs and Crime (UNODC) have invested great efforts in developing indexes for the assessment of the impact of national drug strategies or the overall drug situation.

2. 5. 5. Drug abuse data and monitoring

Collecting, analysing data and applying results in future steps of drug policy is a major pathway in the battle against drugs. Nevertheless, this field is one of the most complicated. Until a decade ago, the monitoring capacity worldwide and specifically in Europe, was extremely limited. Improving the comparability of drug information in the EU has therefore become a central point of European drug policy [11].

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was therefore founded in 1993, in order to change the until then limited capacity of Europe to monitor the drug problem, by compiling and analysing reliable and comparable data on every drug issue among the Member States of the EU [29]. EMCDDA's target is to provide the EU and its Member States with a factual overview on the European drug problem and to build an information framework to support the drugs research and debate. The centre of EMCDDA in Lisbon receives country data for analysing, according to common data-collection standards and tools, fed by ca. 30 national monitoring centres (National Focal Points – NFP) across Europe (Reitox network). The EMCDDA became fully operational in 1995; since then and through the reliable and comparative data collected, the efforts on different areas (e.g. demand reduction, national and EU strategies and policies, international cooperation, geopolitics of supply, trade control, implications for producer, consumer and transit countries, etc.) have been continuously assisted.

Two years later, in 1997, the UNODC was founded and has been since then the centre of the UN fight against drugs, organised crime, terrorism and human trafficking. UNODC aims through coherency and flexibility to be a strategic player at both the global and country levels and to respond with efficiency to demands for a variety of policy and operational services.

Since 1999 is also Europol in full action. Europol is a European Law Enforcement Organisation with the target of promoting the cooperation and effectiveness between the Member States and their authorities towards combating and preventing serious international organised crime, including drug trafficking. Europol and EMCDDA are responsible for analyzing all information and its communication to all Member States, the Commission and the European Agency for the Evaluation of Medicinal Products (EMA), as well as for preparing and submitting a joint report to the Commission and to the Council (Horizontal Drugs Group) [30].

Finally, in the year 2002, Eurojust – a new European Union body – was established to promote the effectiveness of the Member States' authorities in the investigation and prosecution of serious cross-border and organised crime. All these new establishments have supported in the last years the struggling for fast and effective responses in the battle against drug abuse.

2. 6. Cyprus in Europe

Cyprus takes an individual place within the borders of the European Union, especially through its special geographic position at the crossroads of three continents. Cyprus itself does not produce or consume significant amounts of drugs, but its strategic location in the eastern Mediterranean makes it an attractive destination for drug trafficking. According to the Cyprus Police, illegal drugs, enter the country mainly from the Turkish occupied part of the island. Other countries of origin of illicit substances are mainly considered to be Greece, the U.K., Turkey and Bulgaria. The seized quantities of drugs, in particular for cannabis, heroin and MDMA, have increased over the last years. Cannabis smuggling seems to play the most significant role with respect to seized quantities and arrested persons involved. The illicit drug supply and demand increase over the last years is also reflected in the increasing number of drug possession arrests in this period [31]. This data points out an increasing drug-related crime trend, although at a much lower pace than in comparison with the average of the EU. Concerning the current situation, Cyprus' National Drug Strategy 2004-2008 was adopted in 2004, mainly focusing on drug supply reduction and drug demand reduction [32].

The current EU drug action plan calls however not only for drug supply and demand reduction, but especially for high-quality treatment and harm reduction services, which has resulted in facilities evolving towards more target group specific services. Units or programmes specialised on specific target groups are common across the EU. Almost all EU Member States offer specific treatment programmes for adolescents (23 countries including Cyprus) and/or for drug users with a double diagnosis (18 countries including Cyprus), although the availability and accessibility of these programmes vary enormously between the countries. Gender specific programmes for women are reported to exist in all countries except Cyprus, Latvia, Lithuania, Bulgaria and Turkey, while treatment programmes for migrants or special ethnic groups exist only in nine countries (excluding Cyprus) [33]. Concerning harm reduction services it is worth mentioning that Cyprus's only needle and syringe exchange programme is still not officially endorsed.

The provision and financing of drug treatment services differs greatly among the EU Member States. In many countries – especially of Eastern Europe – drug treatment is mainly provided by public agencies and only in four countries (Finland, Germany, the Netherlands and Luxembourg) mainly by NGOs. Seven countries (Cyprus, Austria, Greece, Italy, Malta, Poland and Portugal) have a drug treatment system based on both, public

agencies as well as NGOs. Concerning their diversification, these services vary greatly across the Member States. In particular Cyprus, Romania, Bulgaria, Estonia, Hungary and Latvia show in general a poor diversification of treatment provision and services [33].

Maintenance treatment is one of the major responses to the needs of opioid users, who still represent the main group of users in treatment, and it so became their predominant treatment option, combined with psychosocial care. With the introduction of high-dosage buprenorphine maintenance treatment in Cyprus in 2007, substitution treatment is now available in all Member States. Nevertheless, although the most EU countries offer also a prison-based substitution treatment, seven countries (including Cyprus) do not offer such a treatment option for prisoners. Of all Member States, Spain is currently the only EU country that provides a wide range of harm-reduction measures in prisons [33].

The EU Member States do not only vary concerning their drug treatment provision, but also with respect to their legislation. The threshold quantities for personal drug possession have been one the issues on which Member States have shown the greatest degree of divergence within the EU. In the last years Bulgaria removed the concept of personal possession, Italy re-enacted it after 12 years without, and the U.K. enacted the concept but without applying it. Belgium and Cyprus introduced defined limit quantities in 2003, for all drugs and for especially for cannabis [33].

Another focusing target of the European policy has been the inclusion of monitoring and evaluation as essential components of national drug strategies and action plans. The Cyprus National Focal Point (NFP) was created in March 2004 by the Cyprus Anti-Drugs Council, with the main target of the collection, analysis, and evaluation of information and data concerning the drug use situation in Cyprus, as well as the implementation of EMCDDA activities and other related national activities. The most EU Member States have produced or plan to produce a progress review of the implementation of their drug strategies or action plans, and some of them (e.g. Ireland, Cyprus and Portugal) could produce more in-depth evaluations in the next years [33].

3. Objectives and methods

3.1. Objectives

One of the main responsibilities of the Cyprus Anti-Drugs Council (CAC), as the national coordinating body of drug issues in Cyprus, includes the planning, encouragement, coordination, and evaluation of all drug-related programmes existing in Cyprus in the public and private sectors. As the CAC supports treatment and prevention programmes by public funding, it is important to base decisions on financial grants upon a profound knowledge of the functioning of the services and programmes, and on defined quality criteria. This report presents the results of the evaluation of the Cyprus addiction services and their coordination.

The overall objective of this evaluation is to enhance the capacity of the addiction services of Cyprus, as regards the implementation of a continuum of care for drug addicts. Main target was the assessment of the entire drug care system of the Cyprus, covering drug treatment and prevention, demand policy and harm reduction, as to their structure, proceedings, quality, efficiency and requirements for improvement. On this basis, recommendations for the improvement of the current drug services and for the introduction of new drug treatment services are formulated.

The report consists of two major evaluation parts and respective recommendations. The first part is directed towards a more global evaluation and comprises the analysis of the data concerning the Cyprus population in need for drug treatment and the investigation of the realisation of addiction services in Cyprus with respect to coordination issues, legal framework, as well as current availability and utilization of the different types of drug treatment. The second part concentrates on the detailed evaluation of each of the governmental and non-governmental (NGO) addiction services, with the objective of an in-depth assessment of their structure, processes and results and the formulation of concrete recommendations for the improvement of their services. The results and recommendations of this evaluation aim at supporting the Cyprus Anti-Drugs Council (CAC) in improving its response to the main drug problems in Cyprus.

3. 2. Methods

The evaluation of the governmental services was part of the Twinning project CY/2005/IB/OT/01-TL between Cyprus and Germany, which started in April 2007. The twinning project consisted of nine different activities and their related tasks were to be fulfilled within the eight months duration of the project. The evaluation of the governmental drug services presents the results related to the Cyprus situation existing in July 2007.

Nevertheless, in order to provide a comprehensive picture of the Cyprus drug services and prevention programmes, the evaluation of the NGO service providers was missing. Therefore, the CAC subsequently mandated the Centre of Interdisciplinary Addiction Research of the University of Hamburg (CIAR), in order to carry out the evaluation of the NGO drug services, prison services and the prevention network existing in Cyprus. The evaluation of the NGO drug services and prevention programmes, which started in January 2008 and ended in November 2008, completes the picture regarding the Cyprus responses to drugs and drug addiction.

3. 2. 1. Methods to examine the Cyprus drug service provision

The examination of the current situation bases upon a thorough understanding of the Cypriot drug treatment system. For this reason the methods applied included two major evaluation approaches:

- Repeated group discussions with members of the most important committees such as the CAC Committee and the coordination committee “Synthesis” of the Mental Health drug services.
- Analysis of several relevant documents, such as legal foundations, population surveys, yearly reports of the Cyprus NFP on drug treatment utilisation, standard tables of the EMCDDA on demand for drug treatment, as well as further documents on existing drug services made available by the CAC.

The purpose of the group discussions was to examine the structure and effectiveness of the Cyprus responses to drug problems. This included an inventory of the legal framework, as well as the evaluation of the procedures of implementation and coordination of the Cyprus drug treatment system. Along with the examination of the Cyprus health

policy tasks, it was intended to identify current difficulties and gaps as regards the drug treatment coverage and the functioning of drug services coordination.

The analysis of relevant documents was directed towards an assessment of the Cyprus populations in need for drug treatment, as well as the inventory of existing services and service utilisation. In particular, the inventory of services existing in Cyprus and the utilisation of available services was carried out in close cooperation with the CAC and the Cyprus NFP. Based on the results of the inventory, the coverage and gaps in the Cyprus treatment system were evaluated with special attention drawn to the concordance with standards for drug treatment services within the European Union.

The evaluation of the current situation as to health policy tasks, coverage and functioning of the current drug treatment services and the assessment of the existing drug services regarding European standards resulted in the elaboration of recommendations. These recommendations address future demands towards the improvement of the coverage and efficiency of the drug treatment policy in Cyprus.

3. 2. 2. Methods to evaluate the existing drug services

A main goal of the services' evaluation was to assess the quality of the structure, methods and approaches applied. This also included the evaluation of the results of the services, as regards the number of clients and treatment outcome. Special attention was also drawn to the quality and outcome of the treatment and prevention programmes. The evaluation resulted in recommendations on the enhancement of structure, processes, quality and outcome of the drug services and prevention programmes.

The methods used for the evaluation were

- repeated visits of the facilities,
- expert interviews with staff members,
- structured questionnaire distributed to all facilities,
- analysis of the regular reports submitted by the facilities to the CAC, and
- analysis of any other reports as well as of internet material.

During the visits, repeated expert interviews took place, focussing mainly on structural, conceptual and financial aspects of the respective facility. One major target of the expert interviews was the examination of the services delivered to drug addicts as to their objectives, methods and duration. Within this context, also the question of staff

qualification and staff number played a role. The staff members were asked about difficulties they face in providing adequate services and about future needs, in order to improve their services. All facilities have been visited at least twice in order to investigate all aspects of the location, rooms and services.

On that basis, a structured questionnaire has been developed, requesting precise information on the drug services provided in the governmental facilities. The questionnaire covers the following five topics: general information on the facility, target groups, service utilisation and processes, cooperation and coordination, and structure. Two free question fields also assessed the most important problems in the provision of services and recommendations in order to enhance a continuity of care for the clients on the part of the staff members. The questionnaire was filled by all facilities and the data collected provided the basis for measuring the quality of structures, processes and results.

The data analysis was completed by the assessment of the regular reports which all facilities have to deliver to the CAC. In consideration of all available information and data, the facilities were evaluated as to their structure, processes and results, including also aspects of accessibility, care planning, interlinkage between the services and continuation of treatment.

The evaluation was to contribute to the further development of effective drug services under the capacity of the CAC. Based on the evaluation of the results recommendations are worked out on how each of the drug facilities can improve their interventions provided to the respective target groups. The evaluation of the facilities and its related recommendations has been communicated together with the Cypriot experts.

The author participated in four of the missions of the two projects, attending almost all first visits of the governmental and NGO organisations. During the four missions he also attended group discussions with members of the most important committees and coordinating bodies, interviewed many staff members and clients, presented several results of the evaluation to the committees, etc. The Greek ethnical background of the author has also markedly supported in matters of communication with Cypriot partners and understanding of the cultural and structural background.

Another major responsibility has been the examination of all printed material collected through the missions. All data concerning treatment facilities, system structure and background, legislation and health policy, as well as several relevant documents and facilities' reports have been translated, elaborated and included in this evaluation.

Furthermore, the author was responsible for the assessment of the questionnaires of each facility. The collection and elaboration of this data led finally to the global evaluation of background, structure, staff, processes and results in all facilities.

3. 2. 3. Limitations

The different cultural background, the very different drug treatment system in Cyprus and Germany, as well as the communication of all partners in a foreign language were a big challenge in the procedure of this evaluation project. In addition, the evaluation process was partly rather difficult, because of continuous structural and conceptual changes of many drug services during the evaluation period. In fact, three out of six governmental facilities (Perseas, Promitheas, and Pixida) restructured their services after completing the inventory. Many coordination committees also changed their structure during the evaluation. However, it was an encouraging and valuable experience to carry out an evaluation in Cyprus, due to the fruitful and constructive cooperation between the Cypriot and German partners.

4. Results

4.1. Population in need in Cyprus

One basic element of a need assessment is the exploration and description of the current situation and the identification of the nature and extent of the problematic drug use. The number of problem drug users is one indicator for the extent of treatment needs within a community. In addition, the assessment of the drug users' characteristics allows the identification of treatment needs and treatment delivery gaps and promotes the priority setting for future changes in the drug service provision.

In Cyprus epidemiological data are available from surveys, indirect statistical estimation methods and from the treatment demand data reported to the EMCDDA. By considering the different data sources the number of drug users in need for services can be estimated.

4.1.1. Prevalence of drug use in the general population

Information on the prevalence of drug use in the general population allow a conservative estimation of the extent of the drug problems in Cyprus by converting the prevalence reported in national surveys into the number of drug experienced individuals among all inhabitants of age 15 to 65.

In Cyprus there are two nationwide surveys to explore the prevalence of drug use in the general population. The first one was carried out in 2003 and based upon interviews with 1,000 respondents at the age of 15 to 65 [34]. However, the results of this survey are regarded by Cyprus experts as rather invalid. Consequently, a new general population survey has been conducted recently, which base upon face-to-face interviews with 3504 samples (valid sample) 15 to 65 years old [35]. The results of the recent survey are presented in table 1.

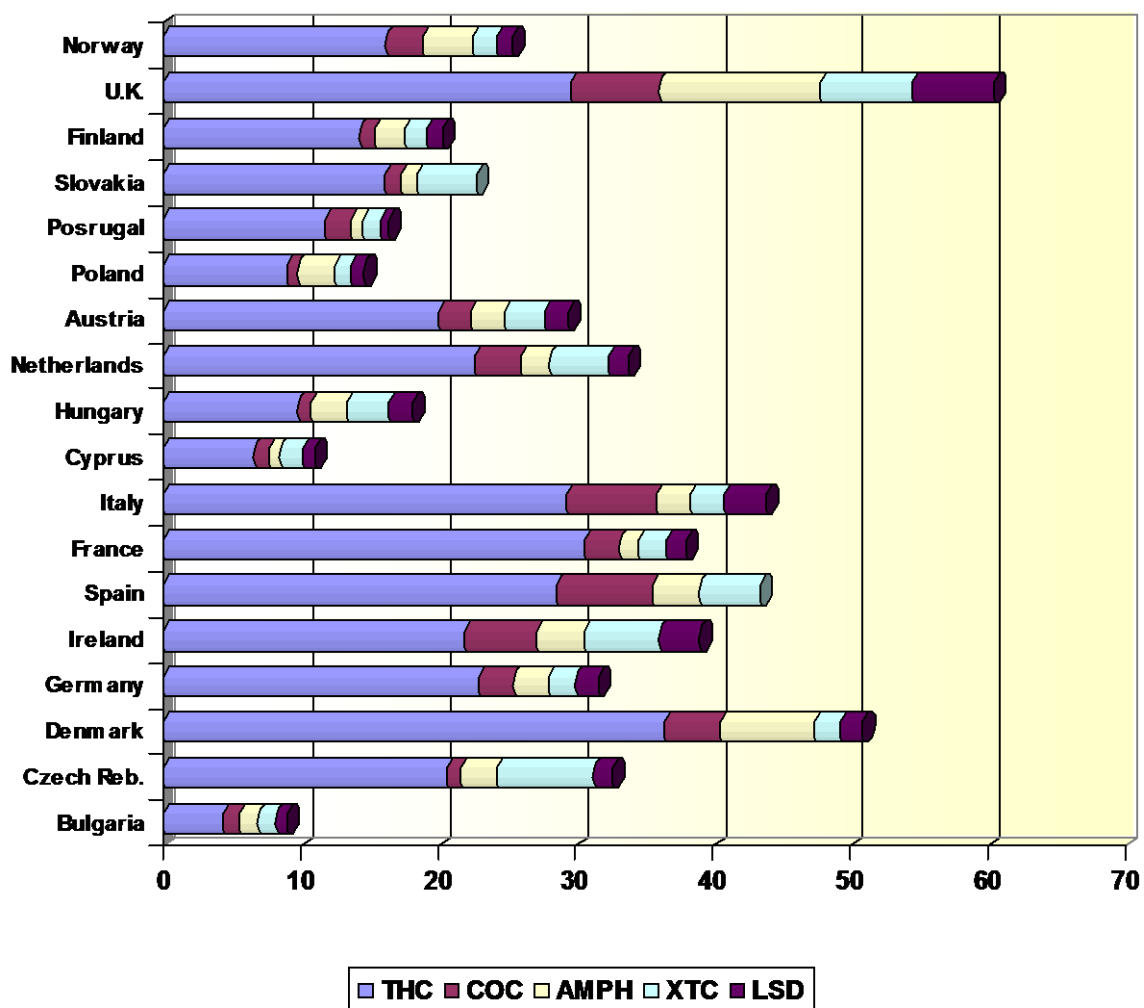
In Cyprus, cannabis is the most widespread illicit substance ever used by adults. However, the life-time prevalence for cannabis use in Cyprus is lowest among the majority of European countries (Figure 2). As regards the last year prevalence of cannabis use, Cyprus is with a reported prevalence of 2,1% comparable with European countries such as

Lithuania and Sweden, which as well have a rather low percentage of last year cannabis use.

Table 1. Prevalence (%) of the use of illicit drugs in the Cyprus general population [35].

Sample N = 3504	THC	XTC	AMPH	COC	HER
Life-time prevalence	6.6	1.6	0.9	1.2	0.9
Last year prevalence	2.1	1.0	0.4	0.6	0.4
Last month prevalence	1.4	0.6	0.3	0.4	0.3

Figure 2. Lifetime prevalence of illicit drug use in Europe [36].



The life-time prevalence of amphetamines is as well quite low compared to other European countries. In most European countries the life-time prevalence for amphetamines is 2-3 % [36]. As regards cocaine use the life-time prevalence in Cyprus is again low but comparable with many Eastern European countries such as Latvia, Estonia, Hungary,

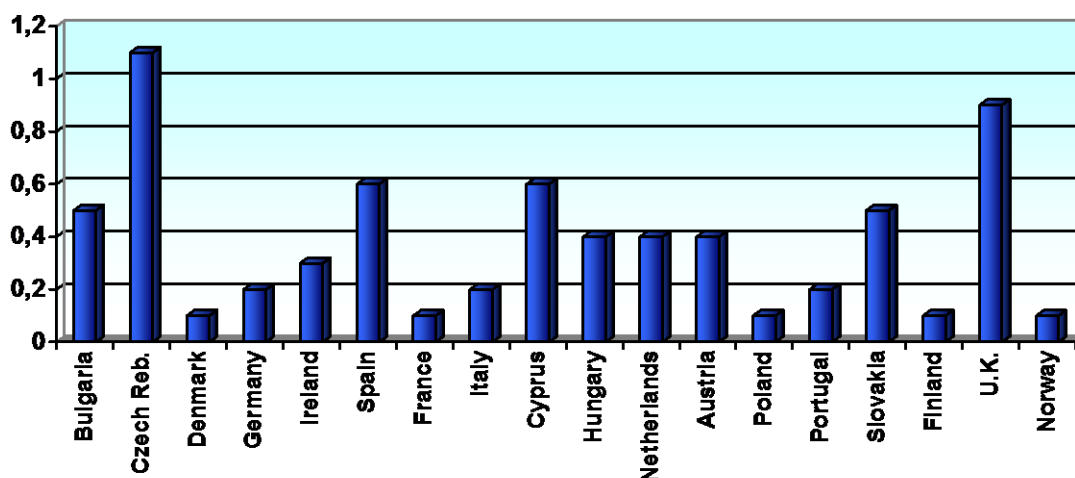
Slovakia, Bulgaria and with Finland [36]. A comparison of Cyprus to other European countries, regarding the life time prevalence of ecstasy and/or heroin is hard to assess. Firstly, the life-time prevalence for ecstasy varies considerable throughout Europe. Secondly, the EMCDDA provides no data on heroin use among the general population in Europe. However, in Cyprus the prevalence for heroin use is the same as for amphetamine use.

While the life-time prevalence of illicit drug use among the general population in Cyprus is comparable low, this turns somehow to the opposite if regarding the last month prevalence. The last month prevalence is one indicator for current drug use which also includes daily drug use. Some of the current drug users might develop a problematic drug use and are consequently a target group for drug services.

With regard to the last month prevalence of cannabis use, Cyprus ranks with 1,4% in the middle of Europe as the prevalence rates range from 0.8% (Sweden and Bulgaria) to 7.6% (Spain) [36]. This prevalence rate is similar to Eastern European countries such as Estonia, Hungary, and Poland. On the other hand, the last month prevalence reported in Cyprus for amphetamines, cocaine and in particular for ecstasy is considerable high. In the last month 0,3% of the Cyprus general population used amphetamines and only six out of 28 countries show a higher percentage [36]. With respect to the 0,4% prevalence of last month cocaine use in Cyprus, the data of the statistical bulletin of the EMCDDA (2006) indicate that only five countries are above this percentage. Finally, out of all European countries, the last month prevalence for ecstasy use in Cyprus is on top in Europe, topped only by U.K. and the Czech Republic with a prevalence of about 1% (Figure 3). Considering the high last month prevalence in Cyprus it can be assumed that those individuals with an experimental drug use at the beginning show a high likelihood to develop a problematic use of illicit drugs.

If calculating the number of individuals using illicit drugs in Cyprus on basis of the reported prevalence, the following appears: According to the Statistical Service of the Republic Cyprus in 2005 there were 532,800 inhabitants of age 15 to 64. Within this age group 35,165 individuals have ever tried cannabis, of them 7,495 used cannabis in the last month. 4,795 individuals have ever used amphetamines and the same number have used heroin. In the last 30 days 1,598 individuals used amphetamines and/or heroin. Cocaine has ever been tried by 6,394 individuals, and 2,131 reported the current use of cocaine in the last 30 days. Last not least 8,525 people ever experienced the use of ecstasy and 3,197 individuals used this substance in the last month.

Figure 3. Last-month prevalence of ecstasy use in Europe [36].



4. 1. 2. Prevalence of drug use in adolescents

The nationwide survey among the general population provides some data on the prevalence of the use of illicit drugs among the specific target group of adolescents and young adults [32]. In addition, there are data on the prevalence of illicit drug use among students from a European survey [37, 38]. The prevalence data of these two surveys are presented in the next table.

Table 2. Prevalence of the use of illicit drugs among youngest adults in Cyprus

	THC	XTC	COC	AMPH
Life-time prevalence (%)				
- age 15-24*	6.9	2.1	1.4	0.9
- age 15-16**	4.0	2.0	0	1.0
Last year prevalence (%)				
-age 15-24*	3.6	1.3	1.0	0.5
-age 15-16**	3.0	n.a.	n.a	n.a
Last month prevalence (%)				
-age 15-24*	2.0	0.8	0.4	0.4
-age 15-16**	2.0	n.a	n.a	n.a

* The data refers to the general population survey conducted in Cyprus in 2006 [35]. A subgroup of 1.753 people aged 15 to 35 years has been analysed separately in the survey. Unfortunately the concrete sample size of the age group 15-24 was not provided.

** The data refer to the 2003 European School Survey Project on Alcohol and other Drugs (ESPAD) study which focussed on students born in 1987. In Cyprus 2152 students participated in the study with a response rate of 88%. According to the authors the results show a national representativeness of 74% [38].

First of all the results show that amphetamines do not play any role among young adults in Cyprus. Unlike other European countries in Cyprus only about 1% of the students reported any amphetamine use during their life.

In Cyprus the most prevalent illicit drugs among young adults are cannabis followed by ecstasy. Almost 7% of the young adolescents ever tried cannabis and more than half of them experienced cannabis at age of 15 to 16. However, compared with other European countries the cannabis life-time prevalence of the young adults (15-24) and students (15-16) is at the lowest level. In most European countries 20-40% of the young adults and 15-30% of the students ever tried cannabis [36]. A similar picture is to be observed as regards the last year and the last month prevalence of cannabis use in Cyprus. Again the prevalence rate for cannabis use is rather low in both age groups compared with other European countries. With regard to the last year cannabis use only Greece shows the same low prevalence, while the last month prevalence in Cyprus is similar low to Lithuania and Greece.

About 2% of young adults in Cyprus have ever experienced ecstasy. Again, this life time prevalence is quite low. According to the ESPAD, six of the European countries show as well a life-time prevalence of ecstasy use at 2% (such as Denmark, Greece, Sweden, etc.). However, in most countries more than 3% of the students ever tried ecstasy. With regard to the last year prevalence of ecstasy, the Cyprus young adults of age 15-24 show a prevalence rate of 1,3%, which is again quite low compared to many other European countries. This picture turns to the opposite when regarding the last month prevalence of ecstasy use. In most European countries the use of ecstasy in the last 30 days is less widespread than the 0,8% found in Cyprus. Thus in Cyprus a relevant number of young adults seem to be current ecstasy users, similar to those in Denmark, Germany, Ireland, and Poland.

As regards cocaine use, the ESPAD study does only provide data on the life-time prevalence among Cyprus students at age of 15-16, but not on the last year and last month prevalence. According to the results, none of the students was found to have ever used cocaine. Among young adults of age 15 to 24 the life time prevalence of cocaine use was 1,4%, which is on a quite low level. In Europe, most of the younger adults show higher rates of cocaine use, with lifetime experience reported by between 2% and 10% [36]. A similar picture is to be found regarding the last year prevalence, as in many countries 2-5% of the young adults used cocaine in that period. However, when comparing the last month prevalence, a considerable number of the Cyprus young adults show current cocaine use. In

Europe, about half of the countries reported a last month prevalence for cocaine below 0,4%, while another half of the countries is above the percentage of Cyprus.

4. 1. 3. Prevalence of problem drug users

Data regarding the number of problematic drug users is always of substantial importance in order to assess the population in need. Available estimations on the prevalence of problematic drug use base upon the data of treatment demand, which reflects the number of drug users requesting treatment during one year. According to this, the estimations on the number of problem drug users are made by extrapolating the clients requesting treatment on the general population of age 15 to 64. The data presented in the table below refer to the years 2004 to 2006 as reported by the Cyprus NFP. However, as the estimation base upon limited treatment data, the given prevalence of problem drug users has to be treated with caution and might represent an underestimation.

Table 3. Estimated number of problematic drug users (PDU) in Cyprus

Population of age 15-64	Number of clients
PDU in 2004*	949 (734-1269)
PDU in 2005**	692 (548-909)
Heroin injectors in 2005***	543 (426-727)
PDU in 2006****	801 (684-966)
Heroin users in 2006****	607 (512-747)
Heroin injectors in 2006****	473 (400-582)

* The number is reported by Stylianou and refers to the data of 2004 [39].

** The data is provided by the 2006 NFP Report to the EMCDDA [40].

*** The number refers to all clients that entered treatment in 2006 in any available drug facility.

**** The number is provided by the 2007 NFP Report to the EMCDDA [31]

With respect to the number of problem heroin and cocaine users among the Cyprus population aged 15-64, the Cyprus NFP recently updated the national estimation. Based on treatment demand data it is estimated that in Cyprus there were 684 to 966 problem users of heroin and cocaine in 2006 [31]. Heroin problem drug users constitute the main group among the problem drug users with about 512 to 747 individuals. The central estimate for problem heroin and cocaine users is 801, and the central estimate related solely to problem

heroin users is 607 [41]. About 78% of these heroin users mainly inject this substance. Based on the central estimate 0,14 % of the Cyprus population aged 15 to 64 are problem users of heroin and/or cocaine.

4. 1. 4. High risk drug use patterns

In Cyprus, intravenous use is the main route of administration among heroin users in treatment. However, since the last three years heroin injection has decreased from 85.5% in 2003 to 71.7% in 2005. On the other hand, 2005 intravenous use of cocaine was observed for the first time in 8.3% of all cases [40]. In comparison with other European countries the current heroin injecting among treatment clients is on the highest level, similar to countries such as Czech Republic, Latvia, Lithuania and Bulgaria [41].

With regard to high risk drug use patterns, a major concern is related to needle-sharing behaviour. The most recent report of the Cyprus NFP mentioned an increase of drug users that have ever shared needles from 12,5% in 2004 to 14,7% in 2005. However, compared to other European countries the prevalence of needle-sharing is low. According to a survey in the French community in Belgium 40% of the injecting drug users reported ever having shared syringes and needles [42]. In Ireland a survey among homelessness showed that 53% current injectors reported sharing injecting paraphernalia in the previous four weeks [43]. In Greece 31% of the treatment clients with last month drug injecting admitted sharing needles [44].

Nevertheless, increasing risk behaviour is a clear indication for the need to provide low-threshold access to clean needles and syringes. This is in particular the case in Cyprus, as the increase of needle-sharing is attributed to difficulties in needle and syringe accessibility. Needle and syringe exchange programmes have been found to be effective in reducing risk behaviour and preventing the transmission of infectious diseases among intravenous drug users [43].

4. 1. 5. Specific target groups

a. Cocaine

Given the fact that in the general population about 2100 adults used cocaine in the last month and considering the fact that the proportion of cocaine users demanding for

treatment the first time almost tripled during six years, cocaine seems to become a future challenge for drug treatment services. According to available data cocaine users in drug treatment obviously have a different profile than heroin users seeking treatment [40]. Cocaine users in need for treatment are mainly female, have high rates of regular employment and tend to use cocaine occasionally. In fact, the proportion of cocaine users consuming cocaine on a daily basis decreased from 55% in 2004 to 44% in 2005. At the same time, the occasional use of cocaine with a frequency of about one time per week became more widespread. In Cyprus, cocaine users are not in a poor health and social situation, but nevertheless in need for drug treatment. Probably future outpatient treatment options are required addressing the specific needs of socially integrated cocaine users seeking for support.

b. Women

First of all the treatment data show that the vast majority of all treatment clients are male. As in previous years only 13.5% of the clients are women (see chapter 4. 2. 4.). A similar low rate of women in treatment is only to be observed in Italy [36]. Even though there is no information on the gender relation of the problem drug users, it can be supposed that in Cyprus more than 13-15% of the problem drug users are women. This presumption is supported by fact that there is a noticeable increase of young female drug users at age of 15 to 19 demanding for treatment for the first time. According to the most recent report the proportion of first treatment young women increased from 17% in 2003 to 36.8% in 2005 [40]. However, despite this trend, women seem in general not much attracted by the current drug services. Regarding women drug users in Cyprus being more disadvantaged considering socio-economic recourses, services need to be more tailored to the needs of young women in order to meet their specific needs.

c. Adolescents

Adolescents with primary use of cannabis have become a growing target group of the Cyprus drug services. In particular cannabis users of the age group 15-19 years seem to constitute the major group among cannabis clients in treatment. The more cannabis users become older the less they seek for treatment. In Cyprus, there has been a significant increase in 15-19 year old cannabis users who made use of treatment for the first time from 7% in 2003 to 31% in 2005.

d. Other specific groups

Even though professionals from the Cyprus drug services consistently pointed out that migrants constitute a significant group among the treatment clients, there is almost nothing known about the seize and characteristics of migrants using illicit drugs. Similarly there is not much information about the health status and prevalence of infectious diseases like hepatitis and HIV among the problem drug use population. Available data on infectious diseases only base upon tested treatment clients, missing however the most clients not been tested at all. Consequently the available data is not really representative.

In conclusion, the increase of cocaine users, young female drug users and young cannabis users in treatment reveal the need to provide specific drug help offers for these specific target groups. Currently, a treatment for adolescent cannabis users is available, but none for women and cocaine users. For this reason drug service require to become more gender sensitive in future. Probably there might as well be the demand to design women-specific treatment options addressing in particular young women. Furthermore it can be assumed that there will be also the need to create target group specific treatment offers for cocaine users as well as for migrants as they constitute a considerable proportion among treatment clients.

4. 1. 6. Summary of findings

- **General population and adolescents:** In Cyprus the use of any illicit drug is not much widespread among young adults and in particular not among adolescents of age 15 to 16. As of this age group only a small number have used cannabis in the last month, it can be assumed that only some of them might be at risk of problematic use. Thus, the target group for drug services will mainly be those older than 17. With regard to populations in need the current use of cannabis, heroin and cocaine is of major interest.

While the life-time prevalence of illicit drug use among the general population in Cyprus is comparable low, this turns somehow to the opposite if regarding the last month prevalence. The last month prevalence is one indicator for current drug use which includes as well daily drug use. In the last 30 days 1,4% of the population reported cannabis use which is still rather low compared to other countries. But the last month prevalence reported in Cyprus for amphetamines, cocaine and in particular for ecstasy is

considerable high as only few countries are above this percentage. In particular, the last month use of ecstasy is on top in Europe.

According to the general population data it can be assumed that in particular cannabis user at age 17+ need a specific service tailored to their needs. In addition, the high number of individuals using ecstasy gives reason to consider specific offers for party drug users such as information and advice. In view of the considerable prevalence reported for current cocaine use actions might be needed to address this target group with specific treatment such as behavioural therapy.

Table 4. Summary of the main drug prevalence data in Cyprus (2007) [36].

Prevalence (%)	THC	XTC	AMPH	COC	HER	LSD
Life-time prevalence						
-Age 15-64	6.6	1.6	0.8	1.1	0.9	0.9
-Age 15-34	9.9	2.4	0.8	1.4	-	1.0
Last-year prevalence						
-Age 15-64	2.1	1.0	0.4	0.6	0.4	0.5
-Age 15-34	3.4	1.3	0.3	0.7	-	0.5
Last-month prevalence						
-Age 15-64	1.4	0.6	0.3	0.4	0.3	0.3
-Age 15-34	2.1	0.8	0.3	0.4	-	0.3

- **Problem drug users:** Due to the fact that heroin users represent a considerable proportion of the treatment clients, even though there is no substitution treatment available, the treatment coverage in Cyprus appears to be very high. However, as the number of heroin users in treatment is continuously decreasing, the current drug services might improve their attractiveness for this target group by introducing substitution treatment. Substitution treatment will result in an extension of outpatient programmes and provide a harm reduction intervention, which could enhance a more efficient outreach for high-risk problematic opiate users.
- **High risk drug users:** In Cyprus, intravenous use is the main route of administration among heroin users in treatment and in comparison with some other European countries the current heroin injecting among treatment clients is on the highest level. With regard to high risk drug use patterns, a major concern is related to needle-sharing behaviour, which is however low compared to other European countries. Nevertheless, increasing risk behaviour is a clear indication for the need to provide low-threshold access to clean

needles and syringes. Needle and syringe exchange programmes have been found to be effective in reducing risk behaviour and preventing the transmission of infectious diseases among intravenous drug users.

- **Specific Groups:** Considering the increasing demand for treatment due to cocaine use, cocaine seems to become a future challenge for drug treatment services. Cocaine users in need for treatment are mainly female, have high rates of regular employment and tend to use cocaine occasionally. Probably future outpatient treatment options are required addressing the specific needs of socially integrated cocaine users seeking for support.

The treatment data show that the vast majority of all treatment clients are male, as in previous years only 13.5% of the clients are women. However, there is a noticeable increase of young female drug users at age of 15 to 19 demanding for treatment the first time. According to the most recent report the proportion of first treatment young women increased from 17% in 2003 to 36.8% in 2005. Nevertheless, despite of this increase, women seem in general not much attracted by the current drug services.

Adolescents with primary use of cannabis have also become a growing target group of the Cyprus drug services. The Cypriot addiction services have seen a significant increase in 15-19 year old cannabis users who made use of treatment for the first time, so that in particular cannabis users of the age group 15-19 years seem to constitute the major future group among cannabis clients in treatment.

In conclusion, the increase of cocaine users, young female drug users and young cannabis users in treatment reveal the need to provide specific drug help offers for these target groups. Currently there is treatment available for adolescent cannabis users but none for women and cocaine users. Furthermore it can be assumed that there will be also the need to create target group specific treatment offers for migrants as they constitute a considerable proportion among treatment clients

4. 2. Drug treatment system coverage and utilization

4. 2. 1. Overall system utilization

The treatment demand data provides yearly information on the overall number of drug users entering the existing treatment services. During the year 2006, altogether 560 individual drug users requested drug treatment (Table 5). This number adds up to 802, when including double counting for clients requesting treatment for several times, which also reflects the treatment demand in the system. In consideration that the treatment system has expanded in recent years, the data shows more or less a steady rise of drug users that make use of drug treatment. From 2004 to 2007 the overall number of treatment clients increased from 450 to 778, which correspond to an increase of 75 % within four year (Figure 4).

In relation to the estimated number of problem drug users the current drug services in Cyprus reach about 59% of this population by counselling, detoxification and outpatient- and inpatient treatment services. Due to the fact that heroin users make a considerable number of the treatment clients, even though there is no substitution treatment available, the treatment coverage in Cyprus appears to be very high. In fact, also countries with a well established drug treatment system – such as Germany, the Netherlands, the U.K. and Spain – show coverage rate of 39% up to 49% if only considering those clients in substitution treatment*. However, as the number of heroin users in treatment is continuously decreasing, the current drug services might improve their attractiveness for this target group by introducing substitution treatment. In many European countries substitution treatment is the major approach to deal with opiate dependence. In Cyprus the introduction of substitution treatment is supposed to have several benefits for both the clients and the drug services. Substitution treatment will results in an extension of outpatient programmes and provide a harm reduction intervention which contributes to reach high-risk problematic opiate users to improve their health and to stabilise their social situation.

The comparison of non-governmental and governmental treatment services reveals a similar increase of clients in both kinds of services. However, until 2006 the majority of

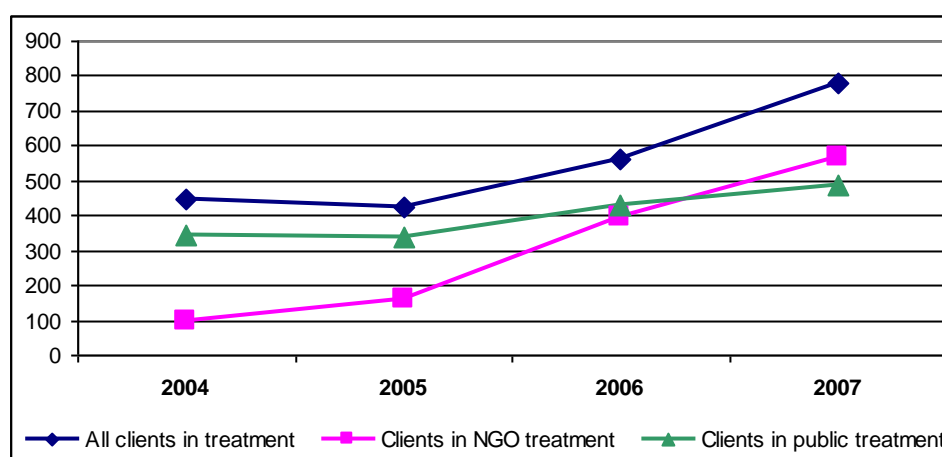
* The number of clients in substitution treatment has been chosen because this data is more reliable and valid than any other client data. For the number of clients in substitution treatment see [36]. For European countries, a calculation of the rate of clients in treatment in relation to the estimated number of problem drug users is also to be found in [46].

drug users entered governmental drug services, while in 2007 the opposite is the case (Figure 4). In the period 2004 – 2007 the following yearly number of clients made use of public drug services: 345, 341, 430 and 486. In the same period the yearly number of clients in non-governmental drug services was: 98, 158, 396 and 567. The differences found in 2006 and 2007 might be due to an enlarged monitoring of clients, as in both years clients of the “Veresies Clinic” have been included in the NGO treatment data. In addition, in the year 2007 only few clients treated in public psychiatric hospitals have been included in the data on public drug treatment.

Table 5. Characteristics of the treatment clients in 2006 [40].

	Governmental	NGO	Total
Number of clients	245	315	560
Mean age	27,1	28,6	28
Gender of clients -male in %	81.2	91.4	87.0
Treatment experiences			
- ever treated before (%)	58.0	60.2	59.2 (n=330)
- first treatment (%)	42.0	39.8	40.8 (n=227)
Years of use of the primary drug	6,2	7,1	6,7

Figure 4. Number of clients in drug treatment from 2004-2007 [31].

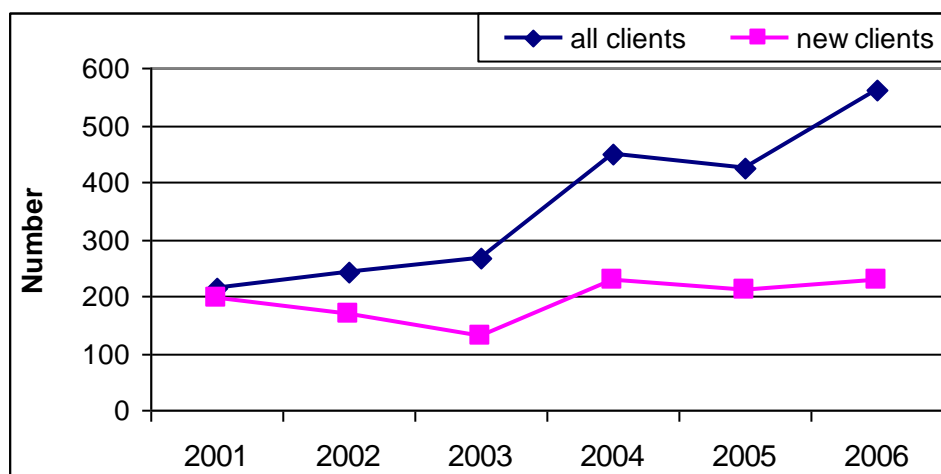


4.2.2. New clients entering treatment

The treatment demand indicator (TDI) measures the number of clients entering treatment for their first time. Figure 5 shows the trend in the number of all and new clients for the period of 2001 to 2006. According to the figure, in the year 2001 almost all clients of the Cyprus drug services had been new clients. New clients refer to those who have never been previously treated. It remains unclear if this data present an artefact, as new clients have been documented separately for the first time in 2001. During the following years further drug services had been established which results in a change of the clients entering treatment. The trend shows that almost half of the clients entered treatment for their first time. In addition, the overall number of clients increased parallel to the increase of drug services. As the number of all clients has increased, the number of drug users must have been increased as well.

Drug addiction is a chronic dysfunctional behaviour, which usually lasts years. Thus, an increasing number of drug users never been treated before indicates a growing drug problem. Nevertheless, it can be assumed that the number of clients still represent a low boundary, as the drug treatment system is not fully established up to now. If the drug services will be further developed and diversified – in particular as regards the introduction of substitution treatment and low-threshold services – the number of clients requesting treatment might further increase.

Figure 5. Trend in the number of clients in treatment in Cyprus*

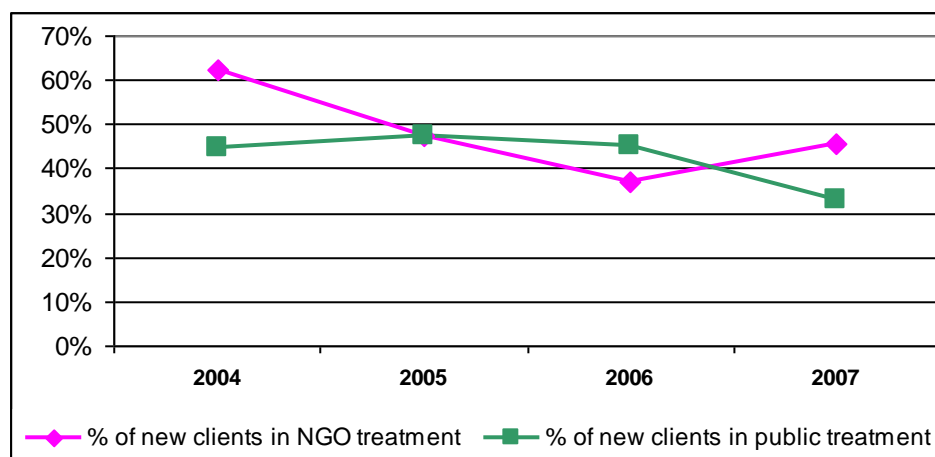


*The 560 clients in 2006 include previously treated, as well as new clients.

Double-counting of clients entering treatment repeatedly has been excluded.

In general, each year more than 30 % of the clients entered treatment for their first time. Figure 6 presents the proportion of new clients among all clients that made use of NGO treatment and public treatment respectively. When comparing NGO treatment services and public treatment services it becomes obvious that proportion of new clients differs considerably in the four-year period of 2004 to 2007. While in 2004 the majority of 62 % of the clients of NGO services were new clients their number decreased in 2005 and 2006 to 37 %. Compared to the NGO first treatment clients the proportion of the new clients of the governmental treatment services appears to be more stable. In the years 2004 – 2006 the yearly percentage of new clients in public treatment was between 44 % and 47 %. In 2007, the proportion of new clients decreased to 33 % in governmental treatment services and increased to 46 % in non-governmental treatment services. The number of clients that enter treatment for the first time is on the one hand an indicator for the acceptance and attractiveness of certain treatment services. On the other hand it also allows an assessment of treatment continuation and thus of treatment retention. In this respect, the data on first treatment entry suggest that non-governmental treatment services may be more likely to attract new clients whereas governmental treatment services tend to have more clients that continue treatment.

Figure 6. Proportion of new clients among NGO and public treatment clients.



4. 2. 3. Drug using profile of clients in treatment

For assessing the population in need for drug treatment it is not only important how many of the problem drug users are reached, but also what kind of drug users are reached by the community drug services. First of all, the available data show that in 2006 opiates

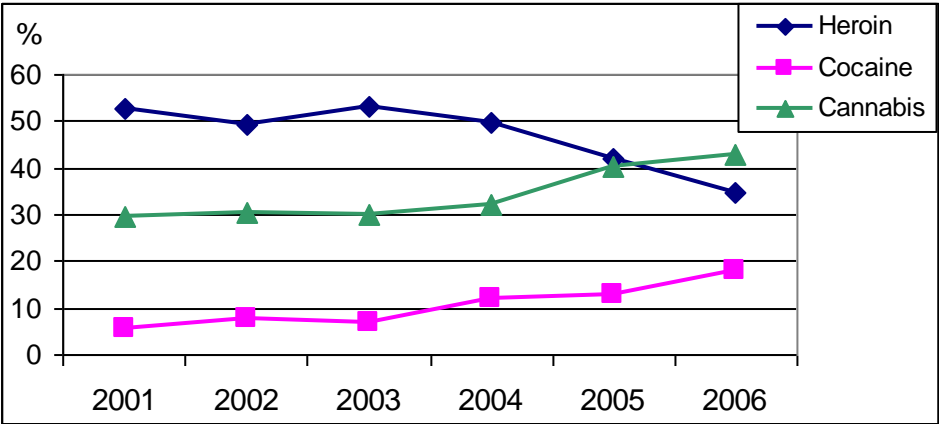
were in 56,8% of all clients the substance primary used (Table 6). Thus, heroin users represent the main client group seeking drug treatment. Cannabis users are the second main client group, accounting one fourth of all clients, followed by cocaine users. However, out of all estimated problem heroin users approx. only 45% made use of drug treatment services.

Table 6. Percentage of clients as related to the main drug of use (2006) [37].

Main drug of use	HER	THC	COC
Percentage (%) of new clients entering treatment	35.7	43.3	17.9
Percentage (%) of all clients entering treatment	56.8	24.1	15.9

As regards the clients making use of the Cyprus drug services, the data on new clients entering treatment indicate a specific trend over the last years (Figure 7). The six-year comparison shows an increasing tendency of new clients with a primary use of cannabis and cocaine seeking help. During this period the number of news clients with primary use of cannabis increased from about 30% in 2001 to about 43% in 2006. An even stronger increase is to be found in new clients with primary use of cocaine, as this proportion more than tripled within six years (from 5.6% to 18%). At the same time there is a considerable decrease of opiate users demanding for treatment the first time. Their proportion decreased from almost 53% in 2001 to 35% in 2006. With respect to the primary use of opiates and cocaine, a similar tendency is found among all clients in drug treatment.

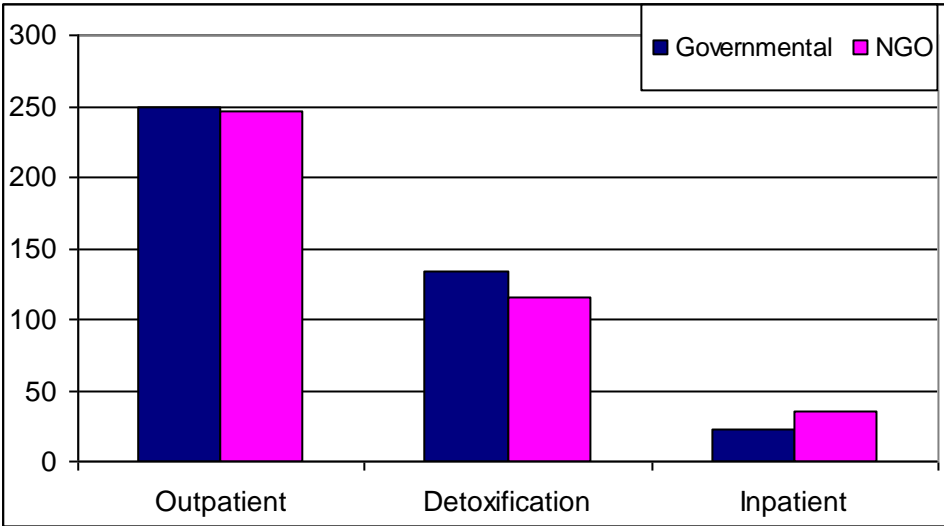
Figure 7. Primary drug used by new clients entering treatment [40].



On basis of treatment demand, the demand proportion directed to outpatient, inpatient and to medically assisted treatment was analysed (Figure 8). As expected, the

majority of all treatment demands concern outpatient psychosocial interventions. Out of 802 treatment demands 496 (62%) of them are directed towards receiving outpatient treatment. A considerable number of the demands for treatment were directed at detoxification. Nearly one third of all requests for treatment targeted at attending detoxification treatment. Inpatient psychosocial drug treatment does not play an important role at all, as only 57 (7%) of the treatment demands addressed the participation in this kind of treatment. There are no further differences in the treatment demands directed to governmental and NGO facilities worth mentioning.

Figure 8. Treatment demands (n=802) according to kind of requested drug service [40].



A comparison of the client’s percentage regarding the main drug of use in NGO and governmental treatment shows quite similar results regarding the primary drug use (Figure 9). In both treatment organisations more than 50% of the clients primarily use heroin, while NGOs appear slightly more attractive for treatment. Primary heroin use is followed by primary cannabis use and thereafter by cocaine. When examining the details, it becomes apparent that the clients differ in their primary use of cannabis and cocaine. Cannabis and cocaine users seem to be more likely to enter governmental drug treatment rather than non-governmental treatment. However, in 2007 the number of clients with primary use of cannabis has increased in both treatment organisations by about 10 % compared to the preceding year.

With regard to high risk drug use patters, the proportion of clients that ever injected drugs is analysed (Figure 10). Compared to governmental facilities, less clients requesting treatment in NGO facilities reported intravenous drug use. However, the highest proportion

of clients with i.v. use is found in detoxification units and inpatient psychosocial treatment: in these treatment programmes 77-83% of the clients affirmed to have injected drugs [40].

Figure 9. Primary drug used by the treatment clients [40].

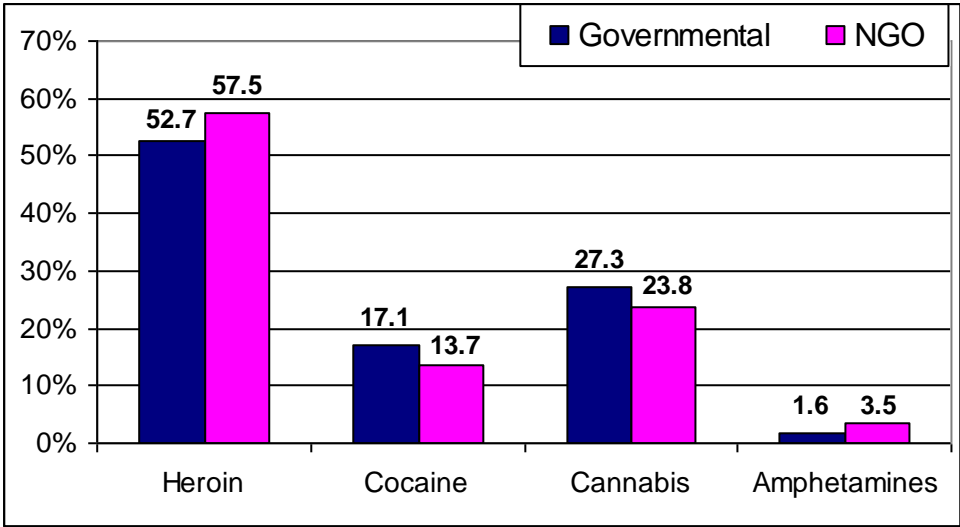
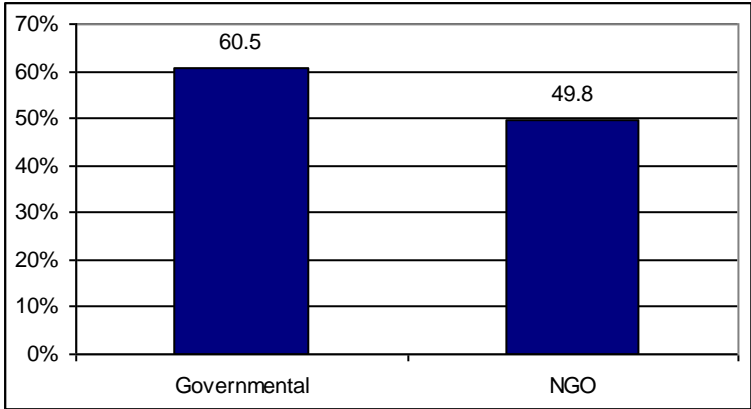


Figure 10. Proportion of clients that have ever injected [40].



With respect to the proportion of new clients seeking treatment for the primary use of cannabis, it can be concluded that the Cyprus drug services reach a high number of cannabis users. The number of new clients treated for cannabis problems represents a very high level among European countries [36]. If the tendency of increased demand for treatment due to cocaine use will remain in future, specific treatment options for this target group should be considered. On the other hand, the decrease in new clients seeking treatment due to heroin use does probably not indicate a reduction of the number of problem heroin users, but reflects the lack of adequate treatment options such as substitution treatment. Available data from the year 2005 [40] reveals that the mean

duration of heroin use has increased from 10.6 years in 2004 to 11.6 years in 2005. Consequently most of the heroin users are long-term drug addicts with specific treatment needs. In most European countries the majority of heroin users are mainly treated with outpatient substitution treatment. For instance, in Germany there had been more than 70,000 clients in substitution treatment in 2003 which corresponds to 39-49% of the problem drug users. In Ireland about 8,000 clients had been in substitution treatment in 2003 which accounts for 52-61% of the problem drug users [43]. Thus, the data clearly indicates the high impact of substitution in the treatment of opiate users.

4. 2. 4. Data on age, gender and nationality

For the years 2006 and 2007 the data on gender, mean age, nationality and main drug of use of clients in treatment are assessed. Regarding all clients in general, the data clearly shows that the vast majority of more than 87 % of the clients is male. Women are significantly underrepresented in drug treatment as they constitute only about 9 – 13 % of the drug users in treatment.

The following figures show the characteristics of the clients differentiated for NGO and governmental treatment services (Figure 11, 12). As regards the male-female ratio among the treatment clients the data reveal that male drug users are the dominant group in both NGO and governmental treatment services. Even though only very small numbers of women drug users are reached with the existing drug treatment services, governmental drug treatment seems to attract slightly more women than NGO drug treatment services; female clients make 9-15% of the governmental treatment clients whereas in NGO treatment 8-9% of the clients are female.

Drug users attending treatment are on average between 23 and 30 years old. In 2006 female treatment clients tend to be almost three years younger compared to male clients (25.8 years vs. 28.5 years). In 2007 the differences in age became less apparent as women were no more than one year younger than men (28.1 years vs. 29.2 years).

There are no differences in the age of male clients that enter NGO or governmental drug treatment. Differences in age are only to be found among the female clients. While the women drug users reached by NGO drug services tend to be at a similar age than the male clients, women drug users reached by governmental drug services are about three years younger than male clients. In addition, the female clients of governmental drug services are also considerably younger than the female clients of NGO drug services. Public drug

treatment services seems to be more attractive to young women drug users than NGO treatment.

Figure 11.

Number of clients according to gender.

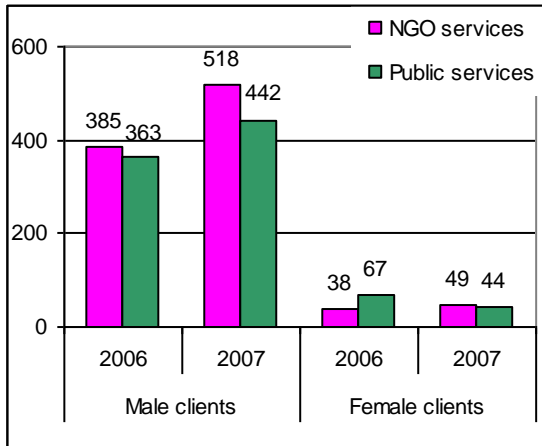


Figure 12.

Mean age of male and female clients [40, 41].

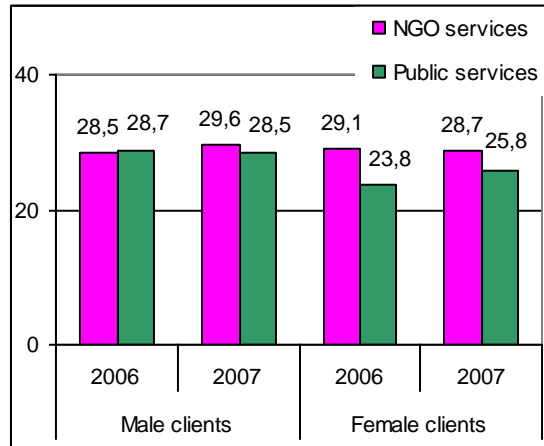
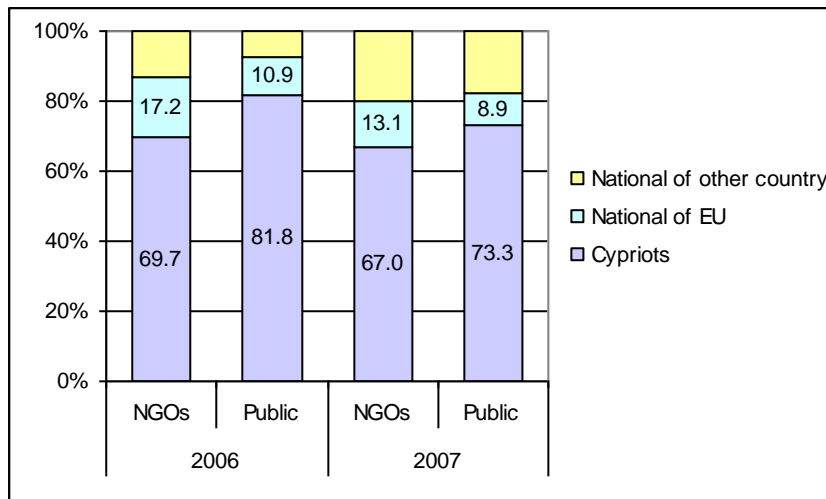


Figure 13. Nationality of the clients in NGO treatment and public treatment [40, 41].



In Cyprus, the majority of at least 67 % of all clients are Cypriots. Figure 13 presents the proportion of clients according to their ethnicity, as well as some trends worth mentioning. First of all, the number of clients from other countries than Cyprus has increased from 2006 to 2007. Secondly, the proportion of foreign clients from non-EU States has also increased. These tendencies are to be found in NGO services as well and in public services. However, compared to public services clients from other countries than Cyprus are more often entering non-governmental drug services. More than 30 % of the

clients in NGO drug treatment in 2007 are national of foreign countries, while 20 % of them came from non-EU countries. This fact may as well reflect certain difficulties in the treatment procedure of non-Cypriots by the governmental facilities.

4. 2. 5. Summary of findings

According to the most recent national estimation in Cyprus, there are 801 problem heroin and cocaine users. This central estimate corresponds to 0,14 % of the Cyprus population aged 15 to 64. A calculation of the treatment coverage, which is based on the number of problem heroin and cocaine users and the number of clients in treatment for primary use of heroin and cocaine, highlights that the majority of problem drug users is reached by the existing treatment services. In fact, in 2006 about 59% of problem heroin and cocaine users attended drug treatment, and in 2007 this was the case for about 70%.

The increased availability of differentiated drug treatment services resulted in a growing number of drug users entering treatment. From 2004 to 2007 the overall number of treatment clients increased by 75 %, up to 778 clients in 2007. The trend shows that almost half of the clients entered treatment for their first time. If the drug services will be further developed and diversified – in particular as regards the introduction of substitution treatment and low-threshold services – the number of clients requesting treatment might further increase.

The available data show that in 2006 opiates were in 56,8% of all clients the substance primary used. Thus, heroin users represent the main client group seeking drug treatment. Cannabis users are the second main client group, followed by cocaine users. Drug users in need for treatment predominately request for outpatient psychosocial interventions and about one third asks (also) for detoxification treatment.

If comparing the clients of NGO drug treatment services with those of governmental treatment services some trends and tendencies became apparent. Governmental drug treatment services tend to attract a stable portion of 44-47 % clients who enter treatment for their first time. Even though women are significantly underrepresented in drug treatment with 9-13 % of the clients, governmental treatment services seem to attract slightly more women than non-governmental drug treatment services. In addition governmental drug services are more likely to reach young women and users of cannabis and cocaine.

In addition, clients from other countries than Cyprus are more likely to enter NGO treatment services. More than 30 % of the clients in drug treatment of non-governmental

services are national of foreign countries. Differences in the characteristics of NGO clients and public treatment clients only indicate slight trends in this area.

4.3. Realisation of drug services in Cyprus

The realisation of drug services in Cyprus will be basically investigated along three questions: What kind of legal framework has been established in Cyprus to put drug services into action? Which are the responsible bodies to implement and coordinate both the establishment and further development of drug services? Which drug services are currently available and do these services meet the relevant requirements formulated in the Cyprus Action Plan on Demand Reduction?

By considering the legal framework, implementing and coordination procedures and the current provision of drug services, it will be assessed how the Cyprus drug treatment system responds to the needs of the population of problem drug users. In addition, this assessment enables to identify gaps in current provisions of drug services. The results of the assessment will be the basis for recommendations for the improvement of drug treatment.

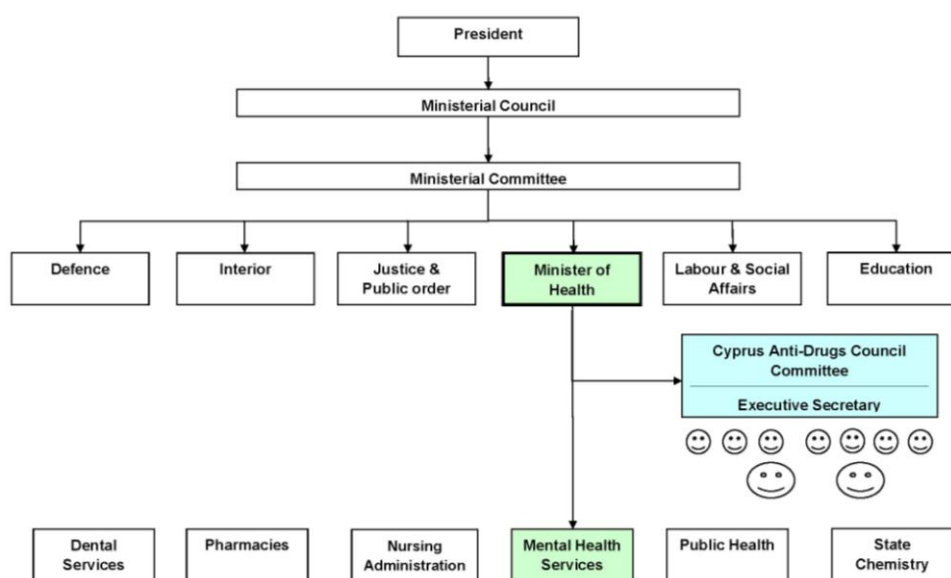
4.3.1. Legal framework

Since May 1st 2004 Cyprus is a full member of the EU. Regarding drug policy, the process to full integration required the harmonisation with the methods and principles of the European Strategy on Drugs. Accordingly the “Law on the Prevention of the Use and Dissemination of Narcotic Drugs and Other Addictive Substances” was enacted in 2000, which led to the establishment of the Cyprus Anti-Drugs Council (CAC). Specific regulations within the aforementioned law also provide for the creation of the Cyprus Monitoring Centre for Drugs and Drug Addiction (EKTEPN – NFP).

4.3.1.1. The Cyprus Anti-Drugs Council

The CAC was established with the aim to create an organisation for the monitoring of the implementation, coordination, of the Cyprus Drug Strategy. The CAC lies under the jurisdiction of the Ministry of Health and is financed by this Ministry. The Council is the supreme coordinating body in the field of addictive substances, and in this function responsible for the coordination of governmental as well as non-governmental addiction services.

Figure 14. Organisation chart of the political bodies in Cyprus



The Cyprus Anti-Drugs Council consists of the board itself with nine members and an Executive Secretariat. According to legal requirements, the members of the CAC are appointed by the Ministerial Council for a period of three years. The CAC is chaired by the Minister of Health who fulfils the function as the president of the CAC. The president of the Cyprus Youth Board plays also a significant role as the vice-president. In addition, seven experts are appointed as members of the board. Their nomination is based upon their scientific training and/or specialised knowledge or activities regarding prevention, treatment or rehabilitation of addicted persons. In the middle of 2007, some members represent governmental drug services (operated by the Mental Health Services), while other members belong to further professional areas, such as the Drug Law Enforcement and the NGOs. In order to reach political independency the board does not consist of political experts, but only of practicing experts from the current field. The members of the board meet twice per month.

The executive secretariat consists of the executive secretary and five officers who have expertises in the field and undertake tasks pertaining to the following areas: prevention, treatment, supply reduction and legal issues, international relations/cooperation and mass media/campaigns.

The Council shall have the following competencies and functions:

- To act as a liaison between the Republic of Cyprus and organisations abroad regarding the transmission of information on addictive substances, without affecting the competencies of other services.
- To develop and implement the National Drugs Strategy and the National Action Plan on Drugs, aligned with the EU Drugs strategy.
- To undertake the strategic planning of the national drug policy, and to promote, monitor and control its implementation.
- To encourage, promote, coordinate and evaluate drug treatment and prevention programmes in the public and private sectors.

The CAC is not responsible for the realisation of drug services and for the monitoring of the function of the services. However, it has an advisory function for the Ministry of Health in terms of recommendations. The CAC is obliged to submit every three months a report to the Ministry of Health in order to inform about procedures on suggested plans and their realisation.

The encouragement, coordination, monitoring and evaluation of treatment and prevention programmes is based upon specific legal regulations which imply that:

- All programmes drafted by public services and private sectors shall be submitted to the Council for processing, evaluation and approval.
- The Council shall elaborate the philosophical and methodological approach, as well as any guidelines and operation specifications, determining the objects and the activities of each programme.
- The Council may grant financial assistance to prevention, treatment and social reintegration as well as research and prevention programmes on its approval.
- Before being allowed to proceed with any programme, the respective person or organisations must secure the Council's approval of the programme. The approval shall be given according to procedures and criteria that the Council sets out by internal rules. Organisations which act without the authorisation of the CAC will be punished by law.

In praxis this last regulation is not respected, as organisations disposing the needed funding initiate new addiction services, without the permission of the CAC. Only the governmental facilities are cautious to act within the legal framework.

The Council is funded by an amount specially provided within the state budget. To receive this amount, the Council has to draft the annual budget regarding expenses

necessary to finance its activity. This is submitted to the House of Representatives and the Ministerial Council for approval and inclusion in the state budget of the Minister of Health.

The CAC has a small budget to support programmes either of the public or the private sector. Yearly there is an open invitation to apply for financial support. The application procedure is clearly defined, but improvements as to quantitative standards and criteria need to follow. Principally, the CAC gives a maximum of 30% of the applied budget demand. The financial support is only given for one year, a long-term budget does not exist. The budget is only provided for a specific programme, but not for infrastructural and organisation requirements. The programmes funded need to be assessed as appropriate and in line with the national drug strategy. In the year 2007 about 30-40 organisations have applied for funding and the funding budget reached 180.000 CYP. The financial support by the CAC is of existential meaning for the most NGO's.

Latest Developments:

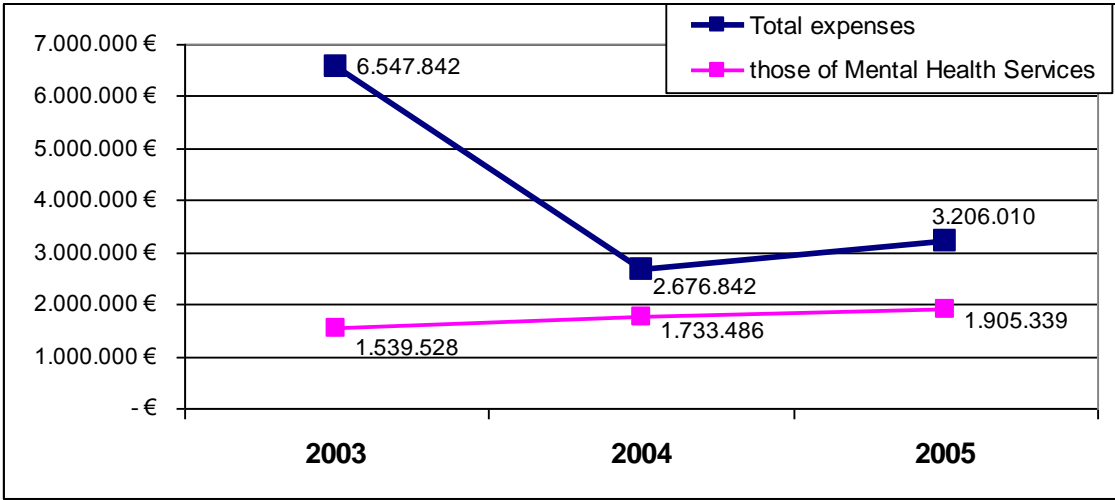
A new board - the Drugs Legislation Board - has been appointed by the CAC, in order to study and review the existing legislation on drug related issues. The suggestions of the Drugs Legislation Board shall promote contemporary legislative measures in order to enhance the effectiveness of the prevention of the use and dissemination of drugs. This Board consists of representatives from the CAC, the Ministry of Health, the Customs Office, the Law Office of the Republic, the Police and the Pharmaceutical Services. It has completed its work on the "Care and Treatment of Drug Addicts Law" of 1992, and it is currently working on the "Narcotic Drugs and Psychotropic Substances Law" of 1997. The Board's suggestions are forwarded to the Anti-Drugs Council, which shall meet decisions on further steps.

4. 2. 1. 2. Further relevant political bodies

First of all, it is of utmost importance that all drug-related decisions are made by the Cyprus Ministries; they are the executive bodies of the treatment system. The final decisions upon the establishment and introduction of public drug services are clearly made by the Ministry of Health. The Ministry of Health and the Ministry of Finances are responsible for the financial budget for all Mental Health Services. Financial support for drug issues was offered by several Ministries such as the Ministry of Education and Culture, Ministry of Health, Ministry of Justice and Public Order, Ministry of Defence, Ministry of Labour and Social Insurance, and the Cyprus Youth Board. All related

Ministries have their own budget for implementing their own actions. Yet, there is no clear structure of the distribution of the budget and indeed, the budget is not distributed according to the actual needs of the respective drug services. Even after specific articulation of the actual needs, these applications are often not being considered. The CAC can only recommend which kind of drug service should be developed and supported but the decisions are taken strictly by each Ministry.

Figure 15. Drug-related expenditures from 2003 to 2005 [37]*.



*The high amount of drug-related expenditures in 2003 is related to the establishment of the Cyprus Monitoring Centre for Drugs and Drug Addiction.

Apart from the CAC and the political decisions there are two further public institutions which are of significant importance for the organisation of the drug treatment services in Cyprus. These are the Mental Health Services and the Nursing Administration which are described below.

Mental Health Services

The Mental Health Services (MHS) is a network organisation whose responsibility is to offer effective care relating to treatment, rehabilitation and prevention of mental disorders. Especially the following aims and targets are pursued:

- Modernisation of therapeutic approaches on the basis of recommendations of the WHO and the EU.
- Further decentralisation community and socially oriented services throughout Cyprus.

- Promotion of a closer cooperation with other public services involved, especially with primary health services and the social welfare department.
- Further the involvement of the voluntary sector and generally of the community in the areas of psychosocial rehabilitation and prevention (especially in relation to drug addiction and domestic violence), as well as in the area of quality of life and mental health promotion.

During the last 20 years there is a clear tendency towards community-integrated care. The number of patients in clinics declined from 800 to 120 today. At present 35 psychologists are offering their service within the MHS, among them only 8 in the addiction field.

Basic services under the responsibility of the MHS are:

1. Hospital treatment which is offered in the psychiatric clinics of the Nicosia, and in the general hospitals in Limassol.
2. Outpatient clinic services which are offered in all district hospitals, in urban and rural health centres, and in community mental health centres.
3. Services at home such as community nursing and occupational therapy programmes.
4. Services for children and adolescents are offered in the Archbishop Makarios III Hospital in Nicosia and in the Limassol General Hospital.
5. Psychosocial rehabilitation services are offered mainly at the Day Centres in Nicosia, Limassol and Larnaca and at the Vocational Rehabilitation Centres.
6. Services for drug addiction related to alcohol, pills or other legal or illegal substances. These services cover – apart from others – the six governmental drug facilities which have been evaluated and are part of this report.

The governmental drug services report every three month through the director of the MHS to the CAC on their contribution to the national drug strategy. In addition, the governmental drug services submit a yearly report to the director of the MHS.

Nursing Administration

Objective of the Nursing Administration is to ensure the continuous quality improvement of the provision of nursing care. The nursing administration has become

autonomous and independent from the MHS, and lies now under the jurisdiction of the Ministry of Health.

Towards the goal of continuous quality improvement of provided nursing care, the following activities are promoted:

- Determination and application of nursing policy.
- Human resource management of nursing staff and auditing the quality of care.
- Improvement of the working environment.
- Recording and maintenance of necessary information in relationship to the staffing of Hospitals and Rural Health Care Centres.
- Planning and co-ordination of continuous professional development and specialized programmes.
- Development and re-evaluation of the examination system in relationship to acquiring and maintaining license to practice of the nursing profession.
- Co-operation with the School of Nursing so that there is a sufficient amount of graduates to cover the needs of the public and private sector.

During the course of the year, educational programmes are delivered for the nursing staff of all hospitals of the Republic of Cyprus. The issues of training programmes are selected according to the evaluation of the educational needs. Small duration scholarships are offered and participation in conferences and seminars, abroad and in Cyprus, are sponsored.

In Cyprus, there are about 400 psychiatric nurses who can be distributed all over the country. Of them 90 nurses have a specialised education in the field of drug and alcohol addiction, number regarded to be sufficient for the Cyprus needs. There is a special budget for the training of psychiatric nurses. The education's duration lasts two years and is absolved in Greece by KETHEA. The education level of the nurses in Cyprus is considered high in comparison to other European countries.

The nursing administration is also responsible for the 25 occupational therapists which are a new profession group in Cyprus. Their training is often absolved in Greece, England, Spain or Germany. Every two years a new application is required in order to continue offering occupational therapy. A specific training to gain qualifications and attitudes in the field of drug treatment is considered as necessary.

The high level of training for nurses and occupational therapists creates some difficulties in the practical work. A higher qualification results in a higher position which is

always focused in the administrative field. Thus, the contact to the clients is being interrupted, and the continuity of treatment undermined.

With respect to the legal framework and its related public bodies, it is important to mention the actors deciding on the staff for the addiction services. The decision on staffing lies in the responsibility of the Nursing Administration and the Minister of Health. All affairs considering number and qualification of staff, as well as their distribution to the single facilities are determined by a central organisation. The coordinators of the different facilities have no influence on the kind and number of staff employed in their facility. In addition, nursing staff has been under continuous rotation among several facilities existing in Cyprus. Decisions regarding rotation and staff planning have often been taken neither with consideration of the facilities structure plan, nor after discussion with the affected personal. Yet, there is a clear tendency towards a reduction of rotations in order to guarantee the effective staff planning of qualified personal in the governmental drug facilities. In the future, rotations shall only be undertaken by position upgrades or after application by the staff.

4.3.2. Coordination of drug services

As mentioned above the function of the governmental drug services lies under the responsibility of the Ministry of Health, while the coordination of all available drug services is the task of the CAC. In this chapter the focus is directed towards practical experiences on drug service coordination. Accordingly, the reality of the Cyprus addiction services' coordination and the difficulties towards an effective response to the drug situation are described.

The coordinating board "Synthesis" has the purpose of coordinating all concerns such as staff, qualification needs, target groups, financial planning, etc. of the six governmental facilities. Whereas the CAC plays a role in coordination of all existing drug services, the board "Synthesis" exclusively concentrates upon the six drug services operated by the MHS. This board also faces substantial difficulties in realising their coordination efforts. Both coordination organisations responded to their difficulties in coordination by modifying their structure during the first months of the twinning project.

4.3.2.1. CAC - coordination of the Cyprus drug services

As the national coordinating body of drug issues in Cyprus, the Council's mandate includes the planning, coordination and evaluation of all actions, programmes and interventions aimed at the primary, secondary and tertiary levels of drug prevention. It also has the responsibility for carrying out consistent research about the drug phenomenon in the country.

However, priority of the CAC remains the coordination of the activities within the National Drug Strategy. Furthermore, the control and monitoring of the realisation of the drug strategy remains somehow ineffective as the CAC has no power to enforce treatment services, and thus to decide how the Cyprus treatment system should respond to the demands of the drug policy. Consequently the CAC has a rather low status as it is responsible for the coordination, but not for the implementation of drug services. The CAC only performs an advisory function by giving recommendations to the Interministerial Committee. Even though the CAC was established as a political body, it is limited in their ability to act as political body. This limitation also becomes apparent by the fact, that the CAC has no say in the distribution of budget and staff to the different drug services.

As mentioned above, there is a specific law which obliged drug service providers to obtain permission from the CAC. However actually, drug programmes often started without any permission of the CAC, either because they did not depend on the funding of the Council or because of a lack of defined standards and rules towards the permission of the CAC. Up to now, contracts or other documents determining basic standards and tasks for operating a drug facility do not exist. The lack of defined operating conditions undermines the CAC's potential to fulfil their function of encouraging, coordinating, monitoring and evaluation of drug prevention programmes in the public and private sectors.

In order to improve their capability of coordinating and monitoring the drug treatment services existing in Cyprus, the CAC performs new tasks during the year 2007.

- By decision of the Minister of Health, the CAC develops a treatment profile covering all drug services existing in the private as well as in the public sector. Main purpose is the collection of data on each service, allowing a detailed description of the different types of drug treatment available in Cyprus.
- A process started towards the development of standards and guidelines for drug treatment and prevention, defining accreditation procedures for the introduction of new

programmes. The standards will include defined criteria regarding staff, qualification and procedures of treatment centres.

At the structural level, the position of the CAC as a supreme coordinating body is interlinked with all Ministries of Cyprus. All ministerial departments have to take political and legislative action to improve the coordination of activities and the efficiency of measures specified in the National Drug Strategy.

In detail this concerns not only the Ministry of Health (President of the CAC) and the Cyprus Youth Board (Vice-President of the CAC), but also

- representatives of the Ministry of the Interior,
- representatives of the Ministry of Justice and Public Order,
- representatives of the Ministry of Education and Culture,
- representatives of the Ministry of Labour and Social Security and
- representatives of the Ministry of Defence.

The term „representatives“ refers to a person nominated by each Ministry in order to keep contact to the CAC. The six concerned Ministries evaluate every six months their contribution to the National Drug Strategy and report to the Ministerial Council.

But as the representatives of the Ministries have many other responsibilities, the collaboration with the CAC remains insufficient. At the request of the CAC, the restructuring of the collaboration between CAC and the Ministries for purpose of a proper functioning is planned.

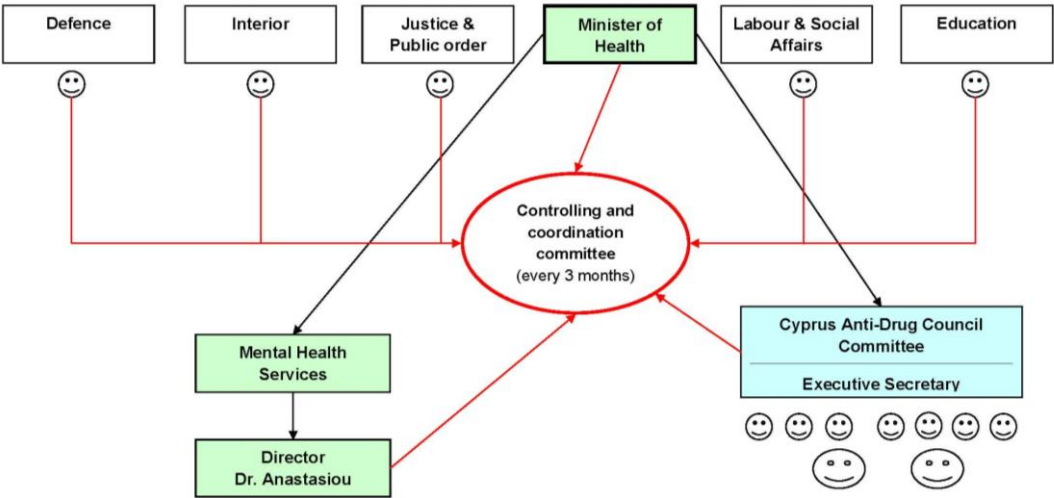
Plans for an optimised collaboration between the CAC and the Ministries

The basic idea towards an optimisation of this collaboration and the enhancement of the coordination of the addiction services lies in the establishment of a new board. This board will be formed by the CAC and the Minister of Health, who will also be the chair of the board, and shall meet every three months. Each Ministry shall nominate one or more liaison persons concerned with the drug problem, who will participate in the board.

Main purpose of the new board will be the enhancement of the coordination as regards the implementation and promotion of the Cyprus National Drug Strategy. Each Ministry is obliged to contribute to the realisation of the national drug demand and drug supply action plan. Liaison persons could be staff members of the respective Ministry, but

also representatives of governmental services provided by the respective Ministry. In the Ministry of Health the liaison person will be the director of the Mental Health Services who has to participate in each meeting of the committee. In addition, one member of the coordination committee Synthesis will be the representative of the governmental drug services.

Figure 16. Organisation of the new board.



The new board will not be responsible for making new resolutions, but for controlling the Ministries` implementation of the national action plans. For this reason, all liaison persons shall submit a report in each meeting of the board, in order to give account on the realisation of the actions determined in the action plans.

The most important benefit from this new board will be the establishment of a clear structure and procedure, enabling the CAC to fulfil its principal duties. The CAC will be enforced by being better embedded on the ministerial level and interlinked with all Ministries. Furthermore, the coordination process will be equally strengthened, by having a clear structure for the communication and for the collaboration of all involved actors. Thus, the controlling board will enable an optimised coordination of the CAC with the Ministries. Finally, the board may function as a platform of discussion about new drug trends and related treatment needs.

4. 3. 2. 2. „Synthesis“ – coordination of the governmental drug services

“Synthesis” is the name of the committee which consists of the coordinators of each of the six governmental drug facilities. The main purpose of its establishment was the creation of a forum for the better coordination of the governmental drug services. “Synthesis” targeted in the enhancement of the collaboration between the facilities, instead of the isolated and independent operational procedures dominating until now. Due to lack of regular communication between the facilities and relevant organisations, such as the CAC and the Mental Health services, one major objective was also the establishment of a regular communication about the major concerns of the six facilities.

Even though the committee has existed for many years, there had only been two meetings within four years. Probably one reason for the rare meetings is that the members of the committee fulfil the coordination tasks in their leisure time. Since 2007 the committee has been reactivated and meetings take place more often, mostly in the psychiatry service of Nicosia. However, the committee still did not function formally and effectively as major demands for coordination remained unsolved.

In fact, the committee aims in playing a role in all concerns regarding:

- staffing (employment of new staff and distribution of staff).
- training and qualification of the staff.
- financing in terms of determining the budget needed for the next year.
- promoting the obligations to the national drug action plan.
- further development of services for drug users.
- identification of further treatment needs.

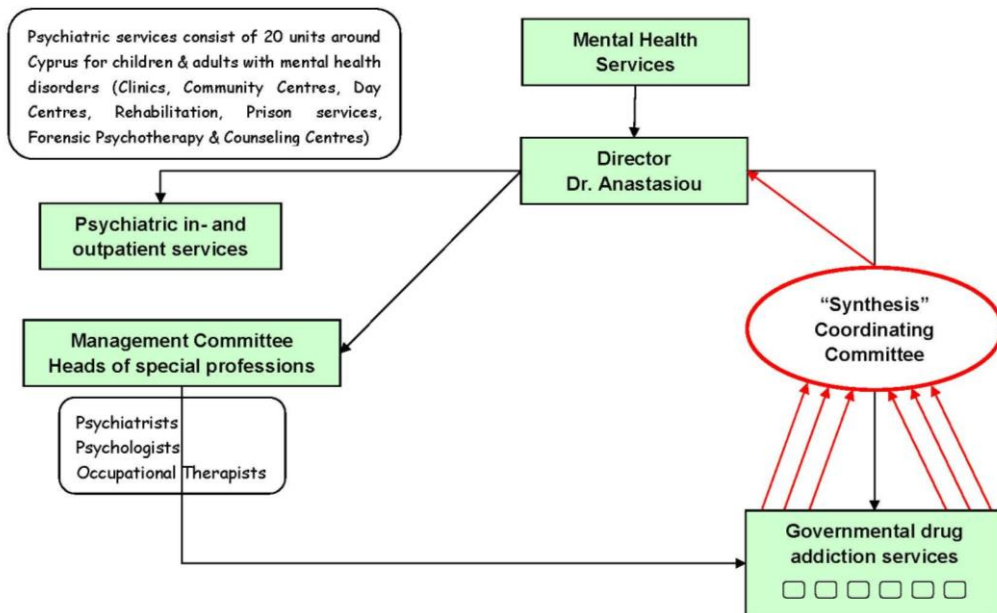
Most of the upper mentioned coordination issues cannot be fulfilled because the committee lacks power concerning the budget for their facilities, the allocation of staff in each facility, as well as the training and qualifications of the staff. Consequently, there is a huge need to make the committee proper functioning.

For this purpose, the members of the committee proposed a restructuring of their committee, which first of all shall ensure a regular communication between the members and between the committee and the MHS and the Ministries.

Proposal for a better functioning of “Synthesis”

According to the proposal, the committee shall still consist of the six coordinators of the governmental drug services, but meet regularly once a month. In addition, there will be additional meetings on demand to discuss special issues. “Synthesis” will be chaired by one of the committee members. The chair shall be either nominated by the committee, or will rotate among the members. The director of the MHS will not be part of the committee, but will be informed about the agenda and the decisions of each meeting.

Figure 17. New structure of “Synthesis”.



The committee will be responsible for the planning of the staff trainings yearly. It shall also be responsible for the planning and rotation of the staff. In addition, the committee shall prepare suggestions for the demand of the yearly budget covering all six facilities. The chair of Synthesis will provide advice to the director of the MHS in form of consultations. Any recommendations developed by the committee should be submitted to the director of the MHS in written form. Last not least, “Synthesis” shall fulfil the obligation to submit every three months a report to the CAC and the ministerial committee on their contribution to the national drug action plan.

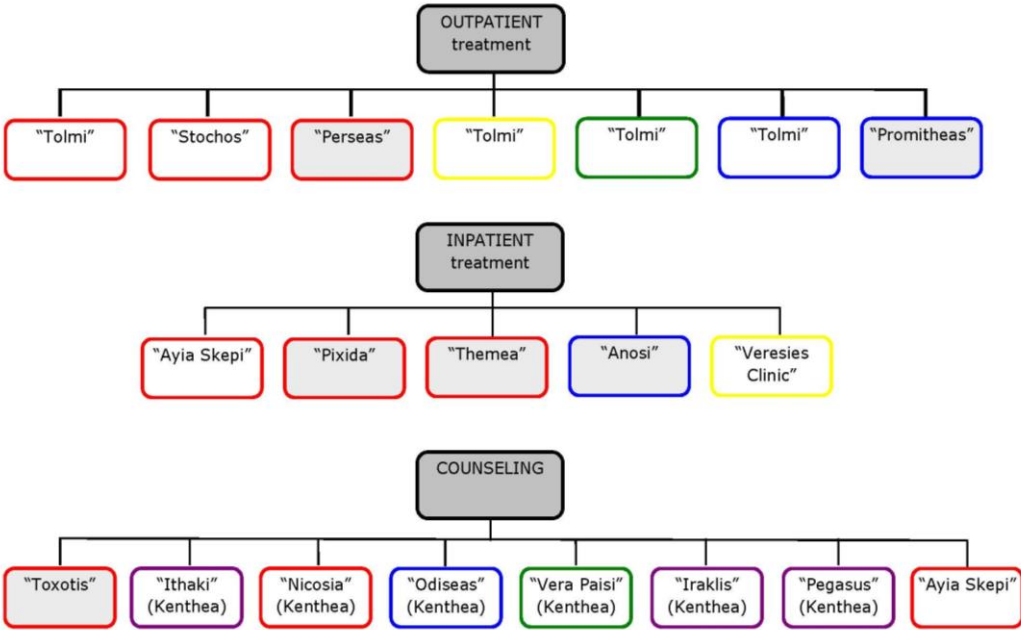
The restructuring of “Synthesis” will enable the governmental drug facilities to coordinate and channel their needs. Furthermore, there will be finally clear pathways to articulate their needs and to communicate them to the director of the MHS. Through the communication with the director of MHS there will be a direct access to the Ministries. By

developing proposals and recommendations, the governmental drug services will achieve more influence on ministerial decisions that are affecting their own drug services.

4. 3. 3. Current availability of drug services in Cyprus

Within the frame of the National Drug Strategy, drug services are part of the objectives formulated under the topic of community-based treatment and social integration. Some of the services started to operate in the 1990ies, such as for instance the two outpatient services PERSEAS and PROMITHEAS and the inpatient TC AGIA SKEPI. However, many of the services have readjusted their concept and target group since opening, while others have been implemented recently during the last three to five years.

Figure 18. Current drug services in Cyprus*.



* The red line is for services located in Nicosia, the blue line for those in Limassol, the yellow line for those in Larnaka, the green line for services located in Pafos, and the purple line is for other regions of Cyprus. The six governmental services are those with the grey background.

In 2007 there are 20 treatment units located mainly in the capital Nicosia but also in Limassol, Larnaka and Pafos. Most of the drug services are NGOs and so independent, but requiring the allowance of the CAC to operate. Six of the current drug services are governmental and coordinated and monitored by the MHS. The NGO “STOCHOS” is also

regarded as a governmental drug service as all staff members are employed by the MHS. All treatment programmes are monitored by the CAC.

The organisation plan of the Cyprus drug services has been provided by CAC (Figure 18). However, the differentiation in outpatient treatment, inpatient treatment and counselling is regarded not only problematic, but also misleading. Often counselling centres offer all kinds of psychosocial interventions including outpatient drug treatment. Some of the inpatient facilities such as PIXIDA and VERESIES CLINIC also offer outpatient drug treatment. For this reason it is strongly recommended to revise the organisation plan of the drug services available in Cyprus according to the treatment classification which is used below to describe the existing drug services.

a) Services for outpatient psychosocial interventions

With the exception of three treatment facilities (THEMEA, ANOSIS and the inpatient unit of AGIA SKEPI), all other treatment units provide outpatient psychosocial interventions. In Cyprus, the first participation in a specific drug treatment requires to contact one of the counselling centres existing in all major towns. The main function of the eight existing counselling centres is the preparation of drug users for the further treatment (e.g. by means of motivation enhancement) and their referral for further detoxification and /or inpatient drug treatment. Due to the lack of a variety of outpatient treatment programmes most of the counselling centres also provide outpatient drug therapy.

All counselling centres provide individual and family counselling. All of them provide services to male and female, but to different age groups. For instance the services of TOXOTIS are addressed to adult clients of at least 18 years which are addicted to legal or/and illegal substances or to gambling. The treatment units PERSEAS and PROMITHEAS are especially designed for adolescents of age 12 to 22. Both facilities provide drug services for marginalised adolescent drug users, while PROMITHEAS offers in addition primary prevention programmes. The NGO service provider KENTHEA operates the six treatment units (NICOSIA, PEGASUS, IRAKLIS, ITHAKI, VERA PAISI, and ODISSEAS). Their services address drug users of all ages by providing mainly early intervention for high-risk groups, motivational enhancement, and preparation for treatment.

In addition, the NGO TOLMI operates outpatient therapeutic communities in four towns. The outpatient TC is designed for drug users of all ages and offers a 12-month treatment based upon an integrative approach of psychotherapy, psycho-educational techniques and coping skills. TOLMI provides also individual, family and group therapy as

well as drama therapy and social reintegration. The governmental drug facility PIXIDA also provides two outpatient drug treatment programmes, one directed towards the preparation for intake in the inpatient therapeutic community and the other one addressing drug users in need for outpatient psychosocial interventions. Last not least, there is the drop-in centre STOCHOS, operating as a harm-reduction programme.

b) Services for inpatient psychosocial interventions

Inpatient programmes are often based upon a biopsychosocial approach and provide individual therapy, group therapy and family therapy. Currently, there are two inpatient treatment units available in Cyprus which offer abstinence-oriented drug treatment. One is the therapeutic community AGIA SKEPI and the other one is PIXIDA, which has been established in 2004. The residential therapeutic community PIXIDA is designed as a short-term drug treatment with a duration of five months. Treatment is provided to adults addicted to illicit drugs.

AGIA SKEPI provides a long-term residential drug treatment to adult drug addicts of age 18 to 40. One criterion for admission is to speak Greek fluently. Originally the therapeutic community was for male and females, but since 2006 only male clients have been treated. In the year 2007 it is planned to establish a residential treatment unit exclusively designed for women drug users. The “Comprehensive Female Drug Rehabilitation Center” will be located in Nicosia and offer traditional inpatient addiction treatment with an emphasis on maintaining long-term recovery. This inpatient facility will also provide prenatal care for pregnant women addicts, a mother-child program, and a mechanism by which children in foster care can be reunited with their mothers.

Both, the residential treatment of PIXIDA and AYIA SKEPI, include social rehabilitation programmes which constitute the final treatment phase.

c) Services for detoxification

Since 2004 there are three different kinds of services available for detoxification. The most recent established facility ANOSIS is located in Limassol and offers inpatient medically assisted detoxification to users of illicit drugs. In addition the NGO facility VERESIES CLINIC in Larnaka recently initiated a buprenorphine treatment for detoxification. VERESIES CLINIC provides inpatient as well as outpatient detoxification.

Since establishing ANOSIS, the inpatient detoxification unit THEMEA focuses on withdrawal treatment of alcohol dependence and dependence from other legal substances. THEMEA became especially designed for the treatment of individuals addicted to legal substances.

d) Services for maintenance treatment

Maintenance treatment constitutes an important aspect of drug treatment programmes, thus the Ministry of Health has set the introduction of substitution treatment in motion. This programme is expected to be fully functional by October 2007 (see also chapter 4.3.4.).

e) New governmental services

In order to improve a therapeutic continuum the Mental Health Services have decided to implement further governmental drug services:

- A programme for vocational rehabilitation has been recently established in Limassol. Ex addicts with mental health problems are offered prevocational and vocational rehabilitation. The main reason for implementing the programme was the estimation of the coordinators of the governmental facilities that drug addicts are more likely to benefit from continuing their rehabilitation in another but the same facility. The programme focuses on vocational training and job placement under the support of a job coach. During the training, the clients do not receive any payment at all. The funding for the vocational rehabilitation is provided by the European Commission, the job coaches shall be financed by private organisations.
- The Ministry of Health decided to introduce an intensive day-care programme for addicted adolescents within 2008. The programme will operate on a daily basis without overnight stays and weekends and will target adolescents addicted on heroin.
- Two new drug counselling centres shall be implemented in 2010 in Pafos and in Larnaka, in order for drug counselling centres to be provided in all districts of Cyprus. One of the counselling centres shall be operated based on an integrated concept for drug and mental health problems. A third one is planned in Famagusta area in 2015.

In conclusion the Cyprus drug treatment system can be summarised as follows:

Psychotherapeutic abstinence focused treatment is the most prominent approach to treat users of illegal and/or legal substances. Most available services address adult drug users, male and females. Currently, there is no treatment programme designed for drug addicted women or for migrants, even though the latter group is partly addressed by staff speaking English and/or Russian. No treatment approaches exist addressing problematic cocaine use specifically.

However, even though there are a number of outpatient and inpatient treatment services available, there is a lack of certain treatment options. First of all, where drug users are offered a comprehensive psychosocial and medically assisted treatment on a daily basis differentiated outpatient programmes are missing. Such services should include regular contact with staff members and participation in treatment procedures, as well as other types of professional support. Second, harm reduction programmes are missing that offer all different kinds of services, such as the provision of syringes, emergency aid for overdose prevention, medical care for drug-related injuries, as well as vaccination programmes for hepatitis.

The detailed results of the evaluation of the governmental addiction services are listed in Annex I. An overview is also presented in Tables 7 and 8. For the detailed results of the evaluation of the NGO addiction services please see Annex II, for the prevention network's evaluation Annex III and for the prison drug services' evaluation Annex IV.

4.3.4. Introduction of substitution treatment in Cyprus

In Cyprus the introduction of substitution treatment has been considered for years. Currently, Cyprus is the only country in the European Union without substitution treatment even though such treatment has been found to be effective in many aspects. Substitution treatment has been found to be effective in attracting problematic drug users, in reducing health risk behaviour, criminal behaviour and marginalisation [47, 48].

The Ministry of Health decided to put substitution treatment into practice this year. It is expected that substitution treatment will start in October 2007, funded by the Mental Health Service and operated as a governmental service. The substitution treatment will start as a pilot programme offered in a newly established substitution clinic located in the old hospital of Nicosia. The objectives of the programme facilitate the immediate admission to treatment and the improvement of psychological rehabilitation and harm reduction by

offering substitution in combination with additional treatment options (medical care, motivation enhancement, psychotherapy, occupational therapy, counselling, social skill training, as well as support for the reintegration in society, family and working environment). The exact implementation of these additional treatment options (same clinic or cooperation with other drug treatment services) is not clear yet.

To offer a range of treatment interventions together with substitution treatment, the programme will be staffed by a multi-disciplinary therapeutic team consisting of

- one psychiatrist for substitution,
- one rehabilitation counsellor,
- one occupational therapist (part time),
- four nurses covering the morning shift seven days per week,
- one secretary (part-time).

The substitution programme is directed to drug users with withdrawal symptoms, but low prospects of a rehabilitation success through other treatment programmes. In particular following target groups will be addressed:

- severe dependent drug users with a poor physical and/or mental health,
- drug users with a failed previous abstinence treatment and
- pregnant women.

Socially integrated drug users will not be excluded from substitution treatment.

Access to the programme will require an evaluation and approval by a committee. Each case will be evaluated by the therapeutic team as to the health and behavioural condition and in addition a laboratory test for any substances will be made. Drug users will be admitted, if the evaluation of the committee regards the certain treatment as appropriate.

The substitution treatment is planned to start with approx. 20 to 40 clients. In the beginning, the programme will be designed for a maximum of 50 clients and be limited to three months. There will also be a contract ensuring treatment for this period, which shall be renewed after three months. Urine samples shall be taken daily in the first two weeks of the treatment, but become less often over the course of time. After establishing, the treatment shall be extended up to approx. 100 clients.

According to the proposal, the treatment will use buprenorphine as an opioid substitute. One major reason for this decision is the more common acceptance of buprenorphine by the most drug users in Cyprus in comparison to mehadone. As regards the treatment structure, a daily operational time schedule from 8 p.m. to 2 a.m. is envisaged.

However, there will be a flexible distribution of the substitution substance in order to offer the clients treatment according to their individual needs. The responsible psychiatrist considers accepting take home dosage for clients after a certain time of treatment. The exact preconditions for this treatment option, as well as the number of contacts with the clients and many documentation issues remain unclear.

The substitution clinic in Nicosia will be the only substitution treatment centre in Cyprus. However, the enlargement and diversification of substitution treatment is considered as a major target in the future addiction policy of Cyprus. The next substitution treatment centre shall be implemented in Limassol.

Table 7. Governmental Institutions evaluated by the Twinning Project (as of April 2007)

Institution	Target Groups	Objectives	Treatment offered	Clients in 2006	Drop outs	Type of Drug
Anosis	Adults (≥18) addicted to illicit drugs.	Inpatient physical detoxification and referral to the next therapeutic step.	Individual inpatient detoxification programme of 3-4 weeks via appropriate medical methods (pharmacological support of withdrawal symptoms, i.e. by methadone), psychological support and counselling, group therapy, educational sessions, occupational interventions and nursing care.	169	121 (71%)	88% HER 4% COC & AMPH 0.5% THC 1% MEDS 4% Other
THEMEA	Adults (≥18) addicted to alcohol and/or legal drugs (medications).	Inpatient physical detoxification and referral to the next therapeutic step and rehabilitation.	Strictly defined detoxification programme by appropriate medical methods, psychological support and counselling, occupational interventions, life skill training and nursing care, with the following structure: 1 st phase: physical detoxification (2 weeks). 2 nd phase: motivation enhancement (1 week). 3 rd phase: social rehabilitation (inpatient and outpatient).	54	1 st phase: 44.4%, 2 nd phase: 29.6% Rehab.: 7.4%.	96% ALC 4% MEDS
Perseas	Teenagers and adolescents (12 – 22) with an initial, experimental or systematic use and their relatives.**	- Outpatient treatment: Prevention of drug use and blocking the course towards dependence in young, high risk, drug-using adolescents. - Prevention activities	-Brief intervention for experimental drug users and their parents. -Intensive therapy programme for systematic drug users and their parents. -Open telephone line for support, information, therapeutic advice and referrals. -Long-term interventions in schools, psycho-educative sessions, printed informational material (flyer) campaign and TV campaigns.	41	15* (36.5%)	82% THC 6% HER 6% COC 6% XTC
Promitheas	Adolescents (<22) with occasional drug use or/and other high risk parameters *** and their families.	Short term goals: Evaluation, preparation and motivation of substance using adolescents, referral to inpatient or outpatient programmes. Long term goals: Drug use abstinence and social rehabilitation.	A. Outpatient Individual counselling/therapy: -Counselling, psychological support and occupational therapy to occasional users or addicted adolescents. -Counselling and psychological support of adolescents' families. B. Prevention programmes	131	56* (42%)	33% THC 21% HER 20% ALC 19% COC 1% MEDS
Toxotis & Stochos	- Toxotis: adults (≥18) with problematic use of legal/ illegal drugs or gambling. - Stochos: drug users in the pre-contemplation stage or drug users without treatment demand	Toxotis: Individual counselling towards referral into treatment (detoxification or rehabilitation) using motivational interviewing (MI), with the main focus set on harm reduction objectives. Stochos: Harm reduction and counselling until clients develop motivation for further treatment. (i.e. detoxification or residential drug treatment).*****	Toxotis: Outpatient individual treatment with motivational enhancement, group sessions, occupational therapy, life skill and sensory-motor assessment, as preparation for entering a specific therapeutic programme. Stochos: Individual counselling and drop-in area with cold meals, drinks and coffee. Personal hygiene (shower, clothing, etc.). Clients receive information material. Needle exchange programme planned.	168 Toxotis	98* (58%)	43% ALC 28% HER 13% THC 9% COC 3.5% MEDS 0.5% Thinner 0.5% Nicotine 1% Gambling
Pixida	Adult clients (≥18) addicted to illicit drugs.****	Residential and out-patient therapy, counselling and support with main goal of involvement and integration into therapeutic programmes towards continued abstinence, social re-integration and rehabilitation.	-Closed programme (>6 months; Therapeutic Community - TC) Inpatient, clearly structured programme, offering mainly group sessions and individual counselling, rehabilitation phase, structured follow-up (outpatient aftercare group therapy once per week) -"Mild" intervention Outpatient treatment for individual needs of clients so that normal day structure may remain (clients can work or study), offering individual and group therapy.	Closed programme: 22 "Mild" intervention: 5	15 (68%)	Closed programme 100% HER

* Drop-out definition not clear, including also cases of referrals.

** Since May 2007.

*** i.e. school failure or drop out, low socio-economic profile, migration background high-risk families, etc.

**** Precondition for an admission is the completion of the physical detoxification therapy phase.

***** Clients who want to undergo detoxification in Anosis or THEMEA are obliged to participate in the counselling programme of TOXOTIS.

Table 8: Synopsis of the evaluation results of the governmental facilities (as of April 2007)

	Themea	Anosis	Perseas	Toxotis & Stochos	Pyxida	Promitheas
General evaluation	<ul style="list-style-type: none"> -Medical and therapeutic concept without sufficient development in the last years; does not reach up to scientific standards. -Therapeutic concept too rigidly focused on only one therapeutic track, no change when entering the next phase of treatment. 	<ul style="list-style-type: none"> -Well-run unit in accordance with the international scientific standards. -Medical methods, psychological support and counselling, occupational interventions and nursing care are appropriate. 	<ul style="list-style-type: none"> -Well-run facility with a multimodal treatment concept. -Well structured therapeutic range for clients and their families. -Many staff members are highly qualified and trained to family interventions. -The main weakness is the low number of adolescent clients reached. 	<ul style="list-style-type: none"> -Two facilities with an important work in harm reduction, counselling and referring. -Low-threshold access. -Big number of clients. -High-frequency individual counselling providing definite support to clients. -Effectiveness concerning increase in motivation and referral rate. 	<ul style="list-style-type: none"> -Very well structured facility with a treatment concept in accordance with the international scientific state-of-the-art. -Therapeutic concept constantly adapting and improving (i.e. "Mild intervention" an important addition to the therapeutic continuum.) 	<ul style="list-style-type: none"> -Well-run facility with the difficult objective of offering individual therapy to adolescent drug users and their relatives and to provide many prevention programmes for young students.
Gaps	<ul style="list-style-type: none"> -Low coverage (low occupancy) and poor outcome (low completion rate, high drop-out rate in the first 3 weeks). -No possibility for entering the programme in the 2nd or 3rd phase. -Therapeutic concept based upon restrictive and inflexible rules being counter-productive and inadequate for effective treatment. -Staff work not adequately managed and supervised; lack of psychiatrist presence in the facility. -Superfluous number of nursing staff (>20) for the capacity and needs of the unit. -Building and location not adequate for the service offered. 	<ul style="list-style-type: none"> -Only poor opportunities to keep clients busy (main reason for drop-outs). -Lack of centres providing diversified aftercare. -High-threshold access, low occupancy. -All scientific personal has a part time status; only one psychologist and no social worker. -Nursing staff number seems too high for the capacity and needs of the unit. -Rooms not enough for a proper functioning. -No access to a garden. 	<ul style="list-style-type: none"> -Low number of clients for the capacity of the facility (8 full-time staff members). -Lack of an established network that would facilitate referrals. -High drop-out rate, which may be due to the length of therapy. Even the "brief" intervention has to be considered rather long (goal 3 to 6 months). -Further training especially in the field of addiction and in motivational enhancement therapy requested by the staff. -Lack of rooms for group therapy and conferences and drop-in area for clients. 	<ul style="list-style-type: none"> -Due to the unspecified profile of the clients, objectives, needs and services often collide. -Lack of more specific therapeutic concepts (especially for substance users and gamblers not needing inpatient detoxification). -Needle exchange programme not implemented yet (objectives of the programme still not clear). -Consultant psychiatrist works 2h/week in Toxotis and Stochos providing assessment for less than 10% of the cases. -Presence of other part-time professionals, due to staff-sharing between different facilities, also not enough. -Insufficient number of rooms. 	<ul style="list-style-type: none"> -Insufficient inpatient occupancy (insufficient attractiveness or/and referral process). -Outpatient programme already reached full occupancy. -Budgetary gaps. -Unit operated only by nurses. No psychiatrist or psychologist available. -Number of nurses very large in comparison to poor occupancy -Regulations for staffing night shifts interfere with the therapeutic programme. -Unit in an unsuitable location. -No special rooms for occupational therapy, specific rehabilitation sessions or privacy. 	<ul style="list-style-type: none"> -Recent readjustment of the concept: Promitheas now focuses on prevention and short-term intervention programmes of 6 to 9 months. -Lack of computerisation and telephone lines. -Only 4 full time staff members, not enough to respond to the demands. -No specific therapeutic training of the psychiatric nurses. -Building's location not suitable for programmes focused on adolescents with illicit drug use. Moreover very old and uncomfortable building with small number of rooms.
Proposals	<ul style="list-style-type: none"> -Conceptual restructuring to improve occupancy and outcome needed. -Introduction of a diversified treatment that includes out-patient and in-patient detoxification as well as long-term in-patient rehabilitation and short-term out-patient aftercare. -Detoxification phase should be separated from rehabilitation, both geographically and conceptually. -Fulltime professional (i.e. psychiatrist) for medical supervision, innovative medical approaches. -No cut-off of communication to the outside world, instead systemic family-orientated concept. -Reconsideration of all rules and regulations. -Clear need for the computerisation of the unit. 	<ul style="list-style-type: none"> -Lower threshold for admissions to improve the coverage. -Diversification of services before, during and after detoxification. -Closer co-operation between detoxification centre and aftercare (presently only TC) strongly needed. -Consideration of admission of younger drug addicts in need for detoxification (Anosis is the only governmental detoxification facility in Cyprus). 	<ul style="list-style-type: none"> -Engage more adolescent drug users in treatment. -All intervention programmes need to be more "adolescent-centered". -Greater emphasis should be placed on adolescents themselves. -Shortening of duration of present treatment programmes. -Add separate intervention programme (initial assessment & brief counselling) of 5 to 10 sessions for adolescents with experimental or occasional drug use. -Shorten "brief" family intervention to 3 months as a standard length of treatment. -Shorten intensive therapeutic treatment programme to a maximum of nine months. -Ensure funding of art & drama therapist. 	<ul style="list-style-type: none"> -General structure and concept should be continued. -Implementation of more specific treatment concepts for cannabis, party drugs, cocaine and gambling, tied to special training for the staff (manualised and semi-standardised interventions). -Consideration of increasing the staff number. -Stronger presence of a psychiatrist. -Moving into another building may be necessary. -Considering a geographical separation of Stochos and Toxotis. 	<ul style="list-style-type: none"> -Further diversification (as already initiated with the "mild intervention"). -Consideration of changing programme into an intensive day care. -Exclusion of nurses night shift regulation, as Pixida is definitely not a medical unit. -Consideration of shortening the overall programme length. -Considering implementation of an aftercare out-patient therapy programme for clients who have gone through TC. -Incorporation of a psychologist in the team. 	<ul style="list-style-type: none"> -Change of therapeutic concept is useful, enabling specialisation on a specific target group. -Need for staff training (i.e. in addiction counselling). -Need for relocation of the unit. -Need for increasing the number of staff by members specialised on adolescents. -Need for a range of interventions, from a brief intervention of up to 12 sessions, to a long-term therapy as well as group sessions. -A day-care setting for an intensive intervention is to be considered

5. Discussion

5. 1. Overview of the current situation

Cyprus takes an individual place within the borders of the European Union, especially through its strategic geographic position in the eastern Mediterranean, which makes the island an attractive destination for drug trafficking. The seized quantities of drugs, especially cannabis, and also the number of arrests due to drug related crime have increased over the last years. Nevertheless, this increasing drug-related crime trend remains of much lower pace than the average of the EU.

Cyprus belongs to the EU countries where the provision and financing of drug treatment services is provided by both public agencies and NGOs. With the introduction of high-dosage buprenorphine maintenance treatment in Cyprus in 2007, substitution treatment is now available in all Member States. Nevertheless, Cyprus shows a poor diversification of treatment provision and services in comparison to other EU Member States. In addition, Cyprus does not manage to keep up with international standards concerning specific target group specialised treatment options. Gender specific programmes for women, special migrant programmes, prison-based substitution treatment and other harm reduction programmes are lacking on the island. However, Cyprus has started to include monitoring and evaluation of its national drug strategies and action plans in concordance with the EU drug action plan. More in-depth evaluations of the national strategies and action plans in the next years could guarantee better responses to the drug problem.

5. 2. Main objectives of the evaluation

The overall objective of this evaluation report is to enhance the capacity of the Cyprus addiction services as regards the implementation of a continuum of care for drug addicts. Evaluation is a method for an assessment of costs, effectiveness or impact of treatment or a treatment system, which provides feedback to key audiences. Before an evaluation study begins, there are many fields which have to be examined, discussed and defined through communication of the interested parties.

This report presents the results of two major evaluation parts:

- The evaluation of the current situation as regards the population in need, the utilization of the current drug services, the legal framework and the responsibilities for the drug treatment coordination.
- The assessment and evaluation of the methods and approaches applied in the governmental and non-governmental drug services and prevention services.

Main target of this evaluation was the contribution to the CAC's knowledge of the concepts, programmes and functioning of the services. As the CAC may grant financial support for treatment and prevention programmes, such a profound knowledge is of utmost importance for decisions on public funding. Based on this evaluation results recommendations are formulated, in order to promote the improvement of the current and the introduction of new drug treatment services in Cyprus.

5. 3. Drug use prevalence, trends and system utilization

5. 3. 1. Drug use prevalence in Cyprus

According to the most recent general population survey the prevalence of illicit drug shows an individual place of Cyprus in the international drug ranking. Cannabis was the most widespread illicit substance used by adults in 2006. However, the life-time prevalence for cannabis, amphetamines and cocaine use in Cyprus is among the lowest compared to the majority of European countries and in particular among adolescents of age 15 to 16.

But while lifetime prevalence of illicit drug use among the general population in Cyprus was comparable low, the last month prevalence was high in comparison to other European countries. In the last 30 days 1.4% of the population reported cannabis use which is still comparably low. However the last month prevalence reported in Cyprus for amphetamines, cocaine and in particular ecstasy was comparably high. In the last month 0.3% of the Cyprus population used amphetamines and only six out of 28 countries showed a higher percentage. With respect to the 0.4% prevalence of last month cocaine use in Cyprus, EMCDDA data indicated only five countries above this percentage. In particular the last month use of ecstasy (0.8%) among young population was on top in Europe, only topped by the United Kingdom and Czech Republic with a prevalence of about 1%. The last month prevalence is one indicator for current drug use, therefore showing the extent of treatment needs within a community. Considering the high last month prevalence in Cyprus, it can be assumed that some current users might develop a problematic drug use and are consequently a target group for drug services.

5. 3. 2. High risk drug use patterns

In Cyprus, intravenous use is the main route of administration among heroin users in treatment. However, in the last years heroin injection has decreased from 85.5% in 2003 to 71.7% in 2005. On the other hand, in 2005 intravenous use of cocaine was observed at for the first time (at 8.3%). In comparison with other European countries, current heroin injecting is on the highest level along with countries such as Czech Republic, Latvia, Lithuania and Bulgaria. High risk drug use patterns, such as needle-sharing, increased from

12.5% in 2004 to 14.7% in 2005, which is low compared to other European countries. Nevertheless, increasing risk behaviour may be an indication for the need to provide low-threshold access to clean needles and syringes. Needle and syringe exchange programmes have been found to be effective in reducing risk behaviour and preventing the transmission of infectious diseases among intravenous drug users.

5.3.3. Treatment demand and utilization

During the last 20 years there is a clear tendency towards community-integrated care. In consideration that the treatment system has expanded in recent years, there is a tendency that increasing numbers of drug users make use of available drug treatment. From 2004 to 2007 the overall number of treatment clients increased by 75 % to 778 clients in 2007. During the year 2006, altogether 560 individual drug users requested drug treatment in Cyprus. In 2007, there were 778 clients, of which 567 clients entered NGO drug services and 486 clients made use of governmental drug services.

In relation to the estimated total the number of problem drug users, the treatment coverage in Cyprus accounts for 59%. Each year more than 30 % of the clients entered treatment for their first time. The majority of all treatment demands concern outpatient interventions. Nearly one third of all requests for treatment aimed at attending detoxification treatment, while inpatient psychosocial drug treatment plays only a minor role. After further development and diversification of drug services (i.e. the introduction of maintenance treatment, low-threshold services, etc.), the number of clients requesting treatment is considered to increase further.

About 60% of the treatment clients have been previously in treatment, with many of them continuing treatment in NGO facilities after having attended their last treatment in a governmental facility. Differences in the first treatment entries suggest that NGO treatment services may be more likely to attract new clients whereas governmental treatment services tend to have more clients that continue treatment.

The clients were on average 28 years old and 87% of them were male. Among all clients, heroin users were the main group (55%) requesting treatment. Cannabis users were the second main client group accounting for one fourth of all clients, followed by cocaine users, representing 15% of all clients in treatment. Within the period from 2001 to 2006 the number of news clients with primary use of cannabis increased from about 30% to 43%, a

high number when compared with other European countries. In the same period the number of new clients with primary use of cocaine tripled to 18%. The proportion of new clients with heroin use decreased from almost 53% to 35%. The mean duration of heroin use increased from 10.6 years in 2004 to 11.6 years in 2005. Consequently most of the heroin users are long-term drug addicts with specific treatment needs. This decrease in new clients demanding treatment due to heroin use may reflect the lack of adequate treatment options such as maintenance treatment.

5. 3. 4. Specific target groups

According to the statistical data of the last-month drug use prevalence and system utilization, cocaine seems to become a future challenge for drug treatment services. Cocaine users in drug treatment have a different profile than heroin users, having higher rates of regular employment and tending to use cocaine occasionally.

Treatment data show also that the vast majority of all treatment clients are male, as in previous years only 13.5% of the clients are women. Even though there is no specific information on the gender relation of the problem drug users, it can be estimated that there are more female problem drug users, which are not being reached by the services. This presumption is supported by fact that there is a noticeable increase, from 17% in 2003 to 36.8% in 2005, of young female drug users at age of 15 to 19 demanding treatment for the first time.

Adolescents with primary use of cannabis have also become a growing target group of the Cyprus drug services. In particular cannabis users of the age group 15-19 years seem to constitute the major group of cannabis clients in treatment. The proportion of newly treated adolescents and young adults with primary cannabis use increased from 7% in 2003 to 31% in 2005.

In Cyprus 30 % of the clients in drug treatment consists of migrant population. Yet, there is no data on the size and characteristics of migrants using illicit drugs. Similarly, there is also no data regarding the health status and prevalence of infectious diseases like hepatitis and HIV among the problem drug use population.

5. 4. Structure, coordination and legal framework

In Cyprus a number of different public bodies are involved in the implementation and coordination of drug services. Even though the overall responsibility for the planning and implementation of drug services is in the responsibility of the Ministry of Health, all Ministries and further organisations are in charge to contribute to the National Drug Strategy and hereby support the realisation of drug treatment and prevention. With regard to the drug issue, the process to full integration into the EU required Cyprus to follow the methods and principles of the European Strategy on Drugs. Accordingly, the “Law on the Prevention of the Use and Dissemination of Narcotic Drugs and Other Addictive Substances” was enacted in 2000, promoting the establishment of the Cyprus Anti-Drugs Council (CAC). The CAC is the supreme coordinating body in the field of addictive substances, and in this function responsible for the coordination of governmental, as well as non-governmental addiction services. The CAC funded drug treatment and prevention programmes of NGOs with 132.215 CYP (about 226.000 €) in 2007. Drug treatment providers received 64.900 CYP (about 111.000 €) public funding and prevention programmes were supported with 67.315 CYP (about 115.000 €). Specific regulations within the aforementioned law also promoted the establishment of the Cyprus Monitoring Centre for Drugs and Drug Addiction (EKTEPN).

However, there is still a lack of communication between the involved public bodies which limits the possibility of effective planning and coordination of drug treatment. It still remains unclear how the strategic planning of the national drug policy is made and according to which processes decisions on the treatment system responses to the needs of drug users are taken. In addition, there is no clear structure for the distribution of the budget, while it is indeed not distributed according to the actual services rendered by the respective drug services. The CAC lacks necessary power, as it can only formulate recommendations concerning the development and support of specific drug services drug services, not having any budgetary power at all. Finally, the governmental drug services are not in the position to decide upon their staffing. All affairs considering number and qualification of staff, as well as their distribution to the single facilities are determined by Nursing Administration and the Ministry of Health.

On that account, the need for a global coordinating structure was apparent. For example, the establishment of an inter-ministerial committee may be meaningful, as it can improve the collaboration and coordination at a governmental level. As the CAC is

designated as a coordinating body, it must dispose of the premises to also act as a coordinating authority, with respect to budgetary power of the separate units, staff control and treatment planning.

In addition, the establishment of a well structured and collaborative network between all drug and other services (mental health, education, employment, welfare, etc.) was suggested in order to ensure the continuity of care. Care coordination and case management implemented in routine treatment, provided by all drug services, may help to respond to individual needs. Finally, the implementation of a uniform documentation system in all facilities was suggested, which would allow a better planning of treatment based on identified treatment needs and provide all data needed for systematic and effective monitoring and analysis.

5.5. Current availability and gaps of drug treatment in Cyprus

In Cyprus, psychotherapeutic abstinence based treatment is the most prominent approach to treat users of illegal and/or legal substances. Most available services address adult drug users, male and females. In 2007 there were 20 treatment units located mainly in the capital Nicosia but also in Limassol, Larnaka and Pafos, all monitored by the CAC. Out of the drug treatment services, 13 are provided by NGOs, which are independent but need the allowance of the CAC to operate. The drug services in Cyprus include: a) services for counselling and drug therapy; b) services for abstinence-oriented residential treatment (i.e. therapeutic community); c) services for inpatient detoxification. The access to detoxification and/or residential treatment requires initial contact with one of the counselling centres for preparation and referral.

As regards primary prevention, respective programmes are predominately provided by non-governmental organisations. The only governmental organisation involved in primary prevention is the Cyprus Youth Board.

Even though a number of outpatient and inpatient treatment services are available, there is a lack of certain, primarily specialized treatment options. The main gaps in the Cypriot drug care system could be summarised as follows:

- **Substitution treatment**

Despite the fact, that heroin users are the main client group in drug services, Cyprus had been the only country in the European Union without an official maintenance treatment programme until 2007. In many European countries substitution treatment is the major approach to deal with opiate dependence. To comply with European standards the further enhancement of substitution treatment was to be a priority task. The Ministry of Health decided to put a maintenance treatment programme into practice in October 2007, funded by the MHS and operated as a governmental service.

- **Specialized outpatient programmes**

Differentiated outpatient programmes, where drug users are offered a comprehensive psychosocial and medically assisted treatment on a daily basis, are missing. Such a service should include regular contact with staff members and participation in treatment procedures as well as other types of professional support.

- **Harm reduction**

In Cyprus, heroin injecting among treatment clients is on a high level. However, there is a lack of programmes that offer all kinds of harm reduction services. To reduce drug related harms, it was recommended to enhance harm reduction by introducing further interventions, such as low-threshold access to clean injecting equipment, possible vaccination programmes for hepatitis in outpatient drug services, rooms for basic medical care for drug-related injuries and emergency aid for overdose prevention in drop-in centres, etc.

- **Specific groups**

The implementation of treatment services for specific groups is also essential for a well structured treatment system. Specific treatment was available for adolescent cannabis users, but not for women and cocaine users. Since young female drug users increasingly ask for treatment, it was recommended to make existing drug services more gender sensitive in structure, concept and support, paying more attention to the different needs of female and male drug users. This requires special training and qualifications of the staff. Considering the increasing demand for treatment due to cocaine use, programmes for cocaine users will be a future challenge for the Cyprus treatment policy. Specific cocaine treatment programmes can be well implemented in the already existing facilities. Furthermore, the introduction of new structured day programmes for specific groups, such as adolescents and drug users not willing to attend inpatient treatment, was suggested as a measure to diversify drug services and thereby increasing attractiveness.

Cyprus is a highly multicultural society, with a strong part of the population having a migrant background. Nevertheless, there is currently no treatment programme especially designed for migrants. Existing drug services necessitate the development of culture sensitive concepts in order to be able to attend migrants adequately, as there is a possibility of a considerable health risk, if remain untreated (e.g. HIV, hepatitis). Thus, the securing of the possibility towards an unimpaired access to treatment for migrants, even without papers, was also a major recommendation.

5. 6. Continuity of care, decentralisation and treatment offer

The overall objective of the twinning project was to enhance a “therapeutic continuum” in the field of drug addiction. Continuity of care implies that ongoing assessment and care for drug users entering the treatment system is ensured, by addressing changing individual needs and navigating clients through all services, including drug and other health care services, social services, and the criminal justice system.

In Cyprus, the provision of a therapeutic continuum is associated with the idea to make drug services geographically available and to facilitate low-threshold access followed by prompt referral to specific treatment programmes. All cities and regions first need a multifunctional outpatient service, low threshold and easy to access, before concentrating on making other specialised services available. Even though drug services already exist in all major regions and cities, not all of them provide a diversified programme. Consequently, apart from the introduction of maintenance treatment, a first line of treatment with decentralised and multifunctional drug services in all bigger cities and regions, providing a range of different outpatient programmes, was recommended as a major result of the evaluation. Multifunctional outpatient facilities should provide different drug services ranging from information and advice, brief intervention, counselling, drug therapy up to ongoing care, as well as harm reduction as one module of outpatient intervention. One main function of these services should also be the navigation of clients through the treatment system in terms of case management.

The basic principle of this “first line” treatment should be the accessibility to any kind of drug treatment for all users without applying exclusion criteria. Nevertheless, specialised facilities, such as inpatient detoxification units, inpatient (residential) treatment units and services for adolescents are very important and it was recommended that these be maintained, having their access policy changed, in order to enable a direct access.

6. Conclusion

The overall objective of this evaluation report is to enhance the capacity of the Cyprus addiction services as regards the implementation of a continuum of care for drug addicts. A field investigation studied parameters as population in need, treatment demand and coverage, as well as high risk patterns and their trend over the last years, showing an individual place of Cyprus in the international drug ranking. Furthermore, this evaluation studies in detail the current availability of the governmental and non-governmental drug facilities, their structure and coordination as well as the legal framework in which they operate, showing a still adapting drug care system, trying to keep up with the increasing special needs of the Cypriot population, but offering the presuppositions for an efficient and good functioning drug care system in the future.

In Cyprus, drug treatment based on psychotherapeutic abstinence is the most prominent approach to treat users of illegal and/or legal substances, with the most available services addressing adult drug users. Even though a number of outpatient and inpatient treatment services are available, there is a lack of certain, primarily specialized treatment options. In addition, there is still a lack of communication between the involved bodies and facilities, which limits the possibility of effective planning and coordination of drug treatment and makes the need for a global coordinating structure essential.

As addiction services in Cyprus are still adapting to the increasing special needs of the population, an evaluation can guide needed reforms to achieve a more efficient system. Some crucial changes with respect to the structure and coordination of the facilities, in combination with a redefinition of several objectives, in order to cover existing gaps in the treatment offer, can guarantee the continuity of care within a drug treatment conformed to the international state of the art. Specifically, suggestions were aimed at more harm reduction measures, including maintenance treatment, and a good balance between multifunctional services with a low threshold and specific treatment options. The Cypriot authorities have already either put into effect or started to develop adequate responses to the recommendations, so that an overall improvement of services can be expected in the future.

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Annex I - Evaluation of the governmental drug services

The evaluation of the governmental services is part of the Twinning project between Cyprus and Germany, which started in April 2007. The twinning project consisted of nine different activities and their related tasks were to be fulfilled within the eight months duration of the project. The evaluation of the governmental drug services presents the results related to the Cyprus situation existing in July 2007.

In this chapter the six governmental addiction services are assessed according to their target group, objectives, structure and processes. Afterwards the structure and processes are evaluated and recommendations for the improvement of each of the services are formulated.

I. 1. THEMEA – inpatient therapeutic unit

I. 1. 1. Introduction

THEMEA was founded October 1991 by the Mental Health Services and the Ministry of Health and offers its services in the field of addiction problems in the Centre of Mental Health of Nicosia. Addicted patients of all substances have been treated for a long period of time. In the year 2004 THEMEA changed its target group (as Toxotis and Pixida were founded, see below) and recently has moved to another location. The evaluation of THEMEA is based on the work with the new target group.

I. 1. 2. Target groups

Since 2004 THEMEA has a new target group: Alcohol dependence and dependence from other legal substances, such as prescribed medication. This new, clearly defined target group includes adults (at least 18 years old) addicted to alcohol and various psychotropic medication. Patients with a dual diagnosis including a diagnosis of dependence to alcohol or medications are also treated. Exclusion criteria are only illegal status for migrant patients and age below 18.

I. 1. 3. Objectives

THEMEA aims to provide a clearly structured inpatient detoxification programme via appropriate medical methods, psychological support and counselling, occupational interventions and nursing care in order for the patient to accomplish the requirements of the programme and be transferred to the next therapeutic step and rehabilitation.

I. 1. 4. Structure

Staff

THEMEA's staff includes following members:

- 1 psychiatrist (part time) also responsible for the management
- 2 clinical psychologists (part time) – both are also working in the facility TOXOTIS
- 2 occupational therapists (one full time, one part time)
- 3 senior psychiatric nurses
- 20 mental Nurses (full time)
- 1 social server (2h / week)
- 1 secretary (not in a stable basis)
- 4 cleaning women

Regular meetings take place twice a week. These meetings are also used as internal supervision opportunity.

Rooms & facilities

THEMEA moved into a new building in 2006. The present location is a 10+6 beds unit over 2 floors of a building, which also houses a private clinic and privately rented apartments. On the second floor are the rooms for group therapy as well as, since 2007, 6 additional beds for patients being in last phase of rehabilitation and already working (however at the time of the evaluation visits there were no such patients). The rest of the rooms and 10 regular beds are situated on the third floor of the building.

THEMEA offers rooms for individual counselling/treatment, group sessions/therapy and occupational therapy, a drop-in area/lounge for patients, a kitchen for patients as well as sanitary and shower for the patients.

There is a plan of moving the facility into the area of the old hospital in about 5 years.

Setting

THEMEA provides a strictly defined detoxification programme with the following structure.

- 1st phase: physical detoxification (2 weeks)
- 2nd phase: motivation enhancement (1 week)
- 3rd phase: social rehabilitation (inpatient and outpatient)

Most patients' admissions are referrals from Toxotis, on seldom occasions also from the general hospital. Direct admission without referral is not possible. The 1st phase of the programme is the precondition for the whole treatment. There is no possibility of entering the programme in the 2nd or 3rd phase, even if a physical detoxification was completed in the general hospital, i.e. due to treatment of another medical condition. Drop-out patients who wish to re-enter the programme must undergo a new motivational assessment in Toxotis. Any patient can leave the programme after the completion of the first two phases, if so agreed.

Patients of THEMEA receive a multimodal treatment consisting of a residential treatment (therapeutic community) with an inpatient detoxification, outpatient treatment/rehabilitation, educative groups, individual sessions, individual and family therapy, various group sessions, relapse prevention and motivation-increase programmes, occupational therapy, self-help groups, social rehabilitation programmes, entertainment programmes (visiting of museums, theatres, cooking, etc.), life skill training and physiotherapy. THEMEA provides also the following programmes:

- Family support and educational groups once a week
- Open line -02304534 (information, support, referrals)
- Printed information material
- Counselling activities outside the unit

Rules & Setting

Every new patient of THEMEA has to sign a declaration of following and accepting the rules of the unit in order to enter the treatment programme. There is a system containing progressively gained privileges or therapeutic penalties.

For example:

- In the first 2 weeks of the treatment no visitors or phone calls are allowed. Once every 4 days a phone call to the nearest relative, but done by the staff, is possible. Mobile phones

are prohibited. Patients are not allowed to exit the unit. Smoking in closed rooms is prohibited.

- Not until the 3rd week a first leave of 20 minutes under supervision (i.e. together with a nurse) is made possible.
- No smoking of more than 15 cig./d is allowed.
- Not attending a session for 3 times leads to dismissal of the patient.
- Not until the 5th week the patient is allowed to leave the unit for the first time for 20 minutes without supervision.
- These privileges can be revoked anytime by the staff.
- In the third phase a contract must be signed over a two year period, including 5-8 weeks inpatient treatment (same groups as during the first two phases), followed by an outpatient phase with so-called self-help groups (coordinated by nurses) and family interventions.
- Only in the final phase of the rehabilitation phase the patients have the chance of one and then two overnights at home.

There is a further big range of other restrictions and rules, which can not be mentioned all in detail. Disrespecting or neglecting the rules leads to therapeutic penalties.

For example, possible penalties are:

- Wake up at 6.15 am, preparation of breakfast for all, cleaning of rooms and sanitary, cleaning the entrance of the building.
- Seizure of pack of cigarettes
- No phone calls for 3 days, no visitors for 3 days, no TV for one night.
- Isolation in bedroom without music for one hour, hand out written report of behaviour.
- No exit for one week, reduction of privileges for one week

In case of a relapse, the patient may not return to the unit on the same day. The patient is then motivated to return the next morning sober to discuss the relapse and the possibility of the continuation of the treatment.

I. 1. 5. Processes

Programme – Specific Services

New patients are assessed by the psychiatrist (only present Mondays & Tuesdays) and receive medical and pharmacological support for the prevention of a withdrawal syndrome as well as intensive nursing care (blood pressure and pulse monitoring every four hours). If

needed the patients receive an additional evaluation and treatment from the psychiatrist and clinical psychologists. Blood tests and infectious diseases' screening are made during the treatment.

For the detoxification phase Librium, Vit. B complex and sleeping medication is given to the patients. Medication can only be given when 0‰ of alcohol in blood is reached. There are only spare occasions of patients receiving medication with rest-alcohol in blood and only when strongly recommended with the psychiatrist's agreement. There are no anti-craving medication (acamprosate, naltrexone) given.

In general there are neither clearly defined objectives at the beginning nor special care plan developed in close cooperation with the patients. After the first 3-4 days of physical stabilisation, the programme begins with individual and group sessions, educative programmes, etc.

The motivational enhancement work begins during the first phase and lasts for 1 more week after completing the detoxification phase. The completion of the motivational enhancement phase is the precondition for entering the final phase of the programme. All patients are motivated to follow into this rehabilitation and psychotherapy phase lasting 24 months. Further treatment and referral to other therapeutic centres after the therapy in THEMEA is recommended only in individual cases.

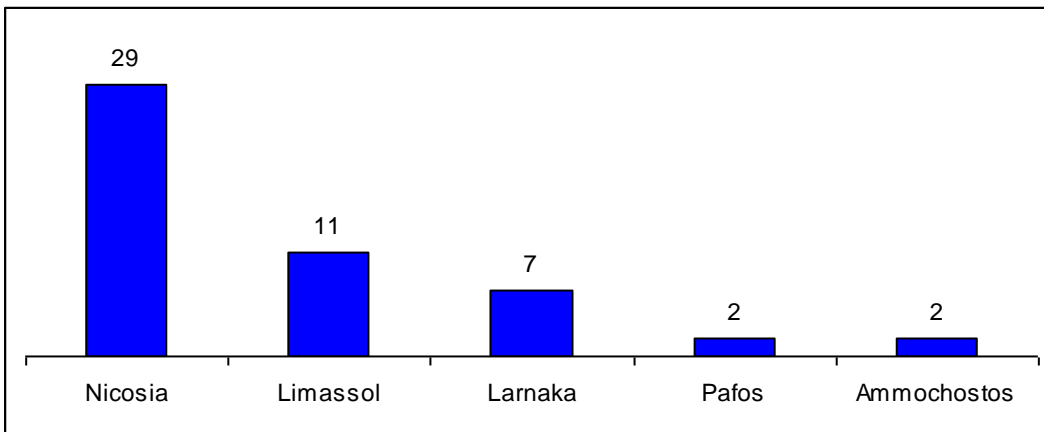
THEMEA works in cooperation with general practitioners, other physicians, hospitals, rehabilitation facilities, residential treatment facilities, outpatient treatment facilities, counselling centres and welfare institutions units for the continuity of the treatment.

THEMEA does not participate in a quality management programme and has never been evaluated before. THEMEA uses a standardised instrument (EuropASI-TDI) for a non-electronic statistical documentation, as there is no PC with internet access used for documentation in the facility. There is no information received by any other service or monitoring centre. There are PCs with internet access, but none used for documentation.

Results – Annual Report

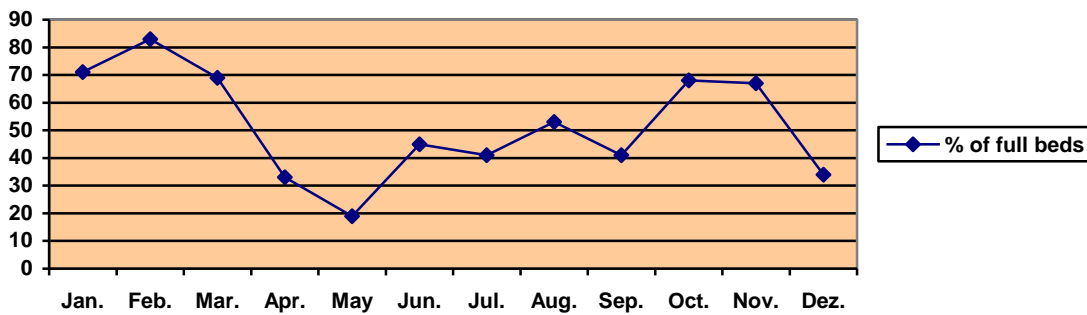
There were 54 admissions of patients in the year 2006. Of these admissions 52 were related to patients with an alcohol addiction and the remaining two admissions were related to the addiction of various medications. Around 5% of the patients had an addiction to more than one substance. The average age of the patients treated was 45 years and over 80% were men. Only 40% of the patients were new cases. All 54 patients received detoxification, individual counselling/therapy, occupational therapy, and life skill training. Most referrals came from various sources in the area of Nicosia.

Figure 19. THEMEA – Number of clients from cities in Cyprus



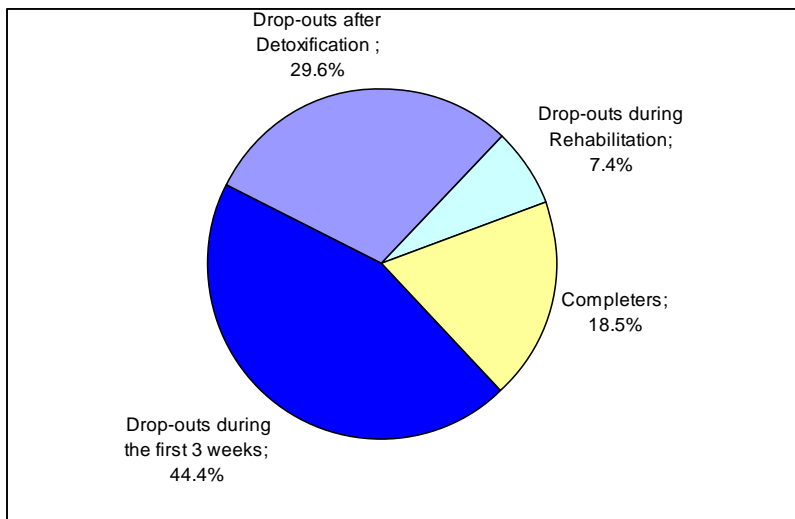
In 2006 only 57.75% of the 10 beds were occupied and the percentage varied strongly (May 19%, Feb. 83%).

Figure 20. Occupancy rates of THEMEA



THEMEA also reaches a high drop-out percentage. The drop-out rate during the 1st phase of treatment (physical detoxification) is 44.4%.

Figure 21. Drop-out rate of 54 patients treated in THEMEA in 2006



I. 1. 6. Evaluation

THEMEA is designed to serve the detoxification and rehabilitation needs of patients with a dependence of alcohol or other medications, and as such is the only service of the MHS that takes care of this population in Cyprus. Unlike the services dealing with illicit drug users, where a lot of development has taken place in the last 5 years, THEMEA seems to run a medical and therapeutic concept that has not undergone any development in the last years and therefore does not reach up to scientific standards in the field. In general the medical treatment is not modern enough, the therapeutic concept is too rigidly focused on only one possible therapeutic track, is strongly based on very restrictive rules, the rationale for the rules is often not clear or clearly counter-productive and the work by the staff is not adequately managed and supervised by a well-trained, motivated, responsible professional. These drawbacks are reflected by a low coverage (low occupancy despite the unit being small for the size of the population) and poor outcome (low completion rate, high drop-out rate in the first 3 weeks). Considering the fact that according to the WHO alcohol dependence is considered one of the main factors for the global burden of disease, the effect of THEMEA in reducing the burden of alcohol-related disease in Cyprus has to be evaluated as being far too low. The following can therefore only represent a small part of potential criticism of the details of the service.

Structure

- Staff

The staff lacks a responsible professional working fulltime in the service. Such a person would also be in charge of the future development of the therapeutic concept and all the other necessities, which are criticized in this evaluation. In general this professional should be a medical doctor, preferably a psychiatrist, but it would also be possible for this professional to come from another professional field, such as a psychologist.

There is definitely a lack of psychiatrist's presence in the facility. Due to the part-time employment status of the psychiatrist (2 days/week) patients can only start the programme on these two specific days – the service is too inflexible and occupancy cannot be sufficiently regulated by new admissions. A dose adjustment during the week, if necessary, can only be made per telephone, without a clinical evaluation of the patient by the psychiatrist. There is also increasing needs of the social worker services, which cannot be fulfilled in 2 hours per week.

The nursing personal staff number seems superfluous for the capacity and needs of the unit. Even if the service had a full occupancy (16 patients), a nursing staff of more than 20 nurses is unnecessary. (As an example from another country: The detoxification unit at the University Hospital in Hamburg, Germany, has a nursing staff of 12 nurses for 21 beds.) Unfortunately this overcapacity of nursing staff is tied to other rules and regulations – two examples: 1. The fact that patients are only allowed to leave the unit under supervision (with a nurse) for the third to fifth week leads to superfluous work that needs to be covered by nurses. 2. The fact that during the night shifts 2 nurses are always necessary (MHS regulation) leads to an unnecessary number of nurses tied up in night shifts. In addition, as governmental workers, they can be ordered to change their working place and moved from one therapeutic centre to another, without warning and with little chance to protest against it.

- Building

The building in general is not adequate and the location of the unit is not eligible for the service offered. The unit is placed in the centre of the city, in a residential neighbourhood and too far from the general hospital. Residential apartments are located both one floor above the unit (children and others use the same entrance and staircase – anonymity not granted) and across the street (people on balconies drinking alcohol and having parties). There is also a renovation need especially for the kitchen, the sleeping rooms and the lounge area as well as a lack of individual counselling and group session rooms, detoxification room and smoking area.

- Setting

The rules of the programme, being restrictive and inflexible, are not adequate for an effective treatment of alcohol dependence. The lack of attractiveness of the programme implicates the high rate of vacancies and drop-out. The rules also cause many problems to patients and staff members, as they provide a conflict area for the staff members among themselves and staff members have problems in conveying the rationale for each of the rules. Therefore the rules are not unanimously accepted by staff members and interpreted differently, which then leads to discussions and conflicts among staff members. The staff seems unable to unite for a collective decision and for applying rules to the actual needs of the patient. The fact that the rationale for the rules is not transparent enough for all staff members is also reflected by the insufficient occupancy – patients also seem to not be

convinced of the necessity for these rules and opt to look for detoxification possibilities in the private sector.

Unfortunately the Open Line is often not manned, as staff may not be present. In numerous occasions the phone is used to make outgoing calls (even private calls by staff) and is therefore busy for incoming calls.

Processes

In general there are neither clearly defined objectives at initiation of treatment nor a special care plan developed in close cooperation with the patients. Admission is only possible by referral, in general through TOXOTIS, despite the fact that the possibility of self-admission would increase the number of patients reached and also reduce the time until treatment. There is also no possibility of entering the programme in the 2nd or 3rd phase (despite the lack of a rationale for this), even after detoxification in the general hospital. Due to the part-time employment status of the psychiatrist (2 days/week) the patients can only start the programme in these two specific days. A dose adjustment during the week can only be made per telephone.

An ambulance is only available in the morning. In case of a medical emergency, patients have to be transported to the general hospital with a taxi; however taxi costs implicate a higher threshold of the transport.

There is no specific treatment offer for special groups. The therapeutic concept does not change by entering the next phase of treatment. Patients attend the same groups during the whole therapy (up to 25 months!!!), factor which leads to boredom and tiredness.

All group sessions are run by nurses or occupational therapist. In this domain there is also no specific training and no therapy manual, as well as no participation of a psychologist. The responsibility of the one of the psychologists is not clearly defined, as no individual or group therapy are offered by this psychologist. The second psychologist, who also works in TOXOTIS, offers individual therapy and participates more actively in the treatment.

A big demand of staff training has been obvious not only due to a lack of regular official training during the year in Cyprus, but furthermore due to a lack of a systematic initial skill adaptation training and introduction into treatment and therapy methods. There is no consistent standardised procedure of dealing with various situations (health problems, other care needs, etc.) and no active training, guidance or supervision through the senior mental nurses. This situation manifests itself as an insecure feeling among the staff. In addition there is no external supervision taking place.

Further treatment and referral to other therapeutic centres after the therapy in THEMEA is recommended only in individual cases. A follow up does not exist. There are no alternative options offered to patients who complete the first (and second) phase of treatment but do not want to sign a two-year therapeutic contract for rehabilitation.

The cooperation with other services and centres appears also deficient. There is no responsibility of referral by other services, especially not by GPs, who are the ones who see most persons with alcohol dependence. There is no information received by any other service or monitoring centre. There are PCs with internet access, but none used for electronic documentation. There is a lack of a unifying structure of addiction services within the mental health services which would represent all addiction centres to the director and the management committee for the resolution of problems.

Results

There seem to be several reasons that make the programme appear not attractive enough to patients (restrictive rules, building not nice, location inconvenience, lack of information about the programme, etc).

There have been only 54 admissions of patients in the year 2006 and only 57.75% of the 10 beds were occupied and the percentage varied strongly (May 19%, Feb. 83%). The other 6 beds for patients in the 3rd phase were even less occupied, as only 14 patients (=26%) reached this phase and only a small part of these 14 patients are then far enough to also start working while in treatment. THEMEA also shows a high drop-out percentage. The drop-out rate during the 1st phase is 44.4%. Of all patients treated in 2006 only 10 (=18.5%) completed the programme. The results are a sign of low coverage and poor outcome.

I. 1. 7. Proposals

In general it seems to be quite obvious that among the 6 existing addiction services of MHS, THEMEA is the only service that needs a complete restructuring to improve occupancy and outcome. This need is also expressed by part of the staff. A reorganisation of the unit has to be based on a completely new therapeutic concept, which has to start by questioning the meaningfulness of all procedures, rules and regulations of the unit.

The treatment offered to alcohol dependent persons has to be diversified to include out-patient and in-patient detoxification as well as long-term in-patient rehabilitation and short-term out-patient aftercare. Patients have to be initially assessed with respect to the need of in-patient detoxification, but should have the option of out-patient detoxification. In-patient

treatment should have the focus of strengthening the ties with the family, instead of trying to alienate them from the family (as the present rules in effect do).

In-patient detoxification should be the main focus of the therapeutic concept, as it also is presently. There is no necessity to cut-off communication between patient and the outside world; on the contrary, the family (and his friends) of the patient is one of the factors that motivate the patient to continue with treatment and should be included in a more systemic (family-oriented) therapeutic concept. The prohibition for the patient to leave the unit should be restricted only to the first week of treatment, as this is the part of treatment where medical complications occur most often (if at all). Thereafter there is no reason to not allow the patient to leave the unit – the treatment should follow a community-based concept which includes tasks for the patient in the community, such as taking care of things that he was not able to take care of while inebriated, but also confronting the patient with the general availability of alcohol and the resurgence of craving when confronted therewith. There also is no reason to supervise the patient when he leaves the unit; as long as there is a clear rule with respect to relapse, the patient should be confronted with the “outside world” and should then use the therapeutic sessions to reflect the impressions he makes (therapeutic focus on craving and interpersonal conflicts). Presently the rules with respect to leaving the unit are a reason for patients not to enter treatment.

The service also needs a fulltime professional responsible for the service, preferably a psychiatrist, who also introduces more innovative medical approaches to detoxification treatment. These include a more flexible dosing approach for withdrawal medication, closer attention at underlying psychopathology and possible treatment of dual diagnosis disorders, and a stronger role in motivating the patient from a medical perspective with regard to long-term abstinence. Furthermore, the introduction of anti-craving medication (acamprosate, naltrexone) should be considered at least for part of the patients.

It would be helpful to separate the detoxification phase (presently the first and second phases) from the rehabilitation phase (presently third phase), both geographically as well as conceptually. Similarly to the concept with illicit drug users, it is helpful for a patient if his progress in treatment is reflected by a geographical change. Therefore, it would make sense to have the detoxification phase in a unit close to the general hospital and the rehabilitation phase in a residential neighbourhood (as is the present location). The therapeutic concept should also be separated: the therapeutic focus in the detoxification phase is motivating the patient towards abstinence, while in the rehabilitation phase the focus should be on conflicts, skills and emotional management.

In addition there is a clear need for the computerisation of the unit, as documentation is only hand written and insufficient. There should be a broader cooperation with other medical disciplines and a yearly evaluation. Besides the importance of a responsible professional, continuous education and supervision for the staff are necessary. There also is a need for harmonisation of THEM EA with the policy of the Anti-Narcotic Council.

I. 2. Anosis – detoxification unit

I. 2. 1 Introduction

ANOSIS is a physical detoxification and motivation unit with a programme lasting up to 3-4 weeks. The unit was founded in February 2004, is placed in specially arranged spaces of the Old Hospital Complex in Limassol, has a capacity of 15 beds and is the only detoxification unit for dependence from illicit drugs on the island.

References from counselling centres and other services as well as individual treatment applications are individually assessed and admission to the unit is grounded on diagnosis of dependence and sufficient motivation and acceptance of the operation rules.

I. 2. 2. Target groups

ANOSIS has a clearly defined target group, which includes adults (>18) addicted to illicit drugs. Patients with a dual diagnosis are also being treated.

There are practically no exclusion criteria, except illegal status of migrant clients and age.

I. 2. 3. Objectives

ANOSIS aims to provide an individual inpatient detoxification programme of 3-4 weeks via appropriate medical methods, psychological support and counselling, occupational interventions and nursing care that should enable the client to accomplish the detoxification the programme and be transferred to the next therapeutic step.

I. 2. 4. Structure

Staff

ANOSIS' staff includes following members:

- 1 psychiatrist – scientific coordinator of ANOSIS and Promitheas - also responsible for the management (part time)
- 19 psychiatric nurses (full time)
- 1 psychiatric nurse (part time)
- 18 nurses (full time)
- 1 psychologist (part time)
- 1 occupational therapist (part time)

- 1 secretary
- 1 cleaner

There is a staff training project application in cooperation with Hamburg within the frame of the Leonardo programme. 20 staff members will stay two weeks in Hamburg for study visits.

Rooms & facilities

The 10-bed-facility offers a lounge/drop-in area for the clients, rooms for individual counselling, group sessions/therapy, occupational therapy, a kitchen for the clients, sanitary and shower for the clients and a gymnastic and music rooms. In Anosis there is an PC but without internet access. The facility is placed between two police stations.

Other Assessments

- “Sympleusis” - in cooperation with the Volunteering Unit of Limassol
- Educational seminars for prevention
- Specialised volunteers offered entertainment therapy sessions in ANOSIS

I. 2. 5. Processes

Programme – Specific Services

For the admittance to the centre the clients are obliged to keep daily contact the last two days before entering ANOSIS for motivational reasons (clients from counselling centres excluded). ANOSIS provides an individual support based on the individuality of each person as well as social assistance addressing case-specific issues. If needed the clients receive an additional evaluation, support and treatment from the psychiatrist and a clinical psychologist.

The clients receive medical and pharmacological support for prevention of a withdrawal syndrome (i.e. Methadone for 12-14 days) and the treatment of other medical problems. Blood tests and infectious diseases’ screening are made before or during treatment. The average duration of detoxification lasts 3 weeks, with a possibility of a longer stay.

The individual care plan is planned in close cooperation with the clients and a clearly defined objective at the beginning. Mental health problems, infectious diseases, social situation, family and interrelation problems, occupational situation, legal problems, treatment motivation are main focus areas of the additional treatment. The individual

treatment consists of educational sessions, individual and group sessions and psychotherapy, occupational therapy, social rehabilitation, entertainment sessions, etc.

There is a specific treatment for migrants, long-term users/severely dependent persons, socially well-integrated users and patients with a psychiatric diagnosis (dual diagnosis). Individual counselling/therapy can also be offered in English and Russian.

For female clients there is no specific programme. In order to facilitate their stay in the detoxification centre the staff tries not to admit very difficult men at the same time. Women are offered individual sessions in addition to group sessions.

Further treatment and referral to other therapeutic centres after detoxification treatment in ANOSIS is always recommended, but no follow up exists. The staff has regular meetings once a week. These meetings are also used as internal supervision opportunity. ANOSIS works in cooperation with general practitioners, other physicians, hospitals, rehabilitation facilities, residential treatment facilities, outpatient treatment facilities, counselling centres, prisons, and welfare institutions units for the continuity of treatment.

ANOSIS does not participate in a quality management programme. The unit has been evaluated in the year 2005 from the Greek KETHEA Centre. ANOSIS uses an electronic documentation system. Various data is being sent to other services, such as the Cyprus Anti-Drugs Council, the Mental Health Services and the E.K.TE.P.N. for analysis and a common planning of the further strategy.

Results – Annual Report

During the last three years there have been ca. 500 admissions of 300 individual clients. The majority of the clients were referred from counselling centres through a close cooperation.

In the year 2006 99 clients were treated in ANOSIS. There were altogether 169 admissions into the programme with a 71% drop-out rate (121 drop-outs). On average the clients stay 13 to 14 nights in the detoxification treatment. The occupancy rate was around 65% (169 clients x avg.14 nights / 10 beds x 365 nights).

Most admissions were related to clients with a heroin dependence (150 admissions = 88%). 8 admissions were related to cocaine and amphetamine (4%), 1 to cannabis, 2 to medication use and 8 to other substances. The percentage of clients with a dual diagnosis is estimated at about 20%.

In 150 of all admissions individual counselling was applied, in 160 cases group sessions and group therapy, and in 160 occupational therapy.

There are estimated 10% of the clients who are migrants with legal status. The main groups of migrant clients with addiction problems are Georgian, Russians, Romanies and Arabs. This percentage used to be higher in the past, but has decreased due to stricter adherence to the question of legal status.

In 2006 there were 27 acts of violence by 32 patients documented. 20 of the cases refer to violence among patients (9 cases of verbal and physical abuse with light injuries and 11 of verbal abuse) and 7 cases to verbal abuse against therapeutic personnel. There has been an increase of such cases noticed in comparison to 2005 (=11).

Programme completers are referred to a Therapeutic Community but this kind of treatment is not always the first choice of the clients. Thus, a maximum of half of the completers continue treatment in a Therapeutic Community. The remaining completers prefer outpatient treatment and are referred to a counselling centre.

I. 2. 6. Evaluation

In general ANOSIS gives the impression of a well-run unit with a therapeutic concept of detoxification treatment that is in accordance with international scientific state-of-the-art. The treatment concept using medical methods, psychological support and counselling, occupational interventions and nursing care is appropriate. The length of stay for patients of 3-4 weeks is also appropriate and should not be shortened, as this would run the risk of a higher relapse rate. The staff includes persons from different professions, so that the necessary interdisciplinary work can be carried out. The concept is well integrated in a plan which includes counselling before admission to ANOSIS and aftercare (mainly therapeutic community) after detoxification. There are a few points, which can be addressed, which would strengthen the outcome and therefore lead to improvement.

Structure

All scientific personal has a part time status in ANOSIS, fact that generates problems for the proper treatment. There is only one psychologist and no social worker in ANOSIS. The nursing staff number seems too high for the capacity and needs of the unit, as well as during the night shifts, as there are always 2 nurses demanded. On the other hand, the two nurses needed on night shifts presently seems necessary, as in case of violence it seems to take too long for help from outside (i.e. police) to arrive – a better cooperation with the police may need to be addressed in the future. Another problem is the lack of male nurses,

needed for the safer and proper functioning of the centre. By the end of this year ANOSIS will have a permanent staff, without any rotation of the nurses.

The facility offers a variety of rooms for treatment/therapy, but the number seems not to be enough for a proper functioning (i.e. there is no access to a garden). The facility does not have a PC with an internet access.

Processes

There is a high-threshold access to the detoxification centre due to a lack of sufficient beds. The procedure of admission creates conflicts between ANOSIS and counselling centres, concerning the duration until admission. There is a big drop-out percentage of clients in this phase, who consider counselling to be a waste of time. Considering the high drop-out rate during treatment, the high-threshold access should be reconsidered, as a lower threshold would increase the coverage, while the drop-out rate cannot increase much further.

Due to families with several addicted members, even sometimes over 2 generations, more possibilities for family therapy, including couple therapy, are necessary. In addition there are generally only poor opportunities to keep inpatient clients busy, fact which leads to boredom and lack of motivation. This seems to be a more prominent reason for drop-out, as opposed to the lack of motivation before entering the service.

Inpatients treatment, such as a Therapeutic Community (Pixida), are not popular among the clients, as a great part is still socially well integrated (family, job). So due to the lack of centres with a diversified aftercare (i.e. out-patient therapy, day care centres), the therapeutic step after successful detoxification treatment fails. But even if there is sufficient motivation to enter a Therapeutic Community, the threshold is very high and the meetings required before acceptance of a client often cannot be accomplished during the detoxification phase. A follow up of the patients after the detoxification phase does not exist.

There is a lack of a unifying structure of drug addiction services within the mental health services which would represent all addiction centres to the director and the management committee for the resolution of problems. A closer cooperation between detoxification centre and aftercare (presently only TC) appears strongly needed.

A big demand of staff training has been obvious, due to a lack of regular official training during the year in Cyprus. There has been no specific therapeutic training for most psychiatric nurses. Furthermore, an external supervision does not take place.

Results

All patients meet the target group and age group criteria. Nevertheless ANOSIS shows a big drop-out rate (121 drop-outs = 71%), which only in part is the expected outcome for this target group.

The big majority of the clients received individual counselling, group sessions and group therapy, and occupational therapy.

There seems to be a problem concerning the referral of the clients after the completion of the detoxification programme in ANOSIS, fact that could explain the big drop-out rate.

Although a police intervention was needed quite often, the police support arrives too late, in spite of the building of ANOSIS being placed between two big police stations.

Assessment of the treatment process, including outcome variables, needs to be implemented in accordance with the Cyprus Anti-Drugs Council.

I. 2. 7. Proposals

A discussion in the near future is planned for the readjustment of the programmes of ANOSIS, in order to adapt its offer to the changing needs and demands in Limassol and to new, more effective therapeutic methods (outpatient detoxification, outpatient treatment/rehabilitation, harm reduction services, needle exchange programmes, intensive day care and maintenance treatment). It seems clear that the efficacy of the ANOSIS concept depends on a better overall concept of drug treatment in Cyprus, which presently lacks the diversification necessary for a better outcome.

One important step in improving the coverage by the service is to decrease the high threshold for admission into ANOSIS. Considering the already high drop-out rate, decreasing the threshold cannot have such a negative impact on the drop-out rate, as other reasons seem to be responsible for the high drop-out rate. Furthermore, decreasing the threshold leads to detoxification being applied as an earlier intervention.

In the last two years there seems to be the trend that clients go to the North of Nicosia in order to undergo detoxification with buprenorphine. Obviously Cyprus drug addicts seem to prefer buprenorphine instead of methadone, which is the substance offered in ANOSIS. Due to the demand of clients for detoxification with buprenorphine the coverage of ANOSIS might be improved by also offering buprenorphine complementary to methadone. Currently only adults at age of at least 18 years are admitted to detoxification. This excludes all younger drug addicts which are in need for detoxification. In order to offer

them detoxification treatment it is recommended to consider the introduction of an outpatient detoxification programme directed to young addicts.

Aftercare after detoxification seems to be a major problem for ANOSIS. On the one hand, getting patients into Therapeutic Communities is marked by another high threshold: Less meetings before patient is accepted into Pixida could motivate patients to complete detoxification at ANOSIS. On the other hand, other options for aftercare are necessary, i.e. day care centres. There is a need for day care services for rehabilitation and vocational training, which is offered during the day and in the evening the clients go home.

With respect to in-patient detoxification, there is no need for any further detoxification facility, as this one is sufficient for Cyprus and occupancy is not full. However, in order to reach persons with drug dependence at an earlier stage in their addiction, it would be important to consider establishing other decentralized out-patient detoxification units, possibly in conjunction with the establishment of maintenance treatment.

Therefore, in summary, the good therapeutic concept of ANOSIS could be well complemented by some important changes: a reduction in the threshold for admission, the introduction of detoxification with buprenorphine in addition to methadone, and a diversification of services before, during and after detoxification. Furthermore it is recommended to consider the admission of young drug addicts in need for detoxification. As ANOSIS is the only detoxification in Cyprus there is nothing else in place for young addicts.

I. 3. Pixida – inpatient drug therapy

I. 3. 1. Introduction

PIXIDA is a drug free therapeutic community programme for illicit drug addicts, which was founded in November 2003 as a pilot programme of the Mental Health Services of the Ministry of Health, after THEMEA focused its target group on clients addicted to alcohol. In January 2004 came the first treatment demands. The change of name into PIXIDA accompanied the change in structure and treatment offer. The programme is nowadays still adapting its structure, offers and rules to new demands, trying to be as effective as possible.

I. 3. 2. Target groups

PIXIDA's main target group consists of adult clients (>18) addicted to illicit drugs. The specific focus lies on clients of 20-30 years of age, because of the hierarchy structure and the character of the activities of the programme. Precondition for an admission is the completion of the physical detoxification therapy stadium and the motivation of the clients. Clients with a psychotic disorder (schizophrenia, bipolar affective disorder, etc) or clients receiving benzodiazepines or naltrexone as well as migrant clients with no legal status are excluded from the programme. Other psychiatric disorders are not an exclusion factor for the treatment. The participation of clients receiving a substitution therapy is also not possible.

Parents, relatives and friends of addicted persons also belong to PIXIDA's target group.

I. 3. 3. Objectives

Pixida aims to provide individual residential therapy, counselling and support to clients addicted to illicit drugs and their relatives. Main target is the involvement and integration of the clients to the therapeutic programmes or the referral to other services so that the continuity of abstinence, a behavioural change and adoption of new beliefs and lifestyle and the social reintegration and rehabilitation can be reached.

An important aim is to inform the public on the necessity of an effective residential drug treatment (therapeutic community) in order to sensitize and to attract clients and relatives into the programme.

I. 3. 4. Structure

Staff

PIXIDA's staff includes following members:

- 1 psychiatric nurse; scientific coordinator, certified addiction counsellor (IC&RC)
- 1 psychiatric superior nurse; supervisor and certified addiction counsellor (IC&RC) responsible for the management (part time)
- 5 psychiatric nurses; certified addiction counsellors (IC&RC), (full time)
- 9 psychiatric nurses with training in drug addiction awaiting their certification (full time)
- 1 psychiatric nurse (full time)
- 1 occupational therapist (part time)
- 1 drama therapist (from which services are bought once a week for a period of 6 months annually)
- 1 art therapist (from which services are bought once a week for a period of 3 months annually)
- 1 secretary
- 1 cleaning woman

There is also an external cooperation with 1 psychiatrist and 1 psychologist regarding consultation.

Rooms & facilities

The facility has 3 four-bed bedrooms and provides rooms for individual counselling, group sessions and physiotherapy, a kitchen for the clients, sanitary, shower and a PC with internet access. PIXIDA uses also rooms outside the facility for the sessions with the family members. A van for 7 people and bicycles used for therapeutic trips and excursions also belong to PIXIDA. In the garden of PIXIDA are also situated 3 ovens, where the clients bake bread.

Programme

The programme is structured on 5 different work areas:

a) Administration Team

The members of this team have the responsibility for the programme's organisation, proper functioning, supplies, finance and the implementation of decisions made.

b) Pre-community Team

This team's responsibilities are the first meetings, the preparation for the entrance of the clients in the programme, the statistic information documentation and the coordination of the therapeutic network.

- “Free entrance”: once a week for one hour, without appointment. Meetings with the staff and older patients are offered with the objective of increasing the motivation of the clients. There are no exclusion criteria for the participation in this team, the client is an observer.

The programme “free entrance” does not exist anymore due to the cooperation with Toxotis, which has taken this task.

- Preparation Team: once a week. A specific preparation for programme is being offered - only for clients who underwent the detoxification stadium.
- Individual meetings, where clients are being evaluated and specific information are being collected (spec. tools and inventories). The final decision follows.

c) Community Team

- “Soft intervention” programme – Intensive care treatment (presently 5 clients)
- This is a new special programme for the outpatient treatment of not problematic users (users with no severe addiction and previous use of substances such as THC, cocaine, club drugs) with a stable social network. The term “mild” is meant to distinguish this programme from the impatient treatment of a therapeutic community. In this programme up to 30 clients can be treated.
- “Closed” programme (present occupancy: 7 men & 1 woman)

This programme is indicated for the treatment of the so-called problematic users (users with a severe dependency, in particular of opioids). A maximum of 12 clients (8 men and 4 women) can be treated at the same time.

This programme is also divided in a testing phase and 3 basic phases:

The testing phase is the phase prior to the new member phase, where new clients can get an impression of the programme and the staff can see the clients, before they decide to fully enter the programme. The testing phase lasts from 1 day to 1 month and is followed by a written application of the clients in order to enter the programme.

This programme is also divided in 3 phases:

1. The new member phase lasts 2 months. The clients have no responsibilities, but only duties (working, cleaning, etc.)

2. The middle phase lasts another 2 months. The clients take over more responsibilities as cooking and providing hospitality.

3. The old member phase. The clients do not have any duties but the responsibility of supervising the new members, organising the supplies and setting the programme. The finding of a new job and apartment are the main aims of the clients in this phase.

Each phase has a client as coordinator.

d) “Allies” Team

- Independent team for relatives of addicted clients not treated in PIXIDA; this team does not exist anymore due to the cooperation with Toxotis which now fulfils this task.
- Parallel team for relatives with an addicted family member treated in PIXIDA
- Soft intervention allies team for relatives of clients treated in the mild intervention. The certain team has individual meetings with the relatives and group educative sessions.
- Allies’ events – relatives visiting PIXIDA once a month, entertainment combined with educative sessions
- Individual meetings

e) Rehabilitation and Meta-Care Team (Follow up Team)

The objective is the social reintegration of the clients and the parallel support through assessments with respect to various thematic fields. Through the Meta-Care Team regular contacts (1x/week) to the clients are granted, so that all the objectives of the treatment can be secured.

I. 3. 5. Processes

Programme – Specific Services

The objectives of the treatment are clearly defined in the beginning of the programme. There is always a care plan developed in close cooperation with the clients. If needed the clients receive an additional evaluation and treatment from the psychiatrist.

In the observation phase the client has the opportunity for several meetings with older clients and personnel and for the preparation in order to enter the programme. Blood tests, STD screening, testing on TBC and other infectious diseases are also made in this phase.

- Soft intervention

Offered are up to 2 group sessions and additional individual sessions, on a flexible sessions' schedule. The treatment is being developed according to the individual needs of the clients so that a normal day structure may remain (clients can work or study).

- Closed programme

The programme is clearly structured, offering mainly group sessions (plenum, community-, violation-, juxtaposition-, programming-, prevention-, diving-, life-, expression-, orientation-, conversation- and proposal team, individual meetings, social skill training, excursions, entertainment and sport activities, etc.). A rehabilitation phase and a follow up of the clients follow after completing the closed programme (outpatient aftercare group therapy once per week). A further treatment is recommended in individual cases.

Regular staff meetings take place twice a week. These meetings are also used as internal supervision opportunity. External supervision takes place every 14-21 days through the scientific coordinator.

Within the therapeutic community there are various rules which are mostly basic rules and exist typically in nearly all TC's. There are three basic rules which forbid the following: 1. The use of any illegal or legal substance while participating in the programme. 2. The use of physical or verbal violence. 3. Sex with another programme participant. In case of violating the rules clients are sanctioned by immediate expulsion from the programme. The respective client can re-negotiate the treatment contract through the pre- community team on the next day if he/she wants so.

If any further rule is broken, this behaviour is examined in a group session that happens once a week. The client team themselves decides then upon the sanctions and in this way it is given a therapeutic character with the form of redemption towards the rest of the team members.

PIXIDA works in cooperation with general practitioners, other physicians, hospitals, residential treatment facilities, outpatient treatment facilities, counselling centres, probation services and welfare institutions units for the continuity of the treatment.

PIXIDA does not participate in a quality management programme. The unit has been evaluated twice (once in the year 2005 from the Greek KETHEA Centre). Standardised instruments (EuropASI, TDI, Prochaska & DiClemente) for the non-electronic documentation according to EMCDDA are used. Data for analysis and a common planning of the further strategy is being sent to other services, such as the Ministry of Health, the

Mental Health Services, the Cyprus Anti-Drugs Council and the E.K.TE.P.N. monitoring centre.

Results – Annual Report

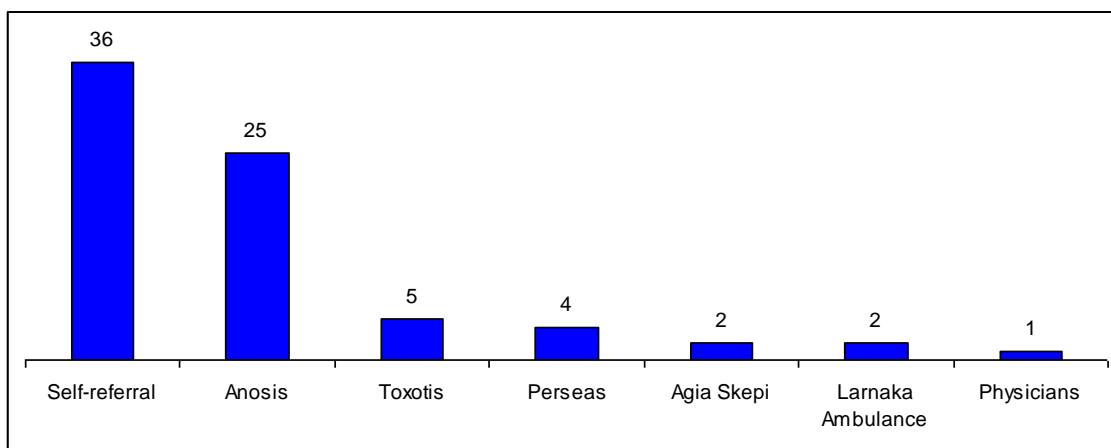
In the year 2006 PIXIDA received 75 treatment demands from 55 patients (14♀, 41♂). There were altogether 55 clients and 74 family members treated in various programmes (=129). There have been altogether 188 pre-community meetings offered.

22 new admissions took place into the closed programme (17 men, 5 women). The middle duration of the treatment was 93 days and 15 drop-outs have been documented (14 on demand of the clients, 1 expulsion). Most relapses happened at the initial stage of the programme which could be an indicator of lack of motivation. In the “mild intervention programme” 5 clients (1♀, 4♂) were treated. There were 11 migrant clients with a treatment demand (20%).

The drop-out reasons are for personal reasons, family matters, lack of motivation and courage to follow a residential treatment. There were no drop-outs due to a relapse and no drop-outs in the rehabilitation phase. Most of them took place in the new member phase.

There was no drug relapse documented in the last years. Among the treatment participants no drug use was observed, neither in the closed programme nor in the rehabilitation and meta-care programme. However, the staff was told from dropouts that they have used drugs after they left the programme but they were not considered treatment participants. As well the staff was informed that there are dropouts who didn't use drugs for a long time and some of them not even have used at all.

Figure 22. Referrals of the 75 clients from other services to Pixida in the year 2006



A big number of activities and excursions have taken place in 2006. There is also a stable income from self baked bread being sold in the community of Pano Deutera.

I. 3. 6. Evaluation

PIXIDA is a very well structured facility offering rehabilitative treatment in form of a therapeutic community and an out-patient treatment with the objective of providing individual therapy, counselling and support to clients addicted to illicit drugs and their relatives in accordance with international scientific state-of-the-art. The fact, that there was no relapse among the clients is an excellent outcome parameter. There is a large variety of therapeutic treatment offers and activities which lead to a social reintegration and rehabilitation. PIXIDA seems also to have a big supportive role for the outpatient clients. The facility is staffed by motivated persons, who are interested in constantly adapting and improving the therapeutic concept. But there are still some points, which need to be reviewed in order for the facility to optimize effectiveness and increase occupancy.

Structure

Currently the programme is only operated by nurses. There is no psychiatrist or psychologist available. However, the nursing personal staff number seems slightly superfluous for the capacity and needs of the unit. Due to a condition determined by the MHS the night duty has to be always staffed with two persons who must stay awake. This fact is not only pointless in a Therapeutic Community, but also disrupts the continuity of the therapeutic care (group sessions are disrupted in their continuity, as qualified staff has to rotate into night duty). The number of nurses also seems disproportionately large in comparison to the poor occupancy rate. Considering the number of patients in the therapeutic community, which does not seem to be attractive enough for patients in Cyprus, the staff has already adapted their overcapacity by initiating the “soft intervention” as an out-patient treatment option, which is an important and excellent addition to the therapeutic continuum.

A big demand of staff training has been pointed out, which is due to a lack of regular official training during the year in Cyprus. There are only few training opportunities for individual staff members abroad (mainly Greece). Nevertheless the staff members of PIXIDA appear motivated and have visited many training activities in the year 2006. In addition, there are 6 already staff members with special training in therapeutic communities working in PIXIDA. Despite the motivation and qualification efforts of the current staff

there are good reasons for including a psychologist in the whole programme. The treatment programmes could benefit from a psychologist in terms of individual therapy for clients with psychiatric disorders or mental health problems.

Furthermore there are still specific needs in the social rehabilitation programme, the occupational therapy (part time status of the occupational therapist) and the physical therapy offer, as well as in the network of cooperation to social services.

Due to an absence of autonomy regarding the financial management of the programme, PIXIDA is also having budgetary problems. There is no budget for extra-recreational or therapeutic activities and needs (for example marathons), despite the importance of these measures for the therapeutic process. Similarly the food budget is not realistic and a permanent problem for the clients (upper price limits for individual items in a specific supermarket with no alternative possibilities).

The unit is located in a house very far from the city, on a very dangerous, high speed road and poorly connected with public transport. There are no special rooms for occupational therapy, specific rehabilitation sessions or privacy and also problems concerning the kitchen, laundry, sewerage and bathrooms. This house was originally conceived as a family house and not for a TC. Furthermore the rent contract of the house expires on 30.09.2008. PIXIDA uses also rooms outside the facility for the sessions with the family members. These rooms belong to the church and there is often a collision of needs.

To PIXIDA belongs also a van for 7 people, which cannot fulfil the transportation needs of the unit, so that in recreational or therapeutic trips either someone has to be excluded or a second car has to be rented. There is also no other transfer possibility for clothing and bicycles.

Processes

One of the biggest problems for PIXIDA is the insufficient occupancy. This either has to do with an insufficient attractiveness of the therapeutic concept, or an insufficient referral process. Both aspects should be looked at more closely: In general there is a reduced attractiveness of a therapeutic community, as the tendency to look for community-based or even family-based solutions seems to be preferred by patients. This preference is supported by the fact, that according to the staff's report the "soft" intervention programme shows an increasing demand and has currently reached full occupancy. Due to the increased demand there is already a waiting list for participation in the "soft" intervention programme.

With respect to the referral process, there seems to be a threshold that may be too high, even though this threshold has already been reduced by PIXIDA (due to their very flexible

approach to solving problems). A better and direct connection and cooperation with other therapeutic and referral centres and a binding cooperation to specific social services would increase the effectiveness of the programme. There seems to be the first efforts for a closer cooperation with Anosis in order to optimise the transition from detoxification to the residential treatment. There are also clear needs in the social rehabilitation programme. There are no specific programmes for teenagers or patients in jail. In addition there is no electronic documentation.

Results

Only 58% of all clients meet the target age group. Those clients treated are mostly not those being severely drug dependent but clients being addicted to heroin for only 2-3 years. Clients with a psychotic disorder (schizophrenia, bipolar affective disorder, etc) or clients receiving benzodiazepines or naltrexone as well as migrant clients with no legal status are excluded from the programme. This could be discussed again, if there was sufficient medical and psychiatric support. The drop out percentage is unclear.

I. 3. 7. Proposals

In general, PIXIDA should on the one hand strengthen their good concept of a therapeutic community, but on the other hand continue down the road of further diversification (as they have already initiated with the “soft intervention”). The staff number is adequate for continuing treatment in the therapeutic community and also offering good out-patient treatment. An expansion in the availability of out-patient treatment could in the future lead to this part becoming the main focus of PIXIDA, even to the extent of giving up the concept of a therapeutic community and leaving this work to the existing other therapeutic community in Cyprus run by a NGO.

PIXIDA should be excluded from the MHS regulation of having to place 2 persons in night duty, as this regulation was conceived for medical treatment units and PIXIDA is not a medical unit and definitely has no reason to expect special events at night. In fact, it might be the best idea to have untrained personnel covering the night shifts, so that the highly trained staff can focus on real therapeutic work. As regard therapeutic work in particular with clients suffering from mental health disorders, the treatment programmes could be improved by including a psychologist in the team.

With respect to the therapeutic community, it might be of importance to have a living facility for the transition phase where patients are starting to work again, similar to the

concept of halfway houses. In order to increase the attractiveness of PIXIDA, it might be important to consider shortening the overall programme length while at the same time having an aftercare out-patient therapy programme for clients who have gone through TC.

The same staff number might also be capable of handling more clients in TC, since most of the therapeutic work is done in groups. This would call for an increase in the number of beds in the TC, which presently would only be possible by renting another location. An optimal number for a TC would be around 30 places, so that specific groups in the different phases of treatment have a sufficient group size. However, to increase the number of TC places, attractiveness would have to be increased (see above). This again might lead to a change of therapeutic concept to out-patient treatment and possibly closing down the TC part of PIXIDA.

As regards the diversification of the programme the introduction of the “soft” intervention seems to be quite successful as an increasing demand for this intervention is observed. In order to enable clients to receive support but to have at the same time a normal daily routine, it is recommended to establish a “soft” intervention programme which differs clearly from an inpatient therapeutic approach. Thus it should be considered to change the current 24 hour programme into an intensive day care unit. Drug users who want to undergo treatment in a therapeutic community still have the option to do so as there is as well a NGO (Agia Skepi) offering a TC programme. But for those drug users preferring a different kind of intensive support the offer of an intensive day care will correspondent to their needs and fill a gap in the current treatment system. In addition, a day care programme would be more cost effective as the duty for staff to work in the night shift will not exist anymore and thus less staff will be needed to operate an intensive day care unit.

Finally it is recommended that PIXIDA starts an electronic documentation (clinical files and archives) in order to increase the possibility to measure outcome. PIXIDA could use an occupational therapist on every day basis, as well as alternative therapies, such as dance and drama therapy, and more physical therapy. The staff needs more training possibilities and external supervision.

I. 4. Perseas – outpatient service for adolescents

I. 4. 1. Introduction

PERSEAS exists since 1999 covering only Nicosia district with the aim of promoting universal and selective prevention programmes as well as indicative programmes for young drug using persons. Until 2002 the programme worked as a pilot programme of the Mental Health Services and had been evaluated four times. After the evaluation period it has been promoted and upgraded through budget and staffing changes. Thus, in the beginning PERSEAS was directed to drug users up to 30 years, and at the end of 1999 the target group was changed to adolescents at risk up to 22 years. Until the end of 2006 PERSEAS offered two different treatment programmes for this age group. The first one consisted in early intervention for high-risk adolescents which are not current drug users. The other treatment programme addressed current drug users without a serious drug dependency.

In the beginning of 2007 it was decided to stop the early intervention programme for several reasons. First, the delay in establishing an intensive day care programme for addicted adolescents, despite their need for help, created the need to offer a structured intervention for more serious cases. Second, it was the conclusion of the staff that mixing drug depended adolescents together with non using adolescents results in difficulties because of the different profile and needs of each group. Third, running two different programmes, with different networking activities for each one, was reflected in a confused identity of the facility in the General Public and professional perceptions. Furthermore, the focus on the target group of drug users allowed the staff to elaborate a comprehensive model of a more intensive treatment programme which corresponded not only to the professional background of the staff but mainly to the complex needs of this target group. At the same time non-using adolescents could be referred to existing services for their needs at the Welfare Department Family Guidance Center and the Services for Children and Adolescents of the Mental Health Services.

I. 4. 2. Target groups

Until April 2007 PERSEAS has had two main target groups. One target group had been high-risk, non-user adolescents; the other one had been adolescent users of illicit drugs, alcohol and psychotropic medication with experimental and/or systematic use.

Since May 2007 the first target group is no longer addressed, and respective clients are referred to the social welfare system. Now the clearly defined target group consists in teenagers and adolescents 12 to 22 years old with an initial/experimental/systematic use. If drug users at age of 23+ request treatment in PERSEAS, they are referred to the counselling centre Toxotis or directly to Pixida, Agia Skepi or Anosis. There exists an agreement for referrals between these drug services.

The target group of adolescents with experimental or systematic use is defined as follows:

- Experimental or recreational drug use means a frequency of drug use less than 10 times per months.
- Systematic use refers to the daily use of cannabis, cocaine or other illicit substances.

Clients with additional diagnoses such as behaviour (ADHD) and personality disorders are accepted for treatment at PERSEAS. Beside age and drug use behaviour the only further exclusion criteria are psychotic symptoms which hinder treatment.

A further target group are family members and social systems surrounding the adolescents (e.g. school).

Since this year PERSEAS was officially renamed from Drug Prevention Centre to a Counselling Centre for Adolescents and Family.

I. 4. 3. Objectives

The two main objectives of the centre were the following until April 2007:

- Prevention of drug use in high risk adolescents.
- Blocking the course towards dependence in young drug users.

The centre aims at drugs use cessation by reinforcing and mobilizing the adolescents' healthy resources towards the development of healthy attitudes and life skills in order to prevent and eliminate drug use and associated risk behaviours. The programme focuses not only on the treatment of the expressed symptom (short-term), but also on changing the dysfunctional mechanisms of adolescents and their families (long-term).

Since April 2007 only the second objective is promoted.

I. 4. 4. Structure

Staff

All of the permanent staff of Perseas is employed full-time.

Perseas' staff includes the following staff members and qualifications:

- 1 clinical psychologist (scientific coordinator), who is a family systemic therapist and addiction counsellor (advanced level).
- 3 clinical psychologists, with an orientation towards family, psychoanalytical and cognitive-behavioural therapy.
- 1 superior nursing counsellor, accredited by the ICRC
- 3 psych. nurses, two of them are addiction counsellors and prevention specialists according to ICRC
- 1 occupational therapist
- 1 secretary, 1 cleaning woman

Two staff members have an ICRC accreditation at advanced level 1 and two staff members have this accreditation at level 2. Since summer 2006 Perseas collaborates with one art- and one drama-therapist. The two specialists are financed by the Cyprus Youth organisation until the end of 2007. Afterwards the financing of the art and drama therapist remains unclear. Both specialists offer one session per week for the clients.

Regular meetings take place once a week and for at least 5 hours. These meetings are also used as internal peer supervision opportunity when needed. Individual supervision exists on a peer level which is usually done by the clinical psychologists. There are case-oriented meetings of the clinical team if there is a demand. In addition there is a weekly meeting with the art and drama therapist.

External supervision does not take place.

Rooms & facilities

The building offers a lounge area for the clients, various rooms for individual counselling and group sessions/therapy as well as a kitchen for the clients. In addition there is a meeting room for adolescents, and an outside veranda with table, chairs and barbeque and table games. Downstairs there are the rooms for drama and art therapy, and a boxing sack. Furthermore there is a toilet for the clients.

In Perseas exists a PC with internet access, which is used for an electronic documentation only for some personal data of the clients (names, age, substances used, employment, education) the clients. In addition standardised instruments such as the TDI and ADAD are used for documentation, but only hand-written without any electronic support.

Funding

As a governmental drug service PERSEAS is funded by the Mental Health Service. The facility gets additional funding for internal telephone line and internet by the Pancyprian Antidrug Association. Funding for the art and drama therapist is provided by the private Cyprus Youth Organisation.

I. 4. 5. Processes

Programme – Specific Services

The treatment programme has changed recently and is not focused any longer on early intervention programme for high-risk adolescents. Before this change treatment was targeted at adolescents with non using high risk behaviour as well as experimental drug users. Now the treatment programme is addressed to adolescents with experimental or systematic use of substances with more severe problems.

In general clients can be served also in English, Russian and French, even though in Nicosia there are less migrant drug users than in other areas.

As regards the treatment process this has been moved from an individual approach to a group approach. All group therapy sessions are always guided by two clinicians. One of them takes a more active role in the treatment while the other one has the function of a second coordinator or a participant observer. All clients and as well parents are offered individual sessions upon request. In addition adolescents, parents and staff share a special non structured time for meetings between group therapy sessions.

With each client a treatment plan is elaborated as part of the therapeutic process. The treatment plan is made in close collaboration with the clients in written form and clients have free access to their files. With adolescent drug users urine tests can be done from 1-5 times by using sticks in order to get the results on cocaine, cannabis, opiates, and amphetamine use immediately. The urine test is performed once during the assessment period and also when the client is promoting abstinence.

The outpatient treatment provided at PERSEAS is split into two different treatment options.

- Brief intervention for experimental drug users and their parents
- Intensive therapy programme for systematic drug users and their parents

The recommendation for one of the two treatment options is made according to the criteria of the severity of drug use and the severity of surrounding problems. By using the instrument ADAD several aspects in the life of the client (schooling, family, legal

problems, medical, work, social, psychological status) are examined in addition to the clinical assessment. On the whole a battery of a full evaluation is administered including personality and social skills assessment using standardised instruments. On the basis of the assessment it is decided if a brief or a more intensive treatment programme is more appropriate. In case of slight family problems and experimental drug use of the adolescent brief intervention is recommended. For more severe problems the intensive therapy is regarded as appropriate.

Due to work/schooling obligations group sessions are held in the evenings with the staff's commitment to work voluntarily on extra curricula time.

Brief intervention

The "brief intervention" for experimental drug users and their parents is a treatment programme with duration of 3 to 6 months and is based upon one to two weekly group and individual sessions. The primary focus is directed towards the family in order to change into more functional patterns. The parents are treatment clients even if their drug using child does not join the treatment. Obviously there are a number of adolescents that refuse to participate in treatment. In these cases only the parents take part in the brief intervention who initially ask for help in order to recognise their negative contribution in their child's drug using behaviour and then resume responsibility towards their child. If adolescents take part in the brief intervention, they should not currently use drugs but still are in need for support and therapy in order to eliminate underlying factors which would again lead them to drug use.

From the perspective of the staff drug use in adolescents is a symptom expressing or masking the difficulties in his or her life, and these difficulties are closely connected to the family's life. According to the systemic point of view the whole family has to change and not only the adolescent.

The therapy aims at changing family patterns of behaviour. The main objectives for parents are to re-establish functional communication with their children, and to resume a clearly defined parental role. The parents are supported to gradually accept the autonomy needs of their child. Aims for adolescents are to reflect the function of drug use and to improve the skills for not developing any other dependence. The goals for parents and adolescents are defined in terms of certain time to achieve the goals gradually.

The brief intervention clearly focuses on family based interventions. If adolescents participate in the programme they are mostly quite young. The treatment process is organised as follows:

- In the first two months the parents participate twice a week in two different sessions. One session is the group therapy and the second session consists in psycho-educational seminars with experiential exercises. Psycho-education implies eight different topics, and new parents can enter the programme at any session and follow the course until all sessions had been attended. This structure is made in order to avoid waiting lists and a delay in the treatment proceeding.
- In the remaining months and after finalising the psycho-education seminars the parents' group intervention is reduced to one meeting per week (group therapy).
- Adolescents are engaged in an individually designed programme which may include individual/group sessions, art/drama therapy and life skills training. Art and drama therapy, offered through external therapists, have an additional motivational impact in preparing the clients for change.

As mentioned above, the vast majority of the treatment takes place in groups. Adolescents and parents can ask for individual sessions if they do not want to discuss certain aspects in the group. Individual sessions are available not only on request but if this is recommended by the staff.

Intensive therapy programme

In addition to the „brief intervention“, there is an outpatient therapeutic treatment programme for adolescents with a systematic or dependent use of illicit drugs. Systematic users are those who use substances including alcohol on a daily basis or who are drug dependent. It is expected that the programme will be attended primarily by young adults. The programme is also directed to the families of the adolescents.

The duration of the outpatient drug therapy has currently been reduced from 18 months to 9 to 12 months. The treatment programme is divided in three phases:

1. Preparation or initiation stage: 3 months
2. Main stage: 6 months
3. Final or integration stage: 3 months

At the end of each stage there is a family meeting to motivate them to participate in the next stage.

During this programme there are group sessions twice a week, but in the last therapy phase the frequency is reduced to once a week.

Preparation phase:

- Parents participate once a week in the group therapy, and once a week in the psycho-educational seminars. For the psycho-education the parents are mixed with those participating in the “brief intervention” programme. New parents can join the existing parent group. In this initial phase the main objective for the parents is to resume parental control and to recognise and avoid any “enabling” behaviour for their child’s drug use. For example, easy access to addictive substances at home or actual addictive behaviour by a parent are considered as one of many enabling behaviours and as such parents are consulted to avoid or even to apply for help to appropriate treatment services.
- Adolescents have group therapy twice a week focussing on enhancement of motivation, activation of refusal skills and development of relapse prevention techniques. Target for adolescents is to change their behaviour and to abstain from drugs and alcohol. If alcohol is still used, the clients receive counselling to achieve controlled drinking. The client is promoted to the main phase when these targets are achieved.

Criteria for adolescents to enter the main treatment phase are that they have reintegrated in school, or have an occupation or have actively searched for a job. They have to present their changes to the peer team and in addition to deliver a documented request for entering the main phase.

Criteria for the parents to enter the main phase are that they have achieved a first initial agreement with their children as regards rules and communication in the family. The parents have to present themselves to the therapy group in a written “narrative” of their life which will thereafter be developed further by gaining a more meaningful insight on their narrative.

Main phase:

As the intensive treatment just started, there are currently no experiences with the main phase. At time of the evaluation there was no client in the main phase.

It is planned that the focus of the main phase will not be on the family but on the adolescents. Parents can continue with their group therapy twice a week. The group will be limited to 16 persons. Adolescents will have two group sessions per week taking place at PERSEAS and one taking place outside in order to engage the adolescents in recreational,

athletic and other age-oriented activities. According to the plans, adolescents will join a structured relapse prevention programme and as well expressive arts therapy workshops in order to develop new hobbies and interests.

To carry out athletic, environmental, cultural activities with the clients there is a need for a budget and transportation (minibus) which are not available at present. In addition, alternative activities remain currently undelivered because of the lack of support by volunteers.

Final phase:

For the final phase it is planned that parents and adolescents group sessions will take place once a week. At this stage parents will be encouraged to promote their child's need for autonomy, which sometimes is facilitated by developing their own interests, hobbies and relations.

In general the treatment of PERSEAS is oriented to the personal needs of each client. This is reflected in the individual treatment plan which contains individual goals. The main goal is directed towards achieving drug abstinence and to support the reduction of the risk factors surrounding adolescents and their families. For this reason the treatment concept of PERSEAS is based on a family systemic approach and offers a multimodal treatment consisting of group sessions and group therapy, family therapy, psycho-educative workshops for parents, art/drama therapy, and life skill training. The care plan on proceedings is planned for each individual case in close cooperation with the clients. A further psychotherapy treatment can also be recommended in individual cases. The recommendation of further treatment includes for e.g. psychotherapy in cases of depression. According to the staff this recommendation is not given in the majority of cases but it is also not rare.

The vast majority of the adolescent clients come into contact with PERSEAS through their parents. In addition some of the clients are referred by school. Since the year 2007 adolescents arrested by the police are referred by the drug squad of the police. The police department introduced a counselling office as a new service which is staffed by social workers, sociologists etc. Adolescent drug users are under the pressure of penal or other legal proceedings if they do not contact PERSEAS. Arrested clients are only accepted by PERSEAS if they request treatment on their own to be sure about their initial motivation. The police provides information on the clients such as age, name, first arrest, contact details

of parents, and if parents will cooperate in treatment to PERSEAS. Furthermore there is a link with school psychologists and counsellors of the Ministry of Education for referrals, which is not though officially established, and is based on personal initiative.

Apart from treatment PERSEAS offers as well a number of different prevention activities.

Prevention

Prevention activities consist in long-term interventions in schools such as the “students-teachers-parents” programme which offers a series of thirteen structured sessions for different age groups of students, their parents and the teachers of the school. In addition psycho-educative sessions for students are offered, printed informational material (flyer) campaign and TV campaigns are carried out.

Various other activities consist in:

- Lectures and seminars, for psychiatrists of the Mental Health Services; practicing psychiatrists participate in seminars as part of their practice.
- Meetings and network activities with other services (i.e. all drug facilities, Cypriot Athletics Organisation, Cyprus Youth Organisation and Social Services of the Ministry of Labour).
- Seminars on the prevention programmes for psychologists and psychology students, as well as for other professions in the field of drug care.
- Structured seminars for new social workers of the Ministry of Labour (14 hours).
- Participation and presentations in congresses, meetings, etc.
- There is a close cooperation with social welfare services, which nevertheless needs to be further, developed.

PERSEAS offers also an open telephone line for support, information, therapeutic advice and referral of the youth (Open line “1456”, Monday-Thursday 8:00 – 18:00, Friday 8:00 – 14:00). Since May 2003 the Open Line of PERSEAS was approved as a full member of the European Foundation of Drug Helplines (FESAT). The Open Line of Perseas is coordinated by FESAT.

PERSEAS does not participate in a quality management programme, but has been evaluated four times during 1999 until 2001 because the service started as a pilot programme. The evaluations were a mixture of supervision with an evaluation of the functioning. Perseas uses standardised instruments (EuropASI, ADAD, MMPI, Beck Youth Inventory for children and adolescents, Rorschach, and Canadian Occupational

Performance Measure) for non-electronic assessment and documentation. Data for analysis and a common planning of the further strategy is being sent to other services, such as the Ministry of Health, the Mental Health Services, the Cyprus Anti-Drugs Council and the E.K.TE.P.N. monitoring centre.

There is no structured follow-up programme of the clients. Up to now an individually planned aftercare was implemented and all family members are sent a standardised questionnaire in order to achieve follow-up information. But there is not much response to the questionnaire. The new programme will offer a structured follow-up procedure.

Results – Annual Report

Treatment

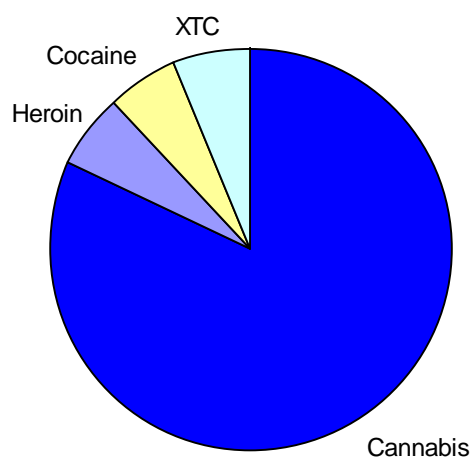
In the year 2006 altogether 41 clients had been treated by PERSEAS; this includes 31 new clients and 10 from the previous year. Out of the clients 15 (36.5%) interrupted their treatment before it was officially concluded. Some of the drop-out cases only participated in some meetings and had then been referred. Some adolescents are regarded as drop-outs as they achieved abstinence and changes in their life style but continued or developed other problematic behaviour for which they did not want treatment.

In the therapeutic treatment programme for adolescent drug users, existing until the end of 2006, there had been 16 new cases (11♂, 5♀) in the year 2006. The middle age of the clients treated was 17.5 years (♀: 31% middle age of 16.8, ♂:69% middle age 18.2). The age of first drug use for male clients lies at 16.2 and for females at 14.4 years. All users started illegal drug use with cannabis. The average duration of drug use until treatment demand was two years. The majority of the clients used cannabis as main substance of abuse. 56% of the clients have also used a second substance, while 94% drank alcohol regularly and 100% smoked cigarettes. Heavy alcohol use is considered as an additional addiction problem and thus included in the treatment programme. Controlled drinking of alcohol is not regarded as a problem.

From the 16 adolescent clients being treated, only three have received life skills training, four art therapy, seven drama therapy and five have taken part to alternative activities.

In the year 2006 there had been 12 new cases (8♂, 4♀) participating in the early intervention programme for high-risk adolescents. The middle age of the clients treated was 14.4 years (15.5 years in 2005). This programme is not offered any longer but the remaining three adolescents with no drug use are offered early intervention programmes until they achieve their goals.

Figure 23. Proportion of main drugs used by the 16 clients of Perseas.



Main drug of use: Cannabis (82%), Heroin (6%), Cocaine (6%), XTC (6%)

With respect to the occupancy of the staff it was reported that each therapist carried out on average 6-7 sessions per week in the last year. Individual sessions have a duration of 60 minutes, while group and family sessions last 90 minutes. On average the following number of sessions is spend with the clients:

- Assessment, evaluation and orientation sessions (including TDI and ADAD): on average 6 sessions per individual client
- Individual counselling and therapy: on average 30 sessions per individual client
- Group therapy including art and drama therapy: on average 10 sessions per individual client
- Average number of sessions for drop-out clients was 20.

In the new programme “brief intervention” – which started in May 2007 – there were altogether 8 cases until July 2007. Cases refer to parents and their child. In July 2007 only two adolescent drug users participated in the family oriented brief intervention programme. Until July 2007, five adolescents with their parents participated in the intensive therapy programme. During the first six months of the programme it is planned that adolescents will have 12 to 24 sessions and parents 32 sessions. In the intensive treatment programme it is planned that adolescents will attend 60 sessions and parents will attend 30 sessions until the full completion of the programme.

Prevention

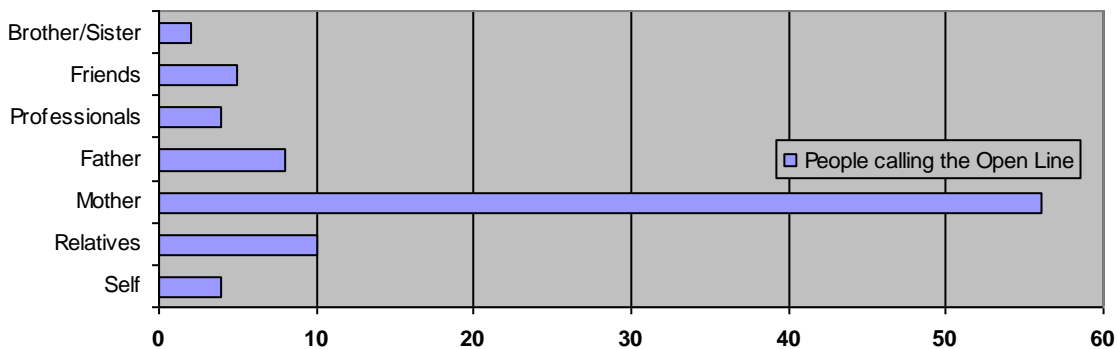
The scheduled long-term prevention interventions in the Pancyprian Highschool of Nicosia had to be ceased, because of a lack of interest and cooperation by the school authorities.

Eventually only the parents programme took place and that after a special intervention of the director. Student and teacher groups had too few participants.

Among different prevention activities the following were structured activities. The intervention in the General Lyceum of Kykkos B'. offered psycho-educative sessions to 519 students. In addition 70,000 information flyers have been sent by postage mail in October 2006 and television spots have been broadcasted in various channels in two different phases.

The Open Line of PERSEAS counts 89 phone interventions in 2006: among them 42 (47%) concerning information, guidance and support, 33 (37%) concerning referrals to other services and 14 (16%) concerning new cases of PERSEAS. However, it has to be considered that many professionals used the normal phone number of PERSEAS and did not use the Open Line when calling to refer a case or to ask for information, so that the 89 phone interventions do not include these phone calls.

Figure 24. Number of people calling the Open Line of Perseas



I. 4. 6. Evaluation

In general Perseas seems to be a well-run facility that has aimed at tackling the difficult task of prevention and reduction of drug use and associated risk behaviours in high risk adolescents and young drug users. The treatment concept of the early intervention programme for high-risk adolescents without drug use has ceased in the beginning of 2007. The therapeutic treatment programme for adolescent drug users consisting in psychological therapy, counselling and occupational interventions in combination with creative arts therapies and a supportive Open Line seems well structured. The staff includes persons from different specific professions, which allows to fulfil the necessary objectives of the centre. For such a facility, the multimodal treatment offers a therapeutic range to the clients

and their families. There are, however, a few points which can be addressed, which would strengthen the outcome and therefore lead to improvement.

Structure

A large demand for training has been obvious, due to a lack of regular and structured official training during the last years in Cyprus. Only three members of the staff are certified addiction counsellors and two are certified prevention specialists. Many of the staff members express the need for further training especially as regards the specialisation in the field of addiction and particularly in motivational enhancement therapy. Training is also wanted in addiction counselling, group and family therapy, relapse prevention and self-control skills.

The standardised tools for measuring the effectiveness of the provided services are rated as insufficient by the staff itself. In addition no external supervision takes place on a regular basis. Currently there are plans by the ICRC to proceed with a training course on drug facility supervision which is going to be implemented in Greece. PERSEAS does not participate in a quality management programme. There is a low priority given by the Mental Health Services concerning budget, further education, supervision, and proper staffing. Up to now there is no officially established cooperation with welfare services, schools, counselling centres, general practitioners, physicians, hospitals, rehabilitation facilities, residential treatment facilities and outpatient treatment facilities, although it is planned to be promoted in the near future through the Director of Mental Health Services. First efforts towards cooperation have already been made by the facility on an unofficial base. There is also no established cooperation with any child and adolescents psychiatrist. The cooperation exists only on an informal personal level.

There are no adequate rooms for implementing group therapy, no drop-in area for the clients, no conference room, and no rooms for multiple activities (handcrafts/photography). The staff members of Perseas consider the existence of a mini-bus as a necessary transportation means for offering alternative activities.

Processes

Basic difficulties are related to the lack of adequate drug services where clients might be referred to. From the perspective of the staff there is the need for implementing an outpatient detoxification treatment and in particular an intensive day care service specifically for adolescent drug users. Due to the characteristics of the clients there are

good reasons to consider target group specific programmes for migrants and for female adolescents.

In order to enhance treatment for adolescent drug users and to engage more adolescents in treatment, PERSEAS started with the following initiatives:

- Together with the prevention service Promitheas it is planned to initiate a working group on adolescent drug users. Main objective is to exchange ideas and to develop concepts. The working group will consist of two staff members of each facility which will have regular meetings. From perspective of the staff such a working group needs to be promoted by the Mental Health Service. From the perspective of the evaluation a formal promotion by the MHS not necessary. The working group can be established informal and if results are elaborated these can be put into action after consultation or communication with the MHS.
- In order to ease access to PERSEAS it is planned to establish a new coordinating committee together with representatives of social welfare services, Ministry of Education, the Police, the Cyprus Youth Organisation, local authorities, and the Parents association of Nicosia high schools.

One general difficulty seems to be the denial of drug problems in specific setting such as the army which results in a lack of cooperation with the army. On the other hand there are psychological and counselling services in schools which do not easily want problematic pupils to be referred anywhere else but to services of the Ministry of Education.

Last not least, PERSEAS lacks of an electronic documentation system.

Results

A large decrease in the involvement of the centre in prevention programmes was necessary in the year 2006, as the staff was unable to correspond to the diversity of actions for non-users and drug users at the same time. Consequently, in 2007 the action of the centre was focused on treatment of drug using adolescents. The large amount of prevention demands has been referred to services of the Ministry of Education.

The scheduled long-term prevention interventions in the Pancyprian Highschool of Nicosia had to be ceased, because of a lack of interest and cooperation. Originally the intervention should last two years. While in first year (2005) there was high interest by students and teachers, in the following year this was no longer the case.

However, the main point concerning the results is that first only 41 clients have been in treatment during one year and second that 36% of these clients did not finish their

treatment. The low number of clients is far under the capacity of the facility – assuming 8 full-time staff members, this is an average of 5 clients per staff member. Even if the therapy with the client is long and intensive, the capacity of the staff should allow for more clients. Thus, the outreach towards the target group needs to be improved in order to better correspond to the treatment capacity and especially the treatment demand. With respect to the high drop-out rate, this may also be due to the length of therapy – even the “brief” intervention has to be considered rather long, if the goal is 3 to 6 months. If an initial phase of the present therapy concepts was considered to be a separate therapy option (i.e. initial assessment & brief counselling, lasting 5 to 10 sessions, then re-assessment to see which clients need longer treatment), then the drop-out rate would automatically be lower and it may actually meet treatment demand more optimally.

Future efforts are needed as regards the question on how to engage adolescent drug users in treatment. A better reaching of the target group may require a modification of the treatment itself in order to be more attractive for young drug users or the access may need to be facilitated by offering a low threshold contact to PERSEAS.

I. 4. 7. Proposals

On the basis of the evaluation of results, the main recommendations concern the treatment concepts. First of all the term “brief intervention” for the family oriented therapy is misleading as standards of brief intervention are quite different from the treatment concept offered in PERSEAS. Due to the focus on families, the term brief intervention should be replaced by the term “short-term family intervention” which is more appropriate for the specific treatment.

Second, given the fact that only a small number of adolescent drug users is currently attracted by the available treatment programmes, this needs to be reflected in order to better address the needs of the target group. Adolescents need first to be interested by various low-threshold activities offered in PERSEAS. The work of the art and drama therapist along with the offer of other activities is a good way that clients become more motivated and engaged in treatment at all. In addition it facilitates to establish contact to young drug users. As the funding is not assured after the end of 2007, it is recommended that the Mental Health Service provides funding for these specialists in future. In case of the funding by the Mental Health Service further governmental drug services are able to benefit as well from art and drama therapy as the specialists can be shared among the services.

Furthermore it can be assumed that the duration of the present treatment programmes is too extensive for some of the adolescents and may act as a deterrence for adolescents to enter treatment at PERSEAS. For this reason it is strongly recommended to shorten the duration of the treatment programmes. In detail it is proposed to

- add an intervention programme (initial assessment & brief counselling) of 5 to 10 sessions as a separate programme, in order to decrease the threshold and have a better filter for the two other therapy programmes;
- shorten the so called “brief” family intervention to three months as a standard length of treatment. If there is an individual need for a longer intervention, the standard length can be exceeded to a maximum of six months. Apart from the treatment duration the programme probably needs to be readjusted as it is currently rather utilised by parents than by adolescents. Instead of focussing primarily on families at risk the focus needs to be directed more to drug treatment;
- shorten the intensive therapeutic treatment programme to a maximum of nine months.
- use the same assessment tools in the beginning and at the end of treatment in order to document progress and success for clients and for parents. By using the same assessment tools it is to achieve results on the impact of the treatment.

With respect to prevention and treatment programmes, an evaluation of effects needs to be done. Research on prevention has shown that many well-meaning (and expensive) prevention programmes are ineffective with respect to reduction of substance use. Considering the resources tied to these prevention programmes, their effects should be measured.

Furthermore there are good reasons to enable a low-threshold access for adolescents at risk of developing drug dependence. The present plans for networking with schools, youth services and social welfare services are a reasonable step towards this aim and are therefore strongly recommended.

In particular for adolescents with experimental or occasional drug use it is recommended to consider the introduction of a standardised brief intervention, such as the one suggested above (initial assessment & brief counselling), which consists of no more than 5 to 10 sessions and is targeted to adolescents with a drug use risk behaviour. It is supposed that this kind of brief intervention might increase the access of adolescents at risk of drug dependence. For the target group of severely drug dependent adolescents and young adults it may be recommended in general to consider the introduction of an intensive day care programme. A day care programme is regarded as adequate to address the needs of this

target group. Within the intensive day care participants might benefit most if in addition to psychological support adolescents are offered opportunities for sport or other age oriented activities. However, the introduction of a day care programme should only be initiated, if sufficient demand for such intensive treatment can be seen in the other treatment programmes (this is presently not the case).

In general all intervention programmes should be conceptualised more “adolescent-centered”. The involvement of family members or other social networks can be included in specific and reasonable cases, but the emphasis should remain on therapy for the adolescent. With respect to the life skills training it is recommended that the training may not only address skills to become abstinent to illicit drugs but also to support coping mechanism for a controlled and less harmful use of alcohol, which is often associated with problematic drug use. Furthermore, for those adolescents not being motivated to abstain from illicit drug use, motivation should be directed towards getting the adolescents to at least observe harm reduction measures, such as controlled use, in order to avoid the rapid drift towards addiction. In this sense, training of the staff in MI techniques and self control skills could be useful.

I. 5. Promitheas – outpatient treatment and prevention

I. 5. 1. Introduction

PROMITHEAS exists since 1992 in the old hospital of Limassol. The programme started as a pilot programme with 2 staff members working mainly with alcohol users and without having a clearly defined concept. Since 2002 PROMITHEAS has evolved, increasing its staff members and following a new concept concentrated more on drug problems of adolescents and on adults with drug and alcohol use. At the same time prevention programmes at schools has been developed. PROMITHEAS has become an official programme of the Ministry of Health and the Mental Health Services. It has also moved to an independent building in the complex of the Old Hospital of Limassol and is nowadays the only prevention centre and the only governmental counselling-intervention centre of Limassol. Under a new concept, presented to the Ministry of Health in 2007, PROMITHEAS would only serve adolescents who mostly use drugs occasionally. Due to the absence of other services for adolescents in Limassol, it now treats drug-using adolescents from the age of 13 up to 22.

I. 5. 2. Target groups

To PROMITHEAS' main target group belong adolescents up to 22 being at risk but not necessarily drug addicted. Adolescents at risk are defined as those with occasional drug use, school failure, drop out of school, low socio-economic areas, transcultural schools, high-risk families, and with problems related to drugs.

PROMITHEAS not only accepts occasional drug users but also adolescents who face drug addiction problems. The main criterion to accept an adolescent for treatment is the drug use and not other risk factors. High risk adolescents are included in prevention programmes such as group sessions at schools.

I. 5. 3. Objectives

Within the new framework PROMITHEAS focuses on prevention and individual counselling and therapy for adolescents. Different to the facility Perseas in particular primary prevention is offered.

a) Prevention programmes

1st grade Prevention:

Prevention of illicit drug use by the reinforcement of protective factors and reduction of risk factors in the general population (students, teachers, parents, etc.).

At present the facility does not accept adolescents at risk for an individual approach because this is offered in other governmental services such as in the educational psychology department or the child and adolescent psychiatry department.

2nd grade Prevention:

Prevention and renunciation of drug use in

- High risk teenagers and adolescents
- Young people using drugs, non-addicted
- Families with communication financial and social problems
- Every pupil in contact with high risk groups
- Specific prevention module for migrants in a transcultural school

In general the prevention programmes are addressed to groups of adolescents. The main target group is the adolescent and his or her environment such as family, teachers, friends etc.

b) Individual counselling/therapy

Main goal is the motivation for the acceptance of the existing problem, the changing of the way of life and the fully reintegration and rehabilitation. The clients receive information and psychological support and in cooperation with the team try to strengthen their surrounding structures (school, family, society). In addition, creative expression and alternative choices of entertainment and activity are being promoted. A care plan on proceedings is always being developed in close cooperation with the clients.

Short-term goals:

- Evaluation, preparation and motivation of substance using adolescents in order to attend to short term intervention or intensive programmes (inpatient or outpatient).
- Counselling, psychological support and occupational therapy to occasional users or addicted adolescents.
- Counselling and psychological support of adolescents' families.

Long term goals:

- Drug use abstinence and social rehabilitation

I. 5. 4. Structure

Staff

Promitheas' staff includes following members:

- 1 Psychiatrist (part time), who is not a team member but who cooperates with the facility if needed
- 1 Superior Nursing Counsellor (2h/week) who has only administrative duties
- 1 Clinical Psychologist (scientific coordinator – full time)
- 3 Psychiatric Nurses (ICRC – full time)
- 1 Occupational Therapist (part time – 2x/week)

By the end of this year PROMITHEAS will have permanent staff without rotation of the nurses, except if the nurses themselves want to change. From the perspective of the staff the new focus on prevention activities meets the qualification of the staff which is specialised in prevention.

Rooms & facilities

The independent building of PROMITHEAS is a part of the Old Hospital Complex and situated between two big police stations. The building is very old, painted and renovated by the staff of PROMITHEAS. The building offers a lounge/drop-in area for the clients and various rooms for individual counselling. Only the central area is air-conditioned. The location of Promitheas and its rooms do not give adolescents the impression of being welcomed.

In PROMITHEAS exists only one PC with internet access, which is also used for the electronic documentation of the clients, and only one telephone line for short interventions (Open Line).

PROMITHEAS offers an Open Line for support, information and therapeutic advice of the youth. The Prevention programmes of PROMITHEAS take place mainly in October and November, when other interventions are reduced by half.

Information about the services and programmes is being provided through informative programmes in schools, student organisations, parents' foundations, teachers' groups, volunteer groups, the Promitheas' Open Line and personal contact to the centre.

The programme of PROMITHEAS also offers practice for students of nursing school and psychology.

I. 5. 5. Processes

Programme – Specific Services

Within the new framework the treatment for adult drug users has ceased but the treatment for adolescents is continued. Now PROMITHEAS is focussing on two different actions:

- Prevention directed to families with high-risk children and to adolescents. Access to adolescents at risks is mainly generated in schools.
- Outpatient treatment for drug using adolescents up to age of 22

The decision for changing the programme was mainly due to the fact that most of the staff is trained for prevention but not for treatment.

Before the new framework PROMITHEAS offered individual treatment for adolescents, couples, drug users with children, migrants, family members, long term users/severely dependant users, socially well integrated users, etc. The new concept reduces the target group to only adolescents up to the age of 22 years. Migrant clients can be treated, as no registration is necessary and the intervention can be also offered in English and in Russian.

New clients have initially 2-3 meetings with the staff for the assessment of the problem. If so decided, clients are then sent to other therapeutic centres (for example, clients with problems concerning heroin are sent to Anosis for detoxification). For those cases, which are not sent to other therapeutic centres, the individual counselling/therapy lasts up to 18 months (average of 9 months). The meetings take place once a week for 45 minutes. Good social functioning and integration, as well as not such a severe dependency, are factors that could reduce the duration of the programme.

If needed the clients also receive medical support by a psychiatrist, in cooperation with the General Hospital of Limassol. There is a close cooperation with general practitioners, other physicians, hospitals, residential treatment facilities, counselling and therapeutic centres, closed communities and welfare institutions. There is no contact and cooperation with prisons, rehabilitation facilities and probation centres.

PROMITHEAS does not participate in a quality management programme and has never been evaluated. PROMITHEAS uses standardised instruments (EuropASI, TDI, EDDRA) for the documentation according to E.M.C.D.D.A.. Through an electronic documentation system data for analysis and a common planning of the further strategy is being sent to other services, such as the Cyprus Anti-Drugs Council, the Mental Health Services and the E.K.TE.P.N.

Results – Annual Report

In the year 2006 131 clients were treated by PROMITHEAS. Among them were 28 clients (12 new cases) with an alcohol problem (23♂, 5♀) and 107 clients (68 new cases) with problems concerning various substances such as opiates, cocaine or amphetamines (89♂, 18♀). 35 of the clients were adolescents. In addition there have been also 20 close relatives receiving support in individual meetings (ca. 80 meetings). In general, about 40 sessions/week are completed by the 4 staff members (about 10 sessions/week per staff member).

Figure 25: Proportion of clients of PROMITHEAS in relation to their age

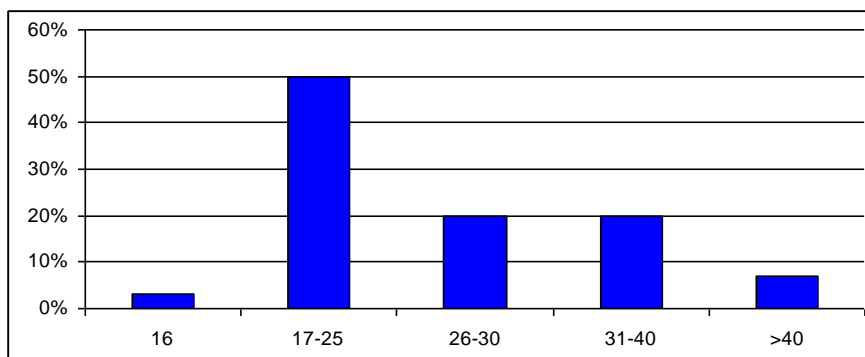
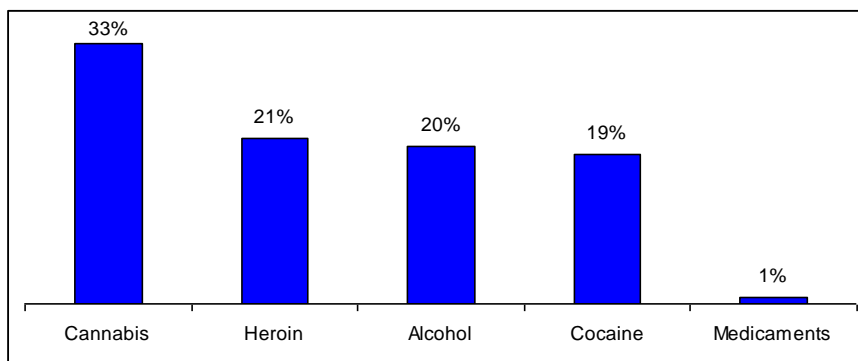


Figure 26. Proportion of clients of PROMITHEAS in relation to main substance use



Most alcohol users receive initial 2-3 meetings and are then sent to Themea; heroin users are sent to Anosis. Since the opening of Anosis in 2004 only a small number of heroin users remain in treatment at PROMITHEAS.

In the year 2006 56 out of 131 clients of the clients interrupted their treatment. Not clear are the drop-out percentage and the number of clients sent for a further treatment to other therapeutic centres. The exact drop-out rate is not available but according to the estimation of the staff about one third of the cases are drop-outs. From the rest of the clients (56), who

received a longer treatment, only 12 have received occupational therapy. These 12 clients presented severe dysfunctions while all other clients are regarded to be not in need for occupational therapy.

According to staff members of PROMITHEAS the percentage of migrant clients is increasing during the last years and has become an important subgroup (ca. 10-15%).

Prevention assessments in 2006 concerning the period of September to November which was the start of the prevention programmes:

- “Diary of Armenistis Ship 1900”: 35 students
- “Danger factors – protective factors”: 570 students
- “Communication within the family”: 60 parents

Practice offered in 2006:

5 Students of nursing school (40h)

8 Psychology students (32h)

4 High school students (30h)

The Open Line of PROMITHEAS counts 170 phone interventions in 2006.

I. 5. 6. Evaluation

In general PROMITHEAS appears to be a well-run facility with the difficult objective of offering information, motivational meetings, individual therapy and support to adolescent drug users and their relatives on their way to social reintegration, as well as many prevention programmes for young students. The long-term treatment, especially adapted to each client's needs, in combination with the broad network of cooperating facilities play a big supportive role in the life of the adolescents. The referral strategy and the prevention programmes seem well structured and planned. The staff appears competent and motivated, having various roles in the facility and fulfilling the objectives of PROMITHEAS. Yet a few points have to be reviewed in order to increase the proper functioning and the effectiveness of the centre.

Structure

The independent building of PROMITHEAS is a part of the Old Hospital Complex and between two big police stations and appears not suitable for programmes focused on adolescents with illicit drug use. In fact, the location of the facility almost seems to hinder

an easy access for adolescents. In addition the building is very old, painted and renovated by the staff of PROMITHEAS and uncomfortable to provide good quality services. The building offers a lounge/drop-in area for the clients and rooms for individual counselling, which are not enough for a proper functioning. There are also no specific rooms for group sessions and occupational therapy. Only the central area is air-conditioned.

There are only 4 full time staff members, a number not large enough to respond to the demands of PROMITHEAS. In addition, these full time staff members were absent for about 12 weeks in 2006 for seminars, organisation meetings and prevention programmes. There is also no social worker in PROMITHEAS. The social rehabilitation programme is coordinated by the occupational therapist in cooperation with other social workers, school principals etc.

There has been no specific therapeutic training of the psychiatric nurses, despite the fact that the clients' meetings do have more therapeutic than counselling character, including many aspects of Cognitive-Behavioural-Therapy. Only the psychologist is trained and applies a psychodynamic approach. In addition there is no external supervision at all.

In PROMITHEAS exists only one PC with internet access, which appears not enough for the demands of the programme. Data from clients should not be accessible on a PC which has internet access, as this is a security problem. The existing telephone lines appear also not sufficient.

Processes

The staff of PROMITHEAS wishes a broader network to other programmes and therapeutic centres. There is no central computer server to offer easier access to information regarding all drug services offered in Cyprus.

Unfortunately the lack of staff, the narrow time schedule of PROMITHEAS and the opening hours of the Open Line cannot cover the demand.

Results

There is a clearly defined age target group (clients between 13 and 22 years of age), but not a clearly defined target group as concerns other factors such as substance use. Currently PROMITHEAS addresses both users of illicit and legal substances. Nevertheless only a small part of all clients in 2006 met the target age. Substance addicted adults build still the biggest percentage of the clients treated in PROMITHEAS, which is expected to change in the future. According to the staff the number of adolescent users is increasing, which is a good result as in Limassol there is no other drug service for this target group. Interesting is

the fact that since 2004 the number of patients with illegal substances has increased (46% in 2003, 61% in 2004, 70% in 2005, 79% in 2006), showing the increasing focus of PROMITHEAS on illicit drugs.

In the year 2006 43% of the clients interrupted their treatment. Not clear are the drop-out percentage and the number of clients sent for a further treatment to other therapeutic centres. However, due to the estimation of the staff about one third of the clients are drop-outs. The question remains, whether this drop-out rate is due to a negative course of treatment (or even relapse) or lack of motivation to continue treatment (maybe because treatment is considered to be too long by the client).

The Prevention programmes of PROMITHEAS started in October and November and continued until May, while other sessions are reduced by half. Expanding the centre activities in the domain of prevention and lack of therapeutic time, as well as the founding of Anosis could be possible explanations for the reduction of incoming patients in the last 3 years.

New framework

Lately, the team of PROMITHEAS decided to readjust the programmes, adapting its offer to the changing needs and demands in Limassol. The decision has been made after evaluation the following facts.

- Multiplicity of clients and activities and therefore lack of specification in the objectives.
- Increase of demands for prevention programmes in schools, family and social area, lack of other facilities to take over this responsibility and the fact that the last 5 years PROMITHEAS has been seriously involved in organisation, application and assessment of prevention programmes
- Increase of treatment demands by young adolescents due to experimental or occasional use.
- Individual adolescents' programmes promoted by the National Drug Action Plan.
- Increase of support demands by family and parents
- Treatment of many adult users (mostly heroin) by other governmental centres in Nicosia and NGOs in Limassol (Tolmi and Odysseas)

As a result of the above, the team decided to continue and reinforce the application of prevention programmes and to continue the outpatient programmes addressed to adolescents up to 22 whereas to cancel the outpatient programmes for addicted adults.

After the programme adjustment the centre will offer two main activities

- Prevention programmes
 - Short-term intervention programmes of 6 to 9 months for adolescents up to 22 years old.
- From this group will be excluded clients with a dual-diagnosis, ADHS, addicted adolescents in need for inpatient treatment. They will be treated by the psychiatric clinic for children and adolescents.

It is obvious that PROMITHEAS is redirecting its focus on prevention programmes and outpatient programmes for adolescent drug users. At the same time the service is moving away from long-term counselling/therapy of adults, which was probably overloading the staff.

I. 5. 7. Proposals

In general the conceptual change presently being undertaken is a reflex to the very broad range of services and to the broad range of target groups in the past. This reform is therefore a useful change of the therapeutic concept, as it enables the staff to specialise on a specific target group. As the staff provides treatment without having a qualification in drug treatment it is obvious that there is a considerable need for training. Currently the staff is qualified for prevention but not for addiction counselling. In order to provide high quality drug intervention the staff requires further training in drug treatment.

However, the therapeutic concept needs to include a range of interventions, from a brief intervention of up to 12 sessions, to a long-term therapy as well as group sessions. In fact, it may be recommendable to consider a day-care setting for an intensive intervention for dependent adolescents, in order not to only attend a selected sample of clients with a better prognosis. Interventions should be goal-oriented and client-centered, adjusting to the needs of the clients. Therefore it is important to have a follow-up assessment in order to learn from drop-outs and negative outcome cases. The proposal for an intensive day care programme implies to expand the present services offered to adolescents in Limassol. In context with the introduction of this service there are further requirements which need to be met. First of all an appropriate building is needed for this purpose. In addition the number of staff has to be increased by trained staff members who are qualified in treating adolescents.

With respect to prevention programmes, an evaluation of effects needs to be done. Research on prevention has shown that many well-meaning (and expensive) prevention programmes are ineffective with respect to reduction of substance use. Considering the resources tied to these prevention programmes, their effects should be measured.

Considering the fact, that the new concept of PROMITHEAS can only be implemented under the assumption, that addicted adults, who previously were also treated at PROMITHEAS, will in the future be treated by the non-governmental organisation (especially in Paphos), this calls for a generally stronger cooperation between the MHS and NGO services.

I. 6. Toxotis and Stochos – counselling centre and day care service

I. 6. 1. Introduction

TOXOTIS is an affiliated programme founded in June 2002 by the Pancyprian Anti-Drug Association in cooperation with the Mental Health Services of the Ministry of Health. In addition, the Nicosia District Welfare Council provides financial and technical support. TOXOTIS is a counselling centre staffed by members specialised in addiction problems. Following the instructions of the National Drug Action Plan, the new Harm-Reduction Programme STOCHOS has been introduced in November 2005 and offers day care services since November 2006.

I. 6. 2. Target groups

TOXOTIS and STOCHOS have a clearly defined but broad spectrum of target groups. There are no exclusion criteria except age.

The main target group of TOXOTIS includes adult clients (at least 18 years old) addicted to legal or/and illegal substances or to gambling. In particular, the target groups are persons with dependence syndrome >18 years old and persons with problematic drug use >21 years old (younger clients are referred to Perseas). In addition the target group includes parents, relatives or friends supporting people with a substance abuse or dependence problem. Clients who want to undergo detoxification (either in Anosis or Themea) are obliged to participate in counselling at TOXOTIS.

STOCHOS focuses especially on drug users in the pre-contemplation stage or on drug users without treatment demand.

I. 6. 3. Objectives

Toxotis

The main objective is an individual counselling towards the referral into a specific treatment (detoxification or rehabilitation) using motivational interviewing (MI).

In many cases such an aim is not realistic and the client ends up having a therapeutic treatment by TOXOTIS for a longer period. The main focus of the treatment is then set on other objectives as harm reduction, promotion of a healthy way of living, prevention of infectious diseases, evolvement of socially accepted behaviour, abstention from delinquency/offending, progressive reduction of drug abuse, etc.. The attendance of the

family members and other important persons in educational and supporting programmes is also broadly promoted.

TOXOTIS focuses also on prevention by informing and sensitizing the public on substance abuse issues with objective and valid material and encouraging active involvement and voluntarism. Therefore TOXOTIS cooperates with other centres and other programmes abroad.

Stochos

The main objective of this programme is the harm reduction and the preparation of the clients for the next stage of the rehabilitation process as well as providing counselling until the clients develop the motivation to become drug-free and to participate in detoxification and residential drug treatment.

In particular this programme supports the reduction of deaths and accidents under illicit drug use, the abstention from delinquency/offending, the reduction of infectious diseases by drug abuse or/and sexual activities, better treatment of mental and physical problems, the reduction of family violence, etc., by short-term counselling and encouraging infectious disease testing and evolvement of socially accepted behaviour.

Both centres aim to provide easy-to-access services directly in the city of Nicosia.

I. 6. 4. Structure

Staff

Toxotis' and Stochos' staff is composed by the same qualified members of the Mental Health Services, specialised and trained in illicit drugs.

- 1 consultant psychiatrist: (2 h/week)
- 2 clinical psychologists: (1 also as scientific coordinator, part time)
- 1 senior psych. nurse: (ca. 1h/week)
- 5 psych. nurses – counsellors: (full time)
- 1 occupational therapist: (part time)
- 1 secretary

Rooms & facilities

The facility offers a lounge/drop-in area for the clients, rooms for individual counselling, group sessions/therapy, occupational therapy, a kitchen for the clients, sanitary and shower

for the clients. In TOXOTIS & STOCHOS a PC with an internet access did not exist for a long time. Currently the facilities have two computers with internet access.

TOXOTIS also offers a telephone assistance (open line 7am-6pm) for addicted persons, parents, relatives or friends who want to learn and make efforts to provide support to people with a substance abuse or dependence problem. Information is also provided on specific substances and health services.

I. 6. 5. Processes

Programme – Specific Services

TOXOTIS provides individual support based on the individuality of each person as well as social assistance addressing case-specific issues. There is practically no rejection of clients, as also patients with dual diagnosis are treated. However, there is no follow-up of the clients, so that outcome data is not available.

New clients of TOXOTIS receive individual counselling in order to be informed on various detoxification centres and therapeutic communities in Cyprus. The meetings focus on the motivational enhancement as well as on individual and group therapy as a preparation for entering a therapeutic programme. Many motivated clients are being referred to others for a further therapy and detoxification (for example clients with problems concerning alcohol are sent to Themea) while other clients stay in TOXOTIS for a longer period and receive drug therapy. The whole procedure is planned in close cooperation with the clients.

The individual counselling/therapy in TOXOTIS takes place normally 2-3 times per week (frequency varies, middle duration ca. 2-3 weeks, the longest duration in 2006 6 months); the duration of each meeting is individually set (at 15-45 minutes). The specific services offered depend on the individual case and include individual counselling/therapy, group sessions, harm reduction and outpatient detoxification (support in continuously reducing of dose for socially well integrated clients without a severe dependency, where no serious withdrawal can be expected – XTC, Cocaine, THC, etc.).

If needed, the clients receive an additional evaluation and support from the psychiatrist and clinical psychologists. Blood tests can be made (obligatory before entering Pyxida or Anosis). A random urine testing of the client is also made for therapeutic reasons.

The clients have the opportunity for occupational therapy, life skill and sensory-motor assessment as well as group sessions. There is also an individual treatment for couples and family members offered, as well as counselling support and group sessions for families of addicted persons.

In the last year TOXOTIS has begun with the treatment of clients with a gambling problem, as there are no other referral possibilities for such a problem. The objective of Toxotis' psychologists is the prevention of relapse through motivational interviewing.

Migrant clients are also treated without problems, as no registration is necessary and the intervention can be also offered in English. Legal advice and support is also being offered through individual counselling. The main goal is to solve problems with respect to papers in order to make further treatment possible (in detoxification centres registration is required).

STOCHOS as day care and harm reduction service provides a different spectrum of services as TOXOTIS. The clients have access to a drop-in area for up to three hours daily, where a physical and mental nurse evaluation, assessment and support as well as a psychiatric treatment is provided. Cold meals, drinks and coffee are offered and the clients' personal hygiene is grounded (shower, clothing, etc.). The clients receive information material and educational assessments in individual and group sessions provided by nurses, with instructions for a safer use and safer sexual activity, in order to reduce the risk of infectious diseases. There is also the opportunity in STOCHOS to have medical tests done (HIV, Hepatitis, TBC, etc).

An individual counselling and psychological support and therapy are also part of the programme as well as group sessions, occupational therapy (social skill training, every day activities, writing, etc.), family member groups and support in case of legal problems.

TOXOTIS and STOCHOS work in cooperation with hospitals (infectious diseases), residential treatment facilities, outpatient treatment facilities, counselling centres and other services and recommend always a further treatment for the clients.

Regular staff meetings take place twice a week. These meetings are also used as internal supervision opportunity. External supervision does not take place, but is planned for the near future.

Two committees guarantee the proper function and effectiveness of the two programmes

- The scientific committee (3 persons of the Mental Health Services, 2 of the Pancyprian Antidrug Association and 1 of the Welfare Council)
- The management committee (3 persons of the Mental Health Services, 2 of the Pancyprian Antidrug Association and 1 of the Welfare Council)

The scientific committee approves the philosophy, the objectives and the scientific validity of Centre while the management committee deals with the finances and administrative subjects of the centre.

TOXOTIS and STOCHOS do not participate in a quality management programme.

TOXOTIS and STOCHOS use standardised instruments (EuropASI, TDI) for the documentation according to E.M.C.D.D.A.. Via an non-electronic documentation system data for analysis and a common planning of the further strategy is sent to other services, such as the Mental Health Services and the E.K.TE.P.N..

Results – Annual Report

In the year 2006 168 patients were treated in TOXOTIS. Among them were 86 clients (77 men, 9 women) with a problem concerning illicit drug use and 82 clients (68 men, 14 women) concerning legal substances. Of these were 51 new cases (47men, 4 women) in 2006 concerning illicit drug use and 54 cases (46 men, 8 women) concerning legal substances. In the year 2005 153 clients were treated. 78 clients (65 men, 13 women) were treated due to illicit substances and 75 (61 men, 14 women) for legal substance problems. There has been an increase in the treatment demand of 8.33% in the year 2006 in relation to 2005.

In the year 2006 58% of the clients (98) interrupted their treatment. Not clear are the drop-out percentage and the number of clients sent for a further treatment to other therapeutic centres, because the referral client numbers are not clear. The remaining 42% of the clients (70) received longer treatment, and 14 of these (20%) received occupational therapy.

Illicit drugs

In 2006 77 men were treated, with a mean age of 28.5 years. The mean age of first use was 18 years and for the main substance of addiction 22 years. The mean duration of dependency is 7 years. Of this group 29% were working, 58% were unemployed. 8% of the clients were positive after testing for infectious diseases. 19% of the clients were migrants.

9 women were treated, with a mean age of 27 years. The mean age of first use was 14.5 years and for the main substance of addiction 18 years. The mean duration of dependency is 8 years. Of this group 22% were working, 78% were unemployed. 11% of the clients were positive after testing for infectious diseases. 22% of the clients were migrants.

33.3% of the female and 14.3% of the male clients treated had a Dual Diagnosis.

Legal substances

In 2006 68 men were treated, with a mean age of 45 years. The mean age of first use was 21 years and for the main substance of addiction 23 years. The mean duration of dependency is 23 years. Of this group 40% were working, 31% were unemployed. Only 1% of the clients were positive after testing for infectious diseases. 22% of the clients were migrants.

14 women were treated, with a mean age of 45 years. The mean age for the main substance of addiction was 28 years. The mean duration of dependency is 17 years. Of this group 7% were working, 72% were unemployed. 7% of the clients were positive after testing for infectious diseases. 36% of the clients were migrants.

12.8% of the male and 71.4% of the female clients treated had a Dual Diagnosis.

Staff/client contacts:	approx. 15 sessions/week per staff member
Individual counselling meetings	985
Family counselling meetings	225
Phone calls	122
Psychiatric evaluations	39

Other educational activities, such as briefing in hospitals, schools, and centres in communities are also part of the tasks of the staff. In addition information is given to individuals and institutions that visit the facility such as for example the police or the army.

Contacts per client:

Minimum: 2-3 sessions for initial assessment of patient, then referral (to Anosis, Themea, Pixida, etc.)

average: 2-3 times/week over 2-3 weeks

maximum: 2-3 times/week for longer periods (longest so far for 6 months, but could be longer)

The clients sent to TOXOTIS came from the Youth Organisation (18), various hospitals (30), general practitioners (17), THEMEA (12), Anosis (6), Perseas (3) and Agia Skepi (4). 37 patients of the clients treated in 2006 were migrants (27%), mainly legal, among them also 4 Turkish Cypriots. In STOCHOS day care service clients are being treated since November 2006 and the data has not been evaluated yet. Nevertheless there are many

positive reactions by the 33 clients actually using the new programme who are presently without a demand for therapy.

Figure 27. Main substance of use of the 168 clients of TOXOTIS

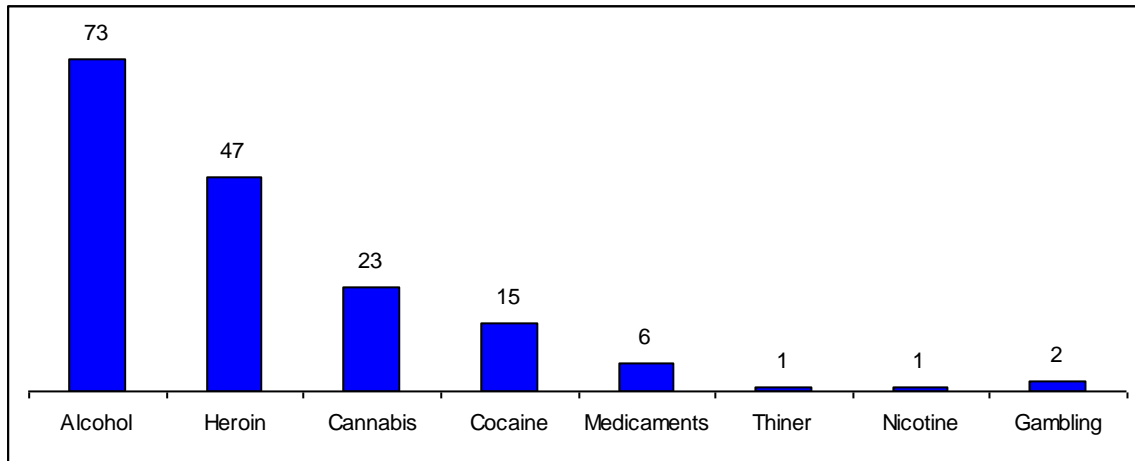
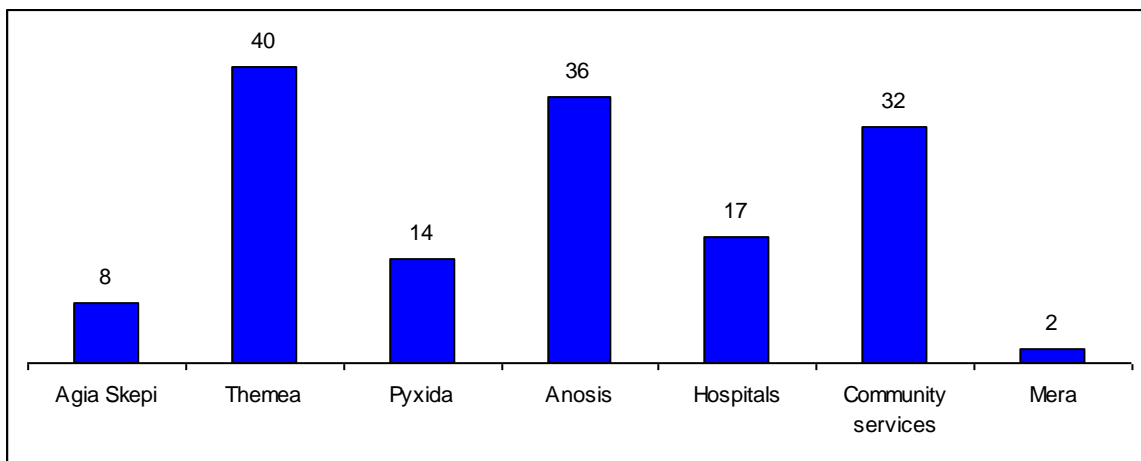


Figure 28. Referrals of 149 TOXOTIS' clients to other services



I. 6. 6. Evaluation

TOXOTIS and STOCHOS appear to be two facilities with an important work in harm reduction, counselling and referring of adult drug addicted clients, offering a low-threshold access to the treatment for a large number of clients. Basically the 2 services can be seen as a mutli-functional addiction services offering low-threshold counselling & out-patient treatment with a harm reduction component just having been added recently. The use of motivational interviewing (MI) as the main basis for their therapeutic work is in line with the international scientific evidence. The two facilities offer an individually adapted

treatment to the clients' needs, within a broad network of other cooperating centres. The treatment concept seems to be well structured. The individual counselling provides definite support to the clients through high-frequency meetings and appears effective concerning increase in motivation and referral rate. The staff includes motivated persons and the profession range allows the centre to fulfil the specific objectives. In addition the facilities try to improve their services as they recently asked for external evaluation.

There are a few points, which can be addressed, which would strengthen the outcome and therefore lead to improvement.

Structure

TOXOTIS and STOCHOS have clearly defined yet broad spectrum target groups. Due to that unspecified profile of the clients treated, objectives, needs and services often collide. An external supervision does not take place, generating an insecure feeling among staff members. However, they plan to establish regular qualified supervision. TOXOTIS and STOCHOS plan the treatment procedure in close cooperation with the clients, yet there is no clearly defined objective at the beginning.

A big demand of staff training has been obvious, due to a lack of regular official training during the year in Cyprus. There are only a few training opportunities for individual staff members abroad (mainly Greece). TOXOTIS and STOCHOS are being coordinated from two specific committees, yet the objectives and function of these committees are not clear. The staff of the centre wishes a more specific support.

The consultant psychiatrist works around 2h/week in TOXOTIS and STOCHOS and provides an assessment for less than 10% of the cases, while the estimated need is around 30% of the clients (only the clients with an alcohol problem reach 42% psychiatric assessment). The presence of the other part-time professionals, due to staff-sharing between different facilities, is also not enough.

Due to the small number of rooms in TOXOTIS, a separation between present drug users and abstinent persons is not possible, so that a collision of the needs is being generated. Clients and staff are also sharing the same kitchen and there is no room for medical care, no laundry and no dressing room for the staff.

Processes

Considering the fact that the service offers help to users of very different substances and recently even to persons with a non-substance "dependence" (gamblers), there seems to be a lack of (substance) specific therapeutic concepts, especially for those substances and the

gamblers, where an inpatient detoxification at Anosis or Themea is not the goal. Considering the aspect of the service as a low-threshold multi-functional addiction service, it cannot be expected that highly specified therapeutic concepts are available. Nonetheless, more specific treatment concepts for cannabis users, cocaine users, for gamblers and possible for party drug users (ecstasy and others) could be established, which are not so highly specialized but still meet specific needs of the respective target groups. This would have to be tied to special training for the staff.

There is an insecure feeling of the staff about their responsibility of providing harm-reduction on the one hand and offering abstinence-based counselling on the other hand. The needle exchange programme has not been implemented yet, as the objectives of the programme are still not clear (needle hand-out or exchange). An internal decision is to be expected soon. Nonetheless, it seems that the staff will have to develop a therapeutic stand which considers users of harm reduction measures at STOCHOS as potential clients for future abstinence-based interventions at TOXOTIS, goals which do not necessarily contradict each other.

Results

In the year 2006 58% of the clients (98) interrupted their treatment. Not clear are the drop-out percentage and the number of clients sent for a further treatment to other therapeutic centres, because the referral client numbers are not clear. The lack of a follow-up assessment makes it difficult to evaluate the outcome of any intervention, as there is no clearly defined endpoint of the intervention which is set at initiation of treatment.

I. 6. 7. Proposals

In general the work of TOXOTIS and STOCHOS seems to be quite effective and the general structure and concept should be continued. This is especially the case with the counselling work for patients with an alcohol or opioid dependence, who are motivated and prepared to enter into detoxification treatment in Anosis and Themea. With respect to the work with other target groups a concept adjustment would help in improving the efficacy of the work with these clients as well as improving the satisfaction of the staff in working with these clients. For this purpose it would be helpful to develop and work with manualised and semi-standardised interventions for cannabis users, cocaine users, and gamblers, which can be considered as specific interventions without being too specialized.

A stronger presence of a psychiatrist for the assessment of comorbidity and adequate treatment of a comorbid diagnosis would also improve outcome and strengthen the satisfaction of staff. The psychiatric assessment is of special importance for those clients with cocaine and cannabis use, as these clients will not enter a medical treatment unit (detoxification) and rates of comorbidity are especially high for cocaine users. The concurrent pharmacological treatment of underlying psychopathology, but also the use of anti-craving medications needs to be considered as an objective for clients entering treatment.

Any such innovations may lead to the necessity of increasing the staff number, as the present staff has little or no capacity to increase the services offered, especially if innovations lead to an increase in services sought. The staff would benefit if there was a stronger presence of psychologists (next to the above stated increase in the presence of a psychiatrist), as there would be a stronger emphasis on treatment (therapy), and not only counselling clients to move on to another service (Anosis, Themea, Pixida).

The present situation of the building is not satisfactory, as the number of rooms that the staff can use for their services is too limited. Moving into another building may be necessary, however the geographical proximity of Themea is a present advantage which would be lost if the service moved to another location. A geographical separation of STOCHOS from TOXOTIS is of great importance.

The issue of training and supervision, as with all other services, needs to be addressed. This will not only lead to an improvement of outcome, but also increase satisfaction of the staff.

I. 7. Summary – Results of the evaluation on the governmental drug treatment services

All existing governmental drug services have been evaluated as to their effectiveness. The evaluation was structured according to the criteria processes, setting, staff and building. The main results achieved by the evaluation are summarised according to this structure and separately for each facility.

THEMEA, offering detoxification and rehabilitation for patients addicted to alcohol or other medications, seems to run a medical and therapeutic concept that has not undergone sufficient development in the last years. This results in the following major problems:

- **Processes:** Themea does not reach up to scientific standards, and therapeutic concept is too rigidly focused on only one therapeutic track, which does not change by entering the next phase of treatment. This is reflected by the low coverage (low occupancy) and poor outcome (low completion rate, high drop-out rate in the first 3 weeks). There is no possibility of entering the programme in the 2nd or 3rd phase, despite the lack of a rationale for this. Self-admission is impossible; admission requires referral by a counselling centre.
- **Setting:** The therapeutic concept is based upon restrictive and inflexible rules which are counter-productive and not adequate for an effective treatment.
- **Staff:** The work by the staff is not adequately managed and supervised by a well-trained, motivated, responsible professional. There is definitely a lack of psychiatrist's presence in the facility. The number of the nursing staff (more than 20) seems superfluous for the capacity and needs of the unit.
- **Building:** The building and the location of the unit are not adequate for the service offered. There is a renovation need for the sleeping rooms and the lounge area and there is a lack of individual counselling and group session rooms.

ANOSIS, the inpatient detoxification unit, has been assessed as a well-run unit that is in accordance with international scientific state-of-the-art. The medical methods, psychological support and counselling, occupational interventions and nursing care are appropriate. However, some limitations have been identified:

- **Processes:** Anosis provided only poor opportunities to keep clients busy. This leads to boredom and is the prominent reason for drop-out. One major problem is that after

successful detoxification treatment there is a lack of centres providing diversified aftercare (i.e. out-patient therapy, day care centres).

- **Setting:** Access is high-threshold to the detoxification centre: Clients need to be referred by a counselling centre which results in big drop-out percentage of clients in this phase. Occupancy is low when compared to the capacity of the unit.
- **Staff:** All scientific personal has a part time status, and there is only one psychologist and no social worker. Nevertheless, the nursing staff number seems too high for the capacity and needs of the unit.
- **Building:** The facility offers a variety of rooms for treatment/therapy, but the number seems not to be enough for a proper functioning. In general, a building with an option to have access to a garden would decrease the drop-out rate.

PIXIDA, the inpatient and outpatient rehabilitation centre, is a very well structured facility and its treatment concept is in accordance with international scientific state-of-the-art. The facility is constantly adapting and improving the therapeutic concept by for instance initiating the “soft intervention” as an out-patient treatment option. The “soft intervention” is an important and excellent addition to the therapeutic continuum. There are some weaknesses mainly related to the inpatient TC which are summarised as follows:

- **Processes:** One of the biggest problems is the insufficient occupancy. This either has to do with an insufficient attractiveness of the concept of a Therapeutic Community, or an insufficient referral process. Community-based or even family-based solutions seem to be preferred by patients and, in fact, the outpatient programme has currently reached full occupancy.
- **Settings:** There is no budget for extra-recreational or therapeutic activities, despite the importance of these measures for the therapeutic process. Similarly the food budget is inflexible and not realistic and a permanent problem for the clients.
- **Staff:** Currently the programme is only operated by nurses. There is no psychiatrist or psychologist available. However, the number of nurses also seems disproportionately large in comparison to the poor occupancy rate in the inpatient treatment unit. Regulations for staffing night shifts with two nurses interfere with the therapeutic programme.
- **Building:** The unit is located in a house very far from the city, on a very dangerous, high speed road and poorly connected with public transport. There are no special rooms for

occupational therapy, specific rehabilitation sessions or privacy and also problems concerning the kitchen, laundry, sewerage and bathrooms.

PERSEAS, an outpatient service for adolescent drug users and their families, is a well-run facility that base upon a multimodal treatment concept. The therapeutic range offered to the clients and their families seems to be well structured. However, the main weakness is the low number of adolescent clients reached. The main results of the assessment are:

- Processes: The main point concerning the processes is that the low number of clients is under the capacity of the facility – assuming 8 full-time staff members. Even if the therapy with the client is long and intensive, the capacity of the staff should allow for more clients. In addition basic difficulties are related to the lack of an established network that facilitates referrals to Perseas. This network is being established presently.
- Setting: The drop-out rate is high and this may be due to the length of therapy. Even the “brief” intervention has to be considered rather long, if the goal is 3 to 6 months. If an initial phase of the present therapy concepts was considered to be a separate therapy option, then the drop-out rate would automatically be lower and it may actually meet treatment demand more optimally.
- Staff: Further training especially as regards the specialisation in the field of addiction and in motivational enhancement therapy is requested by the staff. However, some of the staff members are highly qualified and trained to offer family interventions.
- Building: There is a lack of rooms for group therapy, a drop-in area for clients, and conferences.

PROMITHEAS, the outpatient treatment and prevention service for adolescents, appears to be a well-run facility with the difficult objective of offering individual therapy to adolescent drug users and their relatives on the one hand and to provide many prevention programmes for young students on the other hand.

- Processes: The multiplicity of clients and activities and therefore lack of specification in the objectives recently lead to a readjustment of the concept. Promitheas now focuses on prevention and short-term intervention programmes of 6 to 9 months for adolescents up to 22 years old.
- Setting: There exists only one PC with internet access, which appears not enough for the demands of the programme. Data from clients should not be accessible on a PC which

has internet access, as this is a security problem. The existing telephone lines also appear not to be sufficient.

- Staff: There are only 4 full time staff members, a number not large enough to respond to the demands of Promitheas. There has been no specific therapeutic training of the psychiatric nurses, despite the fact that the clients' meetings have more of a therapeutic than a counselling character.
- Building: The building is a part of the Old Hospital Complex and appears not suitable for programmes focused on adolescents with illicit drug use. In fact, the location of the facility almost seems to hinder an easy access for adolescents. Moreover, the building is very old and uncomfortable to provide good quality services. Also the number of rooms are not enough for a proper functioning.

TOXOTIS and STOCHOS appear to be two facilities with an important work in harm reduction, counselling and referring, offering a low-threshold access to the treatment for a large number of clients. The individual counselling provides definite support to the clients through high-frequency meetings and appears effective concerning increase in motivation and referral rate.

- Processes: Both facilities address broad spectrum target groups. Due to that unspecified profile of the clients treated, objectives, needs and services often collide. The multifunctional approach lacks a few more specific therapeutic concepts, especially for those substance users and the gamblers, where an inpatient detoxification is not the goal. The needle exchange programme has not been implemented yet, as the objectives of the programme are still not clear (needle hand-out or exchange).
- Staff: The consultant psychiatrist works around 2h/week in Toxotis and Stochos and provides an assessment for less than 10% of the cases, while the estimated need is around 30% of the clients. The presence of the other part-time professionals, due to staff-sharing between different facilities, is also not enough.
- Building: Due to the small number of rooms in Toxotis, a separation between present drug users and abstinent persons is not possible. Clients and staff are also sharing the same kitchen and there is no room for medical care and no dressing room for the staff.

Last not least, all governmental drug services lack of a uniform documentation system. Currently, only the TDI is filled in by all services which is regarded not sufficient for documentation.

I. 8. Recommendations to improve the governmental drug services

In consideration of the evaluation results achieved for each of the six governmental drug services, the following modifications are recommended in order to improve the effectiveness of the drug services:

THEMEA is the only service that needs a conceptual restructuring to improve occupancy and outcome. A new therapeutic concept should be based upon:

- The need for a diversified treatment that includes out-patient and in-patient detoxification as well as long-term in-patient rehabilitation and short-term out-patient aftercare.
- The detoxification phase (presently the first and second phases) should be separated from the rehabilitation phase (presently third phase), both geographically as well as conceptually.
- The service also needs a fulltime professional responsible for the service and who can supervise treatment medically, preferably a psychiatrist, who also introduces more innovative medical approaches to detoxification treatment.
- Communication should not be cut-off between patient and the outside world. On the contrary, the family (and his friends) of the patient should be included in a more systemic (family-oriented) therapeutic concept.
- All rules and regulations should be reconsidered with respect to appropriateness.
- There is a clear need for the computerisation of the unit.

ANOSIS could be well complemented by some important changes:

- The reduction in the threshold for admission to improve the coverage.
- The diversification of services before, during and after detoxification. In general a closer cooperation between detoxification centre and aftercare (presently only TC) appears strongly needed.
- It is recommended to consider the admission of young drug addicts in need for detoxification. As Anosis is the only detoxification in Cyprus there is nothing else in place for young addicts.

PIXIDA basically should continue down the road of further diversification (as they have already initiated with the “soft intervention”), thereby becoming more of a multifunctional service. In addition, their therapeutic work might be improved by further modifications:

- It should be considered whether a change from the current residential programme into an intensive day care unit might increase occupancy, leaving residential TC treatment to the NGO Ayia Skepi.
- Pixida should be excluded from the MHS regulation of having to place 2 persons in night duty, as this regulation was conceived for medical treatment units and Pixida is definitely not a medical unit.
- In order to increase the attractiveness of PIXIDA, it might be important to consider shortening the overall programme length while at the same time having an aftercare out-patient therapy programme for clients who have gone through TC.
- An expansion in the availability of out-patient treatment could in the future lead to this part becoming the main focus of PIXIDA, even to the extent of giving up the concept of a therapeutic community.
- Finally for clients suffering from mental health disorders, the treatment programmes could be improved by including a psychologist in the team.

PERSEAS main future tasks will be to engage more adolescent drug users in treatment.

For this purpose it is recommended:

- All intervention programmes need to be conceptualised more “adolescent-centered”. Family members can be included in specific and reasonable cases, but a greater emphasis should be placed on the adolescents themselves.
- The duration of the present treatment programmes should be shortened, as presently it is too extensive for some and may act as a deterrence for adolescents.
- Add an intervention programme (initial assessment & brief counselling) of 5 to 10 sessions as a separate programme for adolescents with experimental or occasional drug use.
- Shorten the so called “brief” family intervention to three months as a standard length of treatment. If there is an individual need for a longer intervention, the standard length can be exceeded to a maximum of six months.
- Shorten the intensive therapeutic treatment programme to a maximum of nine months.
- The funding of the art and drama therapist should be ensured as their work improves the adolescent’s motivation and engagement in treatment.

PROMITHEAS' change of therapeutic concept is useful as it enables the staff to specialise on a specific target group. Major needs to improve their service are related to staff training and moving to another location.

- First of all an appropriate building is needed, which is appropriate for adolescent drug users.
- The number of staff has to be increased by trained staff members who are qualified in treating adolescents. Currently the staff is qualified for prevention but not for addiction counselling.
- In future the therapeutic concept needs to include a range of interventions, from a brief intervention of up to 12 sessions, to a long-term therapy as well as group sessions. It may be recommendable to consider a day-care setting for an intensive intervention for dependent adolescents.
- An evaluation of effects of the prevention programmes needs to be done to determine its effectiveness.

The work of TOXOTIS and STOCHOS seems to be quite effective and the general structure and concept should be continued. However, there are few points to be mentioned, which would strengthen the outcome.

- More specific treatment concepts for cannabis users, cocaine users, for gamblers and possible for party drug users should be established. For this purpose it is recommended to develop and work with manualised and semi-standardised interventions, which can be considered as specific interventions without being too specialized.
- Any such innovations may lead to the necessity of increasing the staff number, as the present staff has little or no capacity to increase the services offered. In addition, new programmes would have to be tied to special training for the staff.
- There is a need for a stronger presence of a psychiatrist for the assessment of comorbidity.
- The present situation of the building is not satisfactory, as the number of rooms that the staff can use for their services is too limited. Moving into another building may be necessary. However, a geographical separation of Stochos from Toxotis could be both practical due to necessity for more rooms and meaningful from a conceptual level.

Annex II – NGO addiction services

A. Overview on the NGO addiction services in Cyprus

The evaluation of Cyprus non-governmental drug services and prevention programmes has benefited from evaluation of the governmental drug services that has been conducted within the twinning project in 2007. Due to the conduction of the evaluation of drug services in the public sector, there had been synergistic effects for the evaluation of the non-governmental drug services. A major advantage was that the methodological approach was already approved and related instruments for the evaluation of the drug services were already elaborated.

The evaluation of the non-governmental drug services and prevention programmes had to be based upon a thorough understanding of the existing services and programmes in the private sector. For the evaluation an integrated approach has been applied by combining different methods. The evaluation covers 13 drug treatment services operated by NGOs and 17 organisations that offer primary prevention programmes. Many drug services and prevention providers appear not to be very transparent due the lack of documentation and reporting. As there are often no written concepts, no yearly reports and no precise information on the clients served or the participants of prevention workshops, the evaluation shows certain limitations. In this chapter a brief description of the non-governmental community drugs services and prevention programmes is presented.

The main non-governmental provider of drug treatment is *Kenthea*, followed by *Tolmi* and *Agia Skepi*. In addition there is one private clinic – *Veresies* – which offers outpatient and inpatient treatment. Many different organisations are involved in primary prevention such as private foundations, associations of volunteers, prevention centres mandated by the government, and *Kenthea* which also carries out prevention activities.

Different to governmental drug services funding plays an important role for non-governmental drug services. While operational and staff costs of governmental drug services are financed by the Ministry of Health, non-governmental organisations depend on different sources for funding such as private donations, community funds etc. However, non-governmental organisations can also apply for funding of operational costs by the Cyprus Anti-Drugs Council. In sum the CAC funded drug treatment and prevention to an almost similar amount in 2007; in fact, drug treatment was financially supported with

64.900 CYP (about 111.000 €) and prevention was supported with 67.315 CYP (about 115.000 €).

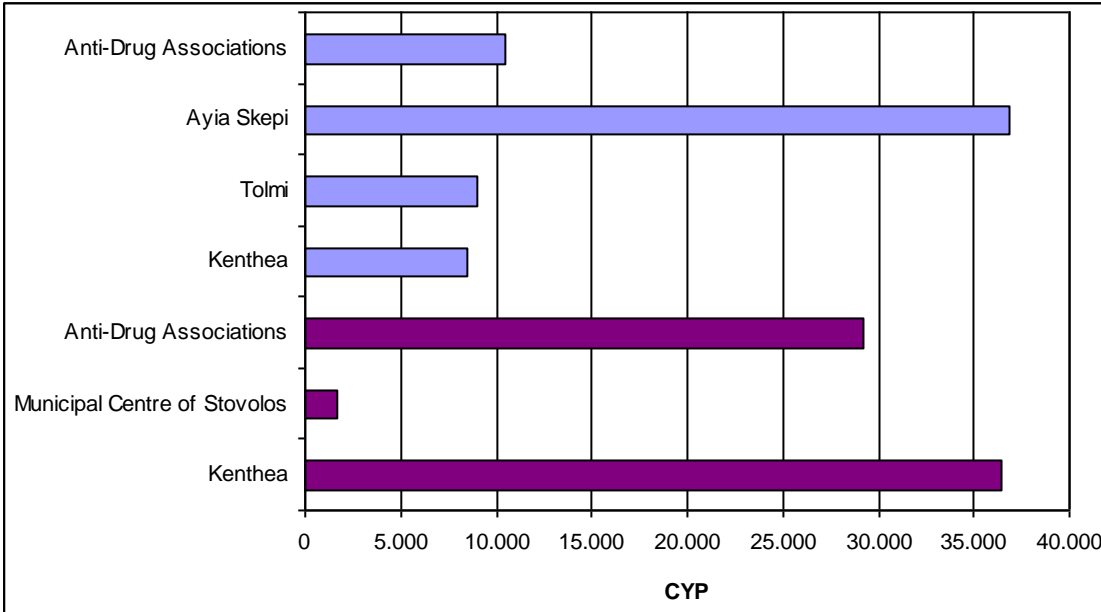
Table 9. Availability of NGO prevention and drug treatment services in Cyprus

District	Prevention	Drug Treatment
Nicosia district	Altogether 7 services	Altogether 6 services
307,100 inhabitants*	<ul style="list-style-type: none"> • Kenthea with the services <i>Ithaki</i> • <i>Fos</i> • <i>Pegasus</i> • Life Education Centre • Kenthea Association Nicosia • Cyprus Youth Board • Lions Quest Foundation 	<ul style="list-style-type: none"> • Kenthea with <i>Ithaki</i> • <i>Fos</i> • <i>Pegasus</i> • Agia Skepi with <i>Counselling station</i> • <i>Therapeutic Community</i> • Tolmi outpatient TC
Larnaca district	Altogether 4 services	Altogether 3 services
130,100 inhabitants*	<ul style="list-style-type: none"> • Kenthea Prevention Department • Kenthea - <i>Iraklis</i> • Larnaca Anti-Drug Association „Sykana“ • „Faros“ Prevention Centre 	<ul style="list-style-type: none"> • Veresies Clinic (private) • Kenthea - <i>Iraklis</i> • Tolmi outpatient TC
Limassol district	Altogether 3 services	Altogether 2 services
223,600 inhabitants*	<ul style="list-style-type: none"> • Kenthea - <i>Odysseas</i> • Mikri Arktos • Anti-Drug Association „Aspis“ 	<ul style="list-style-type: none"> • Kenthea - <i>Odysseas</i> • Tolmi outpatient TC
Pafos district	Altogether 2 services	Altogether 2 services
74,900 inhabitants*	<ul style="list-style-type: none"> • Kenthea - <i>Vera Paisi</i> • Pafos Anti-Drug Association 	<ul style="list-style-type: none"> • Kenthea - <i>Vera Paisi</i> • Tolmi outpatient TC

*Source for inhabitants: Republic of Cyprus, Statistical Service 2007

The figure below shows how the funding was distributed to different non-governmental providers of drug treatment (bright blue bars) and to organisations providing prevention programmes (purple bars). It becomes obvious more than half of the grants for drug treatment were given to the NGO *Agia Skepi* and more than half of the grants for prevention were spent for prevention activities of the NGO *Kenthea*.

Figure 29. Funding provided by the CAC in 2007 for drug treatment and prevention



II. A. 1. Kenthea - prevention and counselling stations

Kenthea is the biggest NGO in Cyprus which was founded in Larnaca in 1994. Since then the Centre of *Kenthea* Cyprus is located in Larnaca and provides mainly prevention programmes, education of professionals and volunteers, and research. Since the beginning *Kenthea* Centre offered prevention for teachers, parents and students.



Dr Kyriakos Veresies

Kenthea has a number of member organisations with the most important members being the Church of Cyprus, the University of Cyprus, the Union of Municipalities, the Union of Communities (with 450 members), the Guild of Public Employees, the Guilds of Teachers and the Cyprus Youth Council.

In 1997 the organisation started to establish decentralised prevention and counselling stations in different regions of Cyprus, and in 2008 there exist six of these stations, providing both prevention and counselling.

Since 2002, prevention is also directed to target groups of substance users and to other experts such as general practitioners.

- Education and training

Education and training is one of the most important activities of the Centre. In this respect *Kenthea* is a NAADAC¹ (National Association for Alcoholism and Drug Abuse Counsellors) approved provider for training and education. The NAADAC provides education in counselling which lasts two years and comprised 100 hours. The American Associations also assigns certifications.

In order to carry out primary prevention activities in each district of Cyprus *Kenthea* trains volunteers, teachers and staff members. Since offering training about 500 volunteers have been trained in 25 different prevention programmes. Training in one prevention programme lasts 30 hours. If trained professionals (psychologists, social workers, nurses etc.) provide prevention they receive 20 CYP (35 Euro) for each activity. Beside the training and the small financial support all other requirements for prevention have to be organised and financed by interest groups such as for e.g. parents associations at school.

¹ Since 1982, the NAADAC is a large membership organisation in the US which offers education in addiction counselling, addiction prevention, treatment and education (see: <http://naadac.org>).

In Cyprus the permission of the Ministry of Education is required in order to provide prevention in public schools. Currently prevention programmes in public schools are only allowed to be provided by assigned (governmental) organisations. However, prevention activities addressing students can either be provided by teachers in public school or by NGOs in private schools or outside school. For this reason *Kenthea* distributes education material for prevention activities and trains interested teachers.

The training of teachers is part of the collaboration between the Institute for Continuing Education (ICE)² and the Pedagogical Institute of the Ministry of Education. The collaboration started in 1998 and since then more than 2500 teachers were trained in a 15 hour educational programme.

Additional to the training of volunteers, teachers and staff members, *Kenthea* provides education for general practitioners and staff of the Cyprus hospitals. This education is based upon an agreement with Ministry of Health and takes place every year. Professionals in primary health care are educated on the topic of early effects of substance abuse.

- Research

Kenthea runs a separate Institute for Monitoring and Research which is among others active in small local research projects and monitoring of the Cyprus press. *Kenthea* Centre participates in the ESPAD survey (European School Survey Project on Alcohol and Other Drugs) since it was conducted in 1995 the first time. Target population for the ESPAD questionnaire are students of all school types that turn 16 years old during the calendar year of the data collection³.

- Counselling

All decentralised *Kenthea* stations offer prevention and counselling. Target group for counselling are individuals who are drug users but not addicted to substances. For this kind of drug users' advice on the telephone, assessment and motivational interviewing, and referrals to treatment are provided.

- Prevention

Along with training prevention plays a major role in the NGO *Kenthea*. Prevention provided by this organisation is designed as universal prevention. According to the coordinating director of *Kenthea* – Dr Kyriakos Veresies – suggestions for prevention

² The ICE is a non-governmental organisation which offers training within the frame of *Kenthea* and collaborates with NAADAC (The Association for Addiction Professionals) in the United States.

³ Data are collected every fourth year since 1995. The fourth data collection was carried out in 35 countries during the spring of 2007 and results will be published in December 2008 (see: <http://www.espad.org>).

activities are made by *Kenthea* and other interest groups or organisations. However, there is an annual plan of the prevention programmes that are going to be carried out by volunteers. In addition, it was reported that prevention is based upon the results of national surveys in order to meet the needs identified. In fact, organisations may suggest a certain prevention activity but *Kenthea* may also modify the proposed activity according to their knowledge and philosophy. In brief this philosophy implies first to offer prevention in general without specification for substances. Afterwards there will be discussions on substances within the frame of workshops.

According to this philosophy all six decentralised *Kenthea* stations offer prevention activities, and the kind of activity provided is decided by the *Kenthea* Centre. To discuss prevention activities there are weekly meetings with the staff of the stations, and in addition there is a group meeting every month. While the staff members offer prevention activities in community, prevention activities in school are carried out by trained teachers.

One of the main prevention programmes provided is called “Standing on my own feet”. This is an educational programme developed and evaluated in Greece. The primary prevention programme is for secondary education pupils and aims at preventing the use of addictive substances by developing attitudes of self esteem and self respect and by promoting the pupils’ skills. “Standing on my own feet” addresses students at age of 11 to 15 years who have already been established as a group. The programme is continuously offered each year and – with the cooperation of teachers – interested students are invited to an information meeting. The programme takes place outside school and consists of 13 workshops which last two hours each. Each workshop focuses on one topic and one of them included information on legal substance such as cigarettes and alcohol. Usually 15 students build one group of participants.

Further prevention programmes offered are “Skills for children in primary school” and “Communication in the family”. In Cyprus, prevention activities of *Kenthea* are also linked to a certain month of the year. Each month is associated with the prevention of a specific substance. For instance, March is on misuse of medicine, May on smoking, June is against use of illicit substances, September against alcohol, October is on PTSD and December on gambling.

In order to inform the public about prevention programmes, since November 2007 *Kenthea* has its own 60 minutes programme on TV every Friday. Within this TV programme NGOs as well as governmental prevention and treatment services are presented in 10-15 minutes.

- Financing

For funding related to three prevention and counselling stations there is cooperation between *Kenthea* and the governmental Cyprus Youth Board, local administrations and the CAC. Each of the stations has been funded with 3.400 Euro. In 2007, the Social Welfare Office decided not to fund NGOs directly anymore but to give the funding budget to the CAC because some of the NGOs became members of the CAC. Since this change in funding *Kenthea* reported to face huge financial difficulties as the CAC only funds one third of the required budget. As mentioned above, the funding of the CAC is for operational costs of an approved programme but not for staff costs etc.

However, due to funding limitations of the CAC *Kenthea* depends on additional funding. In this respect there is an agreement between the organisation and the municipalities which implies that the municipalities of Cyprus pay about one 1 CYP per inhabitant to support the functioning of the *Kenthea* prevention and counselling stations. The donations of the municipalities are centrally given to *Kenthea* Larnaca which pays the salary of the staff and other expenses. It was reported that despite of the agreement partly the municipalities do not pay. Further funding comes from private donors who is collected by Associations and submitted to *Kenthea* Centre.

The managing coordinator of *Kenthea* mentioned the idea that in future all *Kenthea* stations shall become financially independent. Currently funding is either for prevention or for counselling even though both approaches are provided. At present, the station *Ithaki* in the Dhali region functions financially independent, and this already allows using the funding more flexible for prevention and counselling.

II. A. 2. Tolmi – open Therapeutic Community for addicted persons

In 1992, *Tolmi* Larnaca has been established as a non-governmental organisation that resulted from two Associations of volunteers that had existed before. The Associations recognised the need to provide an outpatient TC for alcohol addicts because at that time there was nothing in place to treat alcohol addiction. Until early 1995 *Tolmi* only addressed alcohol addicts by offering group therapy. As users of cannabis also contacted *Tolmi* for drug treatment, in 1996 *Tolmi* started to run two therapy groups – one for cannabis users and one for alcohol addicts. Each group took place twice a week. In addition individual counselling was introduced as further treatment approach.



George Boyiadjis

In 1997, *Tolmi* became an independent non-governmental organisation with its own administrative body. The administration consists of 7 persons; two of them are ex-addicts who have completed the treatment programme, two are staff members of *Tolmi* and three are volunteers. The staff members and the volunteers change every two years and new persons are voted in an assembly to take over their position.

Currently the open Therapeutic Community *Tolmi* exist in Larnaca, Nicosia (since 2000), Limassol (since 2004) and Pafos (since 2007). Each of these organisations have an own coordinator with one managing coordinator – George Boyiadjis – being responsible for all four TCs. According to the managing coordinator all TCs are based upon the same treatment approach and address the same target group. Drug treatment is directed to adults addicted to illegal substances and alcohol. For treatment of addiction individual and group therapy, alternative therapies and family group therapy is provided.

There is a close cooperation between the two NGOs *Tolmi* and *Kentheia*. Staff members of both organisations attend training and also supervision together. In addition both organisations share the offices in Nicosia, Limassol and Pafos.

II. A. 3. Agia Skepi – Therapeutic Community and counselling station

The drug treatment provider *Agia Skepi* runs a close Therapeutic Community and a counselling service in the district of Nicosia. The non-governmental organisation first started to operate the close TC which was established in 1998 by the Bishop of Limassol. The counselling station was implemented some years later in 2005.



Marios Adonis

The TC is located in the forest of Macheras far away from any city, and a huge complex of several buildings and sport fields on an area of 1.5 square kilometres. This area is provided by the Monastery of Panyia of Macheras and also the buildings were financed through charitable donations made to the Monastery. The buildings have been specifically constructed to run a Therapeutic Community.

- Organisation

The clinical director of the Therapeutic Community and of the counselling services is Tina Pavlou. All services of the non-profit organisation *Agia Skepi* are managed by a board of directors which consists of 11 members with the Bishop of Limassol as president and the Father Superior of the Monastery of Panyia of Macheras as vice president. All other board members are from the society.

- Services

When starting the TC, psychiatric nurses were employed. As they were trained in medical approaches and not in drug counselling, the nurses were unable to provide drug therapy. In order to work with well-trained staff, psychologists hired at *Agia Skepi* have to go through a two month training for the Therapeutic Community. Counsellors are from time to time sent to Kethia Greece for further training on a number of topics. Students from the University of Nicosia need to undergo a one year practicum, and some of them fulfilled their practicum requirements in the TC *Agia Skepi*.

The closed Therapeutic Community of *Agia Skepi* is a long-term drug treatment programme for adult drug addicts. In the beginning it was directed to both men and women even though the number of women was always very low. Since the governmental drug treatment service *Pixida* opened, the TC programme is exclusively for men. The counselling station

addresses adults with any kind of drug use including legal substances. One aim of the counselling station is to prepare clients for admission to the TC.

- Financing

The TC of *Agia Skepi* is financially supported by the “Association of Friends of Agia Skepi” and by grants of governmental agencies. The expenses for the land and the buildings are balanced by the Monastery of Panyia of Macheras.

According to the managing coordinator in future it is planned to establish an inpatient drug treatment programme specifically for women. A concept for a women programme already exists and its implementation is envisaged in the next two or three years.

B. Evaluation of the Cyprus non-governmental drug services

II. B. 1. Kenthea Centre and its six decentralised services (Ithaki, Fos, Pegasus, Iraklis, Odysseas, Vera Paisi)

As all six decentralised prevention and counselling stations are said to be based upon the same concept, they are described as one corporate body. Differences between these NGOs are mentioned respectively.

II. B. 1. 1. Introduction

Most of the *Kenthea* prevention and counselling centres have the same philosophy, objectives, target groups and structure. At the same time many differences have been identified. There were also many deviations between the official guidelines of *Kenthea* and the philosophy and services adopted by the decentralised stations.

Vera Paisi station was founded in 2000 in cooperation of *Kenthea*, the four municipalities of Pafos, Geroskipou, Pegeia and Poli Xrusoxous and the Pafos Anti-Drug Association.

Odysseas was founded in 1999 in cooperation of *Kenthea*, the Cyprus Youth Organisation and the municipalities of Limassol, Agios Athanasios, Germasogeia, Mesa Geitonias and Kato Polemidia. The infrastructure has been a donation of Rotarionos AG Amathusia of Limassol. Until 2004 *Odysseas* did not have a stable office and had to move constantly, while the programme offered did not change.

Fos station was founded in October 2005 by *Kenthea* in cooperation with five municipalities (Kokkinotrimithia, Mammari, Paliometoxo, Deneia and Agion Trimithias). These municipalities gather an estimated total number of more than 10.000 citizens. Efforts are made in order to expand the services offered also in the municipalities of Akakios, Astromeritis, Menoikos, Orountas and Peristeronas.

Ithaki was founded in January 2003 in cooperation with *Kenthea*, the Cyprus Youth Organisation and the municipalities of Idaliou, Agia Barbara, Alambra, Lymion, Lythrodonta, Mathiati, Pera Xoriou Nisou and Potamia. In the year 2007 the municipalities of Kotsiati, Mosfiloti, Pyrgon, Pseuda, Sias and Agia Anna have joined the affiliation (total of 14 Municipalities).

Iraklis was founded in the middle of 2007 after an initiative of the ladies' organisation and in cooperation of *Kenthea* and the 17 communities around Lefkara. This initiative was

based on the increase of drug related problems (mainly cannabis) among the school students of these communities.

Pegasus was founded in 1998 by the Youth Organisation of Cyprus and *Kentheia*, in cooperation with several municipalities (Ag. Dometios, Aglantzia, Egkomi, Latsion, Lakatamia, Strovolos and Nicosia). The station is also responsible for offering services in this region.

II. B. 1. 2. Target groups

For a first initial assessment people of all ages, high risk individuals with or without substance use, family members, people in need for information, etc. are accepted. Regardless of any drug problem or actual treatment demand, all individuals in need for support build the target group for the assessment.

Of all cases assessed, adults and non-dependant substance users constitute the main target group of counselling. Clients who do not comply with the objectives and services provided (i.e. drug-addicted clients, minors) are referred to other appropriate drug services. The major target group of counselling are high-risk individuals with or without substance use and family members.

With regard to the universal prevention offered by the *Kentheia* stations two different types of target groups can be identified. One target group are prevention multipliers such as teachers and professionals, the other one consists of children, students, parents and families whom prevention is directed to.

Beside these target groups some of the stations have a more specific focus. The counselling service of *Ithaki* addresses families with any social relation problems which does not necessarily include that a family member has a drug problem. In terms of prevention *Ithaki* sets a priority on addressing families with programmes directed to communication and conflict resolution. The counselling service of *Iraklis* additionally targets at gamblers. *Vera Paisei* does not accept clients with double diagnosis for counselling. Apart from the general population *Pegasus* prevention services have a special focus on children of young age.

II. B. 1. 3. Objectives

The *Kentheia* prevention and counselling stations aim first of all at addressing drug-related issues. There are no clearly defined objectives which results from the variety of target groups. With regard to prevention it was reported that the main aim is to build a social

network against drugs. In addition the stations have the objective of promoting physical and mental health, and preparing individuals for further steps needed towards appropriate treatment.

Specific objectives related to the services are:

- Assessment:

Objective of the assessment is to provide an individual assessment of drug users, addicted persons (illicit drugs, alcohol, medicaments, gambling, etc.) and their families, high-risk individuals, families in need and generally every client in need for information, advice, support and referral, regardless of the specific problem. The assessment is also to refer to or inform about the existing drug treatment services for drug addiction. A further objective is to provide information, advice and support, as well as making an appointment for a personal contact through an Open Telephone Line.

- Counselling:

Aim of counselling is to provide support for experimental substance users in order to motivate them to stop or reduce drug use and undergo treatment. Along with the individual motivation drug addicts are referred to treatment units. Furthermore individual counselling and support for people at “high risk” and their families aims at early intervention.

An additional objective of *Vera Pasi* is to provide group counselling and psychological support for the target groups of family members, individual at high-risk and experimental drug users. In turn, *Iraklis* has no clear objective as the station awaits the proceeding of demands in order to decide upon the focus of the facility. If there is no demand for individual counselling *Iraklis* will implement mainly prevention programmes. However, *Iraklis* plans to offer counselling for problematic families and to identify high-risk groups.

- Prevention:

As mentioned above the main task of the *Kenthea* stations is to build a social network against drugs. In this respect one main aim is the promotion of the establishment of Volunteering Prevention Community Teams (KOPE in the villages and DOPE in the cities). The network of local authorities, schools, youth organisations etc. function as a first line contact for advice, information and support for the general public. Furthermore the network supports the provision of primary prevention. The public and specific target groups (i.e. teachers, parents, etc.) are sensitised for preventing drug use and the idea of volunteerism.

Besides providing information on addiction prevention and treatment to anyone interested, a further objective is to deliver educational programmes for several target groups through

lectures, seminars etc. Aim is to organise and provide interactive workshops in cooperation with the local authorities for special groups such as preliminary school children, adolescents, parents, priests, and teachers. Various groups and organisations receive assistance for the implementation of prevention activities.

II. B. 1. 4. Structure

Staff members and qualification

All staff members of *Kenthea* attend a 300 hours training on prevention and counselling. 100 of the 300 hours are focused on counselling, provided by a trainer from NAADAC of the United States. The rest of the training is on prevention and conducted by Dr. Lazarov and the Interdisciplinary Faculty for Education which is a separate body under the methodological umbrella of *Kenthea*. The participation in this training results in a certification of *Kenthea*.

Every year training and education in prevention, offered by *Kenthea*, has a duration of one year. While the staff of *Kenthea* and *Tolmi* does not have to pay for training, all other participants have to pay the fee of 2 € per hour for attending the training and become certified by *Kenthea*. There is also the possibility of becoming certified by the University of Cyprus for the same training, but the fees will then be higher (details of this possibility are not clear yet, as the programme will be implemented in 2008). In 2008 *Kenthea Centre* plans to introduce training in drug counselling.

As regards the staff of the six decentralised prevention and counselling station one common particularity is that each station is operated by no more than one employee. The qualifications of the staff are as follows:

- Vera Paisi

The only staff member of *Vera Paisi* recently became full-time employed. She attended a three months qualification in general counselling, but neither in drug counselling nor in drug prevention. Between August 2007 and January 2008 the station had no staff member because the former one quit due to low salary – which is less than half the salary paid in the governmental facilities. A *Tolmi* staff member partly substituted the missing manpower for this time.

- Odysseas

Odysseas had for several years only one part-time staff member. Since June 2007, the staff member, who has been working for *Odysseas* for the last 2 years, gained full-time status and is now responsible for both counselling and prevention activities. The staff member has

a degree in psychology and attended special training in motivational interviewing and in some prevention programmes provided by *Kenthea*. According to the staff the help of the secretary of *Tolmi* has become indispensable.

- Fos

The single full-time staff member of *Fos* has a degree in psychology and a master degree in public health aspects from the Kings College in London. She attended many study visits in inpatient and outpatient detoxification units and an inpatient unit with group relapse prevention. The staff member has been working in *Fos* for the last 2 months and this is also her first working position. In all stations she is responsible for both counselling and prevention.

- Ithaki

The staff member of *Ithaki* was working on part-time basis until 2005 and now is a full-time employee. She is a psychiatric nurse/addiction counsellor with further qualifications in conflict resolution and prevention, and responsible for both counselling and prevention.

- Iraklis

The actual staff member of *Iraklis* is on maternity leave, yet still working the helpline and expected to return in April 2008.

- Pegasus

The *Pegasus* full-time staff member has a degree in psychology with one year education in research psychology and some experience in the psychiatric hospital of Nicosia. The staff member is working at *Pegasus* since September 2007 which is her first working position. This position follows a one year of voluntarily work for *Kenthea* in other stations. Like most of the staff of the centres she has no special qualification in the area of drug addiction.

Rooms and facilities

Vera Paisi in Pafos, *Odyseas* in Limassol and *Pegasus* in Nicosia share their rooms with the local facility of *Tolmi*. In all facilities there are rooms available for individual counselling as well as for group sessions. In Limassol and Nicosia there is also a computer available.

Fos in Nicosia area is situated in an office which is in the building of the municipality Council of Agion Trimithias. Everyday but Tuesday the office is at the disposal of *Kenthea* as on Tuesday the doctor needs the office. In the office counselling is provided and a telephone line is operated, but there is no computer. There are rooms for individual counselling as well as for group sessions.

Ithaki in Dhali area is situated in an office within the building of the community medical office of the Red Cross in Pera Chorio Nisou. The office is at the disposal of *Kenthea* everyday but Friday; while every Friday the office is occupied by a doctor. Rooms for individual counselling and group sessions are available, as well as a telephone line. There is no computer in the facility.

Iraklis can use an office in the geriatric health centre of Lefkaron and the office is only used for appointments. There is no PC available.

Quality management

With regard to quality management there is clear structured supervision taking place for all staff members of the six *Kenthea* stations and also for the *Tolmi* facilities. The supervision is held for staff of *Kenthea* and *Tolmi* together. Every week there is a group supervision of 90 minutes provided by Dr. Lazarov and Dr. Veresies. The supervision takes place for all staff members (approx. 12 persons) in the *Kenthea Centre* in Larnaca. Furthermore every two weeks there is a regular individual supervision by Dr. Lazarov for each staff member. Additional individual supervision is provided by Dr. Lazarov if needed. All supervision sessions by Dr. Lazarov are held in English. All participants have to pay the symbolic price of 1 cent per hour for his supervision.

According to the staff of the facilities practically all procedures on clients are decided in the supervision sessions by Dr. Lazarov and Dr. Veresies. If there are gaps or problems in the assessment or counselling proceedings of a client, the staff members always get into contact with the supervisors in order to make a decision.

Due to the lack of computers in most facilities there is no electronic documentation of the clients and services in the prevention and counselling stations. However, standardised instruments for documentation are used. In this respect all *Kenthea* stations fill in the TDI for documentation according to the EMCDDA requirements. The stations *Vera Paisi*, *Odysseas*, and *Ithaki* use in addition the EuropASI. The *Odysseas* staff member is trained in the use of EuropASI. Some stations also write case reports on the clients. At time of the evaluation in *Fos* there was no assessment of the clients carried out. In future, assessment of the clients will be done based on the TDI, EuropASI and a standardised interview of the client (psychiatric history, typical day, family history, social circumstances, etc.).

The data sheets are being sent obligatory to the Cyprus monitoring centre EKTEPN and to *Kenthea Centre* on request.

The *Kenthea* stations do not participate in a quality management programme and have never been evaluated in the past. The management and coordination of the stations is

undertaken by Dr. Veresies of the *Kenthea Centre*. For a better cooperation and networking in the municipalities an additional Council has been created for *the respective six prevention and counselling stations*. The administrative Council is composed of one representative of each municipality, one representative of *Kenthea* (not the staff member), and in case of cooperation the Youth Board. The Council aims at the identification of and access to high-risk groups, and the planning of alternative but specific prevention actions. A further objective is to organise the funding for those prevention activities that had been decided by the board of the Council.

Funding

The CAC funded about 62.750 Euro for prevention programmes delivered by *Kenthea* facilities and 14.650 Euro for drug treatment delivered by *Kenthea* facilities. The funding is centrally given to *Kenthea Centre* which distributes it to the six decentralised stations.

Table 10. Source and amount of funding for the six *Kenthea* stations

Funding of stations (€)	Cyprus Youth Organisation	<i>Kenthea</i>	Local authorities	Sum (€)
Vera Paisi	3.000	15.000	6.000	24.000
Odysseas	2.562	15.000	8.540	26.102
Fos	-	15.000	13.000	
Ithaki	-	-	17.086	17.086
Iraklis	-	15.000	unclear	
Pegasus	3.417	15.000	12.815	31.232

- Vera Paisi

The salary of the staff member is covered by *Kenthea* (15,000 €). In the year 2007, the CAC did not financially support the counselling service of the station. Thus the funding of the station was covered by the local authorities and the Cyprus Youth Organisation. The funding was given directly to *Kenthea Centre* in Larnaca. Additional costs for material, copies, printing, etc. are covered by the Pafos Anti-Drug Association. The CAC funding of the Pafos association in 2007 was 3.340 Euro, but it remains unclear how much of the funding was donated to *Vera Paisi*.

- Odysseas

The five municipalities and the Cyprus Youth Board contribute to the funding of the Station, and pay their contribution directly to *Kenthea Centre*. *Kenthea* covers the salary of the staff member and part of the actions of Odysseas.

- Fos

The staff member is paid by *Kenthea Centre*. The local authorities contribute through a donation of 15 cent per adolescent population.

- Ithaki

According to personal statement there is no financial relationship with *Kenthea Centre* as *Ithaki* works independently. The staff member is not paid by *Kenthea* but by local authorities. In 2007, the amount of 17,086 € was provided by the local authorities.

- Iraklis

The funding of *Iraklis* consists of a certain amount given by *Kenthea Centre* and financial support by the communities (1£ / person in the community population; approx. there are 6-7,000 inhabitants in the 17 communities). This community's support is directly paid to *Kenthea Centre*. There are no clear numbers of the last years' funding. The staff estimated the required budget as to be 11,000 €.

- Pegasus

Pegasus' main funding results directly from *Kenthea Centre*; there is also a contribution by the municipalities the Cyprus Youth Board.

II. B. 1. 5. Processes

Programme – specific services

Even though all stations more or less provide similar services, there are considerable differences in the specific services. For this reason all stations are described separately.

All prevention and counselling stations of *Kenthea* provide motivational counselling, primary prevention and operate a telephone line. The Open Telephone Line is to provide information, advice and support to drug users and their families. *Vera Paisi* reported to operate a 24 hours Open Telephone Line. *Odysseas* provides the Open Telephone Line 12 hours per day (09.00-21.00) and on 5 days a week. *Ithaki* operates the Open Telephone Line on 12 hours per day (08.00-20.00). The Open Telephone Line of *Pegasus* is available from Monday to Friday during 08.00-18.00.

As regards prevention provided by the services it has to be mentioned that all actions planned and implemented depend on the needs of the municipalities. The stations make

proposals for prevention projects but they always have to apply for the proposed projects to *Kenthea Centre*.

Counselling services

The information about the counselling service of *Vera Pasi* is based on the description of the procedures of the past years, as the actual staff member has been employed only for one month. At the time of the evaluation there was no client attending counselling.

In general the station provides information, support and counselling to clients. Counselling include the motivation of the client to attend treatment and to be referred for this purpose to other units (especially to *Tolmi Pafos*).

The concept of *Vera Pasi* is to offer counselling to clients and family members twice a week. An individual treatment plan shall be developed, specifying the partial targets of the counselling. These targets do not vary in the different phases of counselling. If the motivational phase fails, the client theoretically drops out and has the opportunity to restart counselling after one month. Motivational counselling is limited to a maximum of 8 months. The specific proceedings in the motivational phase are decided by the supervisor. The staff member reported that in practice counselling and motivation of occasional and non drug users keeps going on, even if the targets are not achieved. The duration of the ongoing counselling depends on the clients themselves.

Within the frame of counselling provided by *Odysseas* all clients are being assessed and provided information, advice, and support. The assessment aims to motivate clients to accept referral to further treatment. In case that the client is substance user he or she is referred to the psychiatric hospital or to private doctors. After two initial sessions within the first week the targets that should be achieved by the client are defined, and a contract is made about the rights and obligations of the client. This contract covers the duration of two months and is afterwards renewed. The initial phase is followed by the motivational phase where appointments take place one or twice a week for the first two months. After the two months of motivation the client is either referred to treatment or has to leave for a two weeks break before he can make use of the service again. All decisions on the client have to be discussed with the coordinator and/or the supervisor of *Kenthea Centre*.

At the time of the evaluation *Fos* planned to implement counselling and motivational treatment. The scheduled initial meetings shall take place once a week for the period of one month, and each meeting shall last 45 minutes.

Ithaki provides counselling for experimental drug users and for family members of drug users or with various social problems. With regard to counselling for experimental drug

users there are 2-3 appointments within the first week and afterwards the clients are seen once a week. The counselling is to motivate the clients to undergo treatment, and they are given approx. 2 months to decide about attending a specific programme. During the motivational phase urine testing is always made. If further treatment is declined by the client, the counsellor and the supervisor decide upon the further procedure. A continuation of the counselling process for five months is usual.

Assessment, counselling and conflict resolution is offered for family members of drug users. Counselling and conflict management is also provided for several other social or family problems which are not related to drugs. The first phase of the counselling consists in brief intervention where the family members attend 3-4 appointments. The family members have in addition the opportunity to participate in group sessions once a month. Further irregular treatment can also be offered to family members if needed. Finally, a referral to another unit for family therapy is considered. The counselling is considered to be well established at the moment. The majority of the clients are visiting the office, but many meetings also take place at home of the clients. This kind of outreach work is done after appointments made by phone call.

There is not much information on the counselling service of *Iraklis* as it was impossible to evaluate this station; the staff member was not available for direct communication. The only information available is that individuals may have the opportunity to meet at the health centre. *Iraklis* offers psychological help for families with problematic children in cooperation with the school counsellor.

The counselling service provided by *Pegasus* consists of three different stages. In the first stage information on the Cyprus drug care system (treatment opportunities, detoxification centres etc.) is given, and support and advice for people at high-risk is offered. In the information phase, which lasts 1-2 sessions and addresses drug users as well as family members, each case is being evaluated. The following second phase is focussed on treatment motivation and covers 3-4 sessions. The aim of the motivation is predominately to refer the client to a specific treatment. In general there is no specific limitation in the number of counselling sessions as this depends on the actual problems and needs of the client. In case of drug addicted clients they are first referred to detoxification which is a precondition for a further referral.

Primary prevention activities

In relation to prevention *Vera Paisi* is responsible for outreach work with a focus on informing the public, advertising prevention activities and organising prevention actions

that have been applied. From the perspective of the staff the establishment of a network within the community is essential for the organisation of prevention. The staff member does not carry out prevention activities due to the present lack of training. For the implementation of prevention *Vera Paisi* cooperates with *Kentheia Centre* in terms that either a trained person from *Kentheia Centre* or a trained colleague from *Tolmi* is carrying out the prevention activity or programme.

With regard to prevention the Council of *Odysseas* suggests prevention activities and subsequently offers support for the organisation and funding of the activity. Every suggestion requires filling in a special application form, and based on the application the staff member of *Odysseas* in cooperation with *Kentheia Centre* decide which specific action will be carried out. The implementation of the activity is carried out by *Odysseas* staff member or a colleague of *Kentheia Centre* sent for this purpose. The reason for the requirement of the application remains unclear as the Council is represented by the same persons who make the final decision upon the prevention activity.

Fos is actually focussing on achieving more acceptance in the community. Therefore, a closer contact to various organisations of each community such as sport clubs, parents' association, church etc. is intended. It is intended to form volunteer teams in the field of prevention for involving them in the implementation of prevention programmes. For the same purpose the psychologist of *Fos* is having regular meetings (1-2 times per month) with the president of the respective community to discuss relevant themes.

Fos is planning to implement selective prevention programmes (lessons and/or workshops) in youth clubs as its members are considered as high-risk groups. In order to reach high-risk adolescents *Fos* organised karate training.

Ithaki is engaged in community networking in order to specify actual needs in the community (i.e. in schools), and in outreach work in the community for the purpose to build "Addiction Prevention Community Teams" (KOPE) staffed by volunteers (parents, local authorities, teachers, youngsters, etc.). Furthermore information on the work and services of *Ithaki* are disseminated for instance through flyers distributed to each household in the area.

With regard to prevention *Ithaki* organises interactive workshops such as "Communication in the family". This prevention programmes is originally from Greece and is based on closed group programme with 13 sessions. In case that there is a clear demand for prevention activities, the possibility of *Ithaki* conducting the action is considered and by lacking means a volunteer is send from *Kentheia Centre*.

In consideration of the few information collected on *Iraklis*, the station is active in outreach work to introduce the services to the community and to keep contact to youngsters. A committee of the community leaders, who are for instance president of sports, the parents association, the ladies association, or different active citizens, has been built to support activities like tennis lessons for kids, educational projects. Objective is to keep youngsters busy in a healthy way. Additionally, different lectures for parents on topic of educational problems are organised.

Pegasus targets so far on universal prevention. In the last 6 months the major task was to create an appropriate network in order to reach as many people as possible. Networking is done through various advertising activities with informative character and contacting the president of every community. *Pegasus* is trying to establish links between the local authorities, schools, other organisations, the general public and *Kentheia* for the better organisation and targeted implementation of various prevention programmes.

Concerning specific prevention programmes *Pegasus* has tried to organise a group of volunteers in order to get them trained in prevention programmes such as “Standing on my own feet”. Unfortunately the number of volunteers was not sufficient to provide this programme. In the next years *Pegasus* intends to focus on alternative ways of prevention especially for high-risk individuals such as school drop-outs. A respective plan is not clear yet.

II. B. 1. 6. Results – annual reports

The results concerning counselling and prevention cover the number of clients reached by the stations in 2007 and the activities conducted in the field of prevention. The presentation of the results is based on the questionnaire, reports and the personal interview with the staff members.

Vera Pasi reported to have been in contact with 11 clients in 2007. 6 of the clients have been assessed to have drug-related problems; respective 2 had problems due to alcohol, heroin and cannabis use. Thus 4 of the clients had no drug problem at all. No more than three clients made use of counselling and all of them dropped-out. According to the interviewed staff the estimated time spend on counselling is 5 %, while the remaining 95 % is dedicated to prevention activities.

The time spend on prevention predominately involves meetings with the local community network or for organising the volunteer community prevention team (KOPE). Furthermore this time was used for information and advertising activities. Although it was said that

several workshops, informational lectures and educational sessions had been organised, their content, number and target groups remains unclear. In addition most of these activities had been carried out by *Kenthea Centre* in Larnaca. In conclusion, most hours of work were not spent on counselling or prevention activities, but on networking and advertising.

In the year 2007 a total of 28 clients (of them 3 minors) and family members had appointments in *Odysseas*. The clear percentage of clients and family members, as well as the number of high-risk clients and substance using clients is not clear. The numbers of counselling sessions may give a slight impression of the relation between drug using clients and family members. In 2007, there were a total of 13 sessions for high-risk persons, 25 sessions for addicted persons and 65 sessions for family members (=103 sessions). The information available from TDI provided by the National Focal Point suggests that only 5 male clients made use of counselling in *Odysseas* in 2007. The staff member stated that there are a high number of drop-outs, particularly in the motivation phase; a drop-out rate of more than 50 % is estimated. In general, migrants do not play an important role as the first two contacts with migrant population were in 2008 after a closer relation to the Russian community. In last two months before the evaluation, there was no client in counselling.

As regards prevention *Odysseas* delivered the following in 2007:

- 2 educational interactive workshops
- 12 informative and educational lectures (among others in 2 primary schools and 2 lyceums)
- 4 coordination and organisation meetings (among them contact with representing member of the Russian community)

Table 11. Number of Kenthea clients and drop-outs in 2007

Station	Number of all clients	Clients in counselling	Drop-out
Vera Paisi	11	3	3
Fos	0	0	
Ithaki	No information		
Pegasus	12	0	
Odysseas	28	28	16

Since the beginning of *Fos* in October 2005 there had never been any client in counselling. In 2007 prevention issues were conducted by a part-time psychiatric nurse. Since then main business is to achieve acceptance by community. As *Fos* neither had any contact to clients nor provided any prevention programme in 2007/2008, this raises the question as to what the full-time staff is occupied with.

According to the estimation of the respondent from *Ithaki* almost 70 % of the working time is invested in counselling. Of this percentage approximately half of the time is spend on drug counselling; the other half is spend on all kinds of other social problems. However, no numbers on the clients reached with counselling are available.

Similarly no documentation on the clients is available from *Iraklis*, and consequently there is no information on the quantity of the reached drug users or adolescents at risks. The communities expect a yearly report in future.

In the last 6 months (2007/2008) *Pegasus* assessed 12 clients, and about 60 % of them were mothers of people in need for treatment. Two clients – one with an alcohol problem and one with heroin-related problems – have been referred to treatment. At time of the evaluation two clients were receiving counselling; one for cocaine problems and one for alcohol problems.

In general the results of the six decentralised stations of *Kenthea* appear not to be transparent due the lack of documentation and reporting. In addition, the TDI filled in by the stations and submitted to the National Focal Point are only condensed data which do not allow any assessment of the single stations. Accordingly there is no data from the National Focal Point and the stations themselves on the number of clients treated.

4. 6. 1. 7. Evaluation

The evaluation of the six decentralised *Kenthea* prevention and counselling stations includes an assessment of their setting, structure and processes.

Evaluation of the setting

In general the evaluation shows that the *Kenthea* stations have no specificity in the target groups they are addressing. Everybody independently from being adult or adolescent, substance user or not or family member belongs to the target group. This broad range of possible clients can be regarded as the absence of a clearly defined target group. Some stations specifically mentioned addressing high-risk individuals. These are considered as

individuals with an antisocial behaviour, tobacco smoking minors, school drop-outs, migrants etc. However, the definition of “high-risk” seems not to be very distinct.

As regards the objectives of the stations all provide assessment, counselling, motivation, referral to treatment and prevention. Counselling is only offered to those individuals not dependent on substances. In case of addiction, motivational counselling is provided with the aim to refer the client to drug treatment. Based on the evaluation, the impression emerged that the predominant objective is to motivate clients to become abstinent either as effect of counselling or by undergoing drug treatment. In this respect it appears as motivation to treatment is even offered to occasional or experimental drug users. Assessment should consider the individual needs which might be different and must not include motivation to accept treatment. Some stations such as *Iraklis* and *Fos* do not appear to have any clear objectives at all.

Evaluation of the structure

One of the most striking particularities of the six decentralised prevention and counselling stations is that each station is operated by only one staff member. This staff member has to hold all positions covering the Open Telephone Line, counselling and prevention simultaneously. This situation is associated with a number of difficulties. First of all, the person is working alone without direct possibility to reflect the services. Secondly in case of attending education, being ill or on leave, there is no substitute ensuring that the services will still be available. Furthermore some of the stations only have part-time staff and some were partly even without any staff. The described conditions of staffing are mainly related to shortages of (public) funding. However, such circumstances hinder the implementation and in particular the establishment of good quality services.

One staff member being responsible for both counselling and prevention leads to prioritising one part, which is in most cases in favour of prevention. Consequently counselling often does not achieve the same attention. Probably this priority is a result from the training in prevention and the lack of qualification for drug counselling. Even though the ICE of *Kenthea* undertakes considerable efforts to train and educate staff in the field of drugs and drug addiction, many current staff members do not dispose of the competences and skills in dealing with drug users. Consequently there is a clear need for the improvement of qualification in drug issues.

In general, some stations such as *Pegasus* try to combine assessment of clients, counselling, motivational interviewing and referring, as well as prevention in a large area of several municipalities by only one staff member. This condemns the objectives to insufficiency,

despite the given motivation. For this reason most staff member are in need for constant support. For instance the staff member of *Pegasus* had 10 extra individual supervision sessions in order to decide upon proceedings for 12 clients. Even though 10 hours of additional supervision for 12 clients indicates the need for qualification, it also must be regarded as rather inefficient.

As regards supervision – weekly group supervision, two times a month individual supervision and additional supervision if needed – the frequency of supervision is very high. If the staff is qualified and would work in a team, regular monthly supervision is regarded to be sufficient. It is also regarded as problematic that the supervision is held in English even though the staff members have considerably different levels of English knowledge. It is also worth mentioning that the supervision is not done by an external person but by persons who are deeply involved in coordination and management of the *Kenthea* stations and the education of the staff. However, by the end of the evaluation it has been reported that now a new director is involved who is from Greece.

Most of the prevention and counselling stations have no computer. This results in an insufficient documentation, and thus in the lack of monitoring which is of outmost importance to know about the trends and needs. There is a clear need to improve documentation and to provide yearly reports on the service delivered. Due to the lack of documentation and reporting neither the communities nor the CAC have the possibly to be informed about proceedings and outcome of the services. In the light of receiving funding *Kenthea* has to achieve more transparency of their work.

Evaluation of the processes

With regard to the counselling services out of the six prevention and counselling stations *Ithaki* and *Pegasus* are most established. Both facilities reached a number of clients that made use of their counselling services. As drug counselling seems to be underrepresented despite also addressing alcohol users, the question on the demand for drug counselling is crucial. If there is such a demand which is left uncovered, there is a clear need to readjust the focus on drug counselling. If there are just not enough clients requesting drug counselling, the concentration on other problems (i.e. family conflict resolution) seems appropriate. As the exact number of clients was not reported, the capacity for offering counselling remains unclear. However, in case of *Pegasus* it was said that 28 clients received counselling in the year 2007 which is certainly below capacity of the station. These figures indicate the need to improve measures to reach the target groups.

With exception of *Ithaki* and *Pegasus* all other *Kenthea* stations are mainly engaged in prevention and not in counselling. Those stations that have reached clients with their counselling service most often are in contact with family members rather than with drug users. Two stations – *Vera Paisi* and *Fos* – even did not have any client in counselling at all. Thus, the question arises if the counselling services address the needs appropriately or if there is simply no need for counselling.

As in the district of Pafos and Limassol there is no other drug counselling facility but *Kenthea*, the evaluation indicates that the concept of counselling might require to be revised to respond to the individual needs of the clients. Even though an individual assessment of the clients is undertaken, the counselling thereafter is always directed towards abstinence through motivation to enter drug treatment. The target to undergo treatment may not be shared by the client and results in quitting the counselling. An assessment of the individual only makes sense if the clients' perspectives and wishes are taken into account and if the individual progress is considered. This means that also harm reduction for instance by reducing the drug use frequency might be one aim of counselling. However, it is recommended to reflect the current concept of counselling by prioritising targets of counselling in terms of accepting harm reduction as one target. In addition, the discontinuation of counselling in case a client is not motivated to enter treatment needs to be reconsidered. Structured psychosocial interventions should include different options ranging from brief intervention, motivation to ongoing psychosocial support.

However, the evaluation reveals that the stations *Vera Paisi* and *Fos* are not very established as regards their counselling service and prevention activities. Partly this might be due to the fact that the staff members in both stations have only been working there since two months. On the other hand both stations already exist since a couple of years, and the demand for counselling is still rather low. In addition, both stations are still concerned with advertising and networking which indicates difficulties to achieve acceptance by the communities. Accordingly no prevention activities had been implemented by the services so far. The plan of *Fos* to implement selective prevention programmes in youth clubs seems not well thought-out as no specific target group can be defined. Age boundaries, profile and potential high-risk factors of the adolescent club members are not clear. A prior survey of the club members' profile is essential to consider the need for selective prevention. In conclusion, it remains unclear if any revisions of the counselling and prevention provided by the stations *Vera Paisi* and *Fos* will result in a better establishment of the two facilities.

One major concern of all *Kenthea* stations is directed towards community networking and distributing information on their service in order to continue the cooperation with local authorities who may change every five years due to elections. As also the non-governmental Associations and the School Councils regularly have new presidents, it was argued that the staff spends lots of time with meetings with these persons. Concerns of networking obviously result in few prevention activities that had been put into practice. Of those prevention activities that took place most were targeting at adults, parents, and teachers. Prevention addressing adolescents as target group are underrepresented. In addition, some prevention programmes consist in offering alternative leisure activities which are not effective in the field of prevention. Within the context of prevention there is a clear need for a) a need assessment and b) the readjustment of prevention activities according to the results of the need assessment. In general, it is recommended to consider focussing prevention more on children and adolescents and to provide them evidence-based prevention programmes.

II. B. 1. 8. Proposals

Based on the evaluation results one of the main proposals is to carry out a thorough assessment of the needs in each area where the prevention and counselling stations are located. The staff members repeatedly stated to be convinced that the number of clients will increase if more persons in the community know about their station. In the light of stations existing for many years, this opinion is not held to be very realistic. Currently only unsystematic information on the needs of the population are available but there is no reliable inventory of the needs – which is certainly the case in many European regions. However, it is not very reasonable and efficient to operate counselling and prevention stations in areas where the demands are low and needs are not evaluated. As in the Pafos and in the Limassol area there is no counselling station for drug users at all, the *Kenthea* stations may play an important role to fill this gap. In order to do so it is strongly recommended that the respective stations focus on counselling rather than on prevention, and that qualified staff provides low-threshold access to assessment, counselling, and referrals.

In general it is proposed to estimate as accurately as possible the needs for counselling and prevention in the communities. As long as there is no such estimation, the future plans to expand the services of *Kenthea* by establishing four further stations are not supported by the evaluation.

Probably *Pegasus* might be the *Kentheia* station, where the possibility of an additional staff member could actually make sense in order to allow staff to concentrate on counselling and prevention separately. In this case qualification by trainings has to be ensured. In addition the employment of additional staff should be based upon a strict inventory of the actual needs and service utilisation in the community.

In general some stations do not appear to work target-oriented, needs-oriented nor well organised or established. The change of staff does not justify that a station always seems to start from a new point. Furthermore many stations did not seem to achieve full capacity. In order to improve quality and effectiveness of services it is recommended to reassess the concept of counselling and the definition of target groups. An assumption from the evaluation is that the stations would benefit from receiving a clearly defined profile. With respect to counselling offered to drug users, need assessment must be based upon an agreement between client and staff on the first steps to be taken. This also may include harm reduction instead of treatment entry as a first priority.

Even though few stations reached clients and do counselling, many stations mainly focus on prevention which makes about 70 % of their work. Even though it has been stated that it is part of the job description to prioritise prevention, the stations are expected to provide prevention and counselling by name. If stations are not utilised for purpose of counselling this may indicate the lack of demand. In these cases it is proposed to consider the cessation of counselling in favour of becoming prevention stations solely.

In the future it is planned to address risk groups and hidden populations and to provide more selective prevention instead of universal prevention. In general a change in the current prevention activities is regarded as reasonable. Selective prevention might contribute to prevention of risks if being appropriately designed, evidence-based and directed to certain target-groups exposed to risks. Independently from universal or selective prevention any activity or programme in the field of prevention should to be based upon evidence for effective prevention. In this respect it is recommended to define alternative activities such as for instance karate training not as contribution to prevention but as engagement in health or keeping people busy.

Another aspect worth mentioning is to reflect the current concept of supervision. In view of the frequent supervision meetings it is recommended to reduce the number of supervision sessions to once a month with the possibility of additional individual supervision if needed. This does not mean that each client shall require additional supervision furthermore. With regard to quality assurance it is recommended to consider the engagement of an external

supervisor in order to increase professionalism of the staff and to benefit from an external view of the practice.

Finally the evaluation shows that the funding does not always cover the expenses of the stations. For receiving adequate funding it is basically important to improve the quality and outcome of the services provided by the stations in terms of quality management, documentation, and transparency. There is a clear need for documentation of the services performed and the clients served, and this kind of documentation should be done by each service and to be reported separately for each service. The evaluation definitely reveals that the current lack of transparency makes it rather difficult to assess performance and in particular results of the services. To provide appropriate information to funding organisations documentation and reporting is of vital importance.

II. B. 2. Tolmi and its outpatient Therapeutic Communities

II. B. 2. 1. Introduction

The NGO *Tolmi* provides open Therapeutic Communities for addicted persons in Larnaca, Nicosia, Limassol and Pafos. The open TC *Tolmi* in Larnaca has been established in 1992 by the initiative of two voluntary associations (SYKANA and Larnaca Mental Health Association). The associations recognized the need to start an outpatient TC for alcohol addicts as there was nothing in place for these persons. Until early 1995 *Tolmi* exclusively addressed alcohol addicts by offering group therapy. As users of cannabis also contacted *Tolmi* for treatment, in 1996 two therapy groups – one for cannabis users and one for alcohol addicts – were initiated. In addition individual counselling was introduced as a further offer.

In 1997 *Tolmi* became an independent, non-governmental organisation with an own administrative body. This is formed by 7 persons, consisting of 2 ex-addicts who have completed the treatment programme, 2 staff members of *Tolmi* and 3 volunteers. The staff members and the volunteers change every two years and new persons are voted in an assembly in order to take over their position.

Tolmi Nicosia has been established in 2000 and *Tolmi* Limassol in 2004, both are having the same structure and programme as *Tolmi* Larnaca.

Tolmi Pafos has been founded in September 2007 as there are no governmental services in Pafos up to now. A further development of the unit planned up to the year 2009 until the unit reaches its full capacity. This plan includes the employment of two part-time professionals and involvement of 6 volunteers with appropriate training.

II. B. 2. 2. Target groups

The target group of all *Tolmi* units consists in adults (17+) addicted to alcohol or illicit drugs and their families. Also experimental users and adolescents refusing treatment at other specialised units (i.e. Perseas in Nicosia) are accepted. Drug users with dual diagnosis and drug users on prescribed medications (substitution) are treated in cooperation with other experts. Precondition is the decision to become abstinent.

All *Tolmi* units share the same target group with some small variations:

Tolmi Limassol accepts only adults (18+) in a drug-free condition for treatment. *Tolmi* Pafos addresses adult drug users in all stages of drug use. Drug users may still use substances when starting treatment but should show a clear motivation towards abstinence.

II. B. 2. 3. Objectives

The main target of *Tolmi* is to provide psychological support and individual as well as group treatment to adult drug addicts and their families with the aim that addicts achieve long-term abstinence and social reintegration.

In particular, the objectives of *Tolmi* are:

- Immediate help and support for addictive persons and their families.
- Encouragement and motivation towards stabilising the clients' decision for detoxification.
- Accomplishment of an abstinence phase in order to promote long-term abstinence.
- Providing information about substances, addiction, and mood impact.
- Effort to change the family dynamic in order to support the individual.
- Referral of addicts and their families to certain services in order to support long-term abstinence and promote social reintegration.

II. B. 2. 4. Structure

Staff members and qualification

Staff members must have at least a bachelor degree in psychology or social sciences, and they need to be specially training in the field of drug treatment. The training is mainly provided by *Kenthea Centre* which is an accredited educational organisation in Cyprus. Furthermore almost all of the staff members have visited an adult TC in Greece for one month to attend practical training. There is also an in-house training of new staff members on the theoretical basis of addictions. Additionally all staff members received a special training in the field of family therapy and are qualified in providing family therapy to clients.

George Boyadjis, who has been the director of all *Tolmi* units since 1998, is a full-time psychologist and working in Larnaca. *Tolmi* in Larnaca employs also

- One part-time psychologist
- One part-time sociologist
- One part-time drama therapist

- One part-time occupational therapist

In addition Dr. Veresies is available as part-time psychiatrist.

Responsible for the treatment in *Tolmi* Nicosia is a counsellor. In *Tolmi* Limassol there is one full-time staff member who has a degree in psychology and attended a special qualification and training from *Kenthea* in Greece. He is working in *Tolmi* for one year, with the first 5 months without salary due to the lack of funding. Furthermore there is one full-time secretary.

In *Tolmi* Pafos there is one staff member with a degree in psychology, training in addiction counselling (NADAC), several study visits in the United States and ongoing training. In case of vacancies the staff member is being replaced by staff member from other cities. The employment of a Russian-speaking counsellor is planned for the future.

Rooms and facilities

All units have a computer, some with internet access.

As regards the rooms in the present buildings of *Tolmi* Larnaca and Pafos there are not enough rooms for the different group sessions. In both facilities there is only one larger room which can be used for this purpose – and this room is not very comfortable to provide group therapy. This is different to *Tolmi* Limassol where rooms are available for individual counselling as well as for group sessions.

All *Tolmi* units are located closely to the *Kenthea* units; thus *Tolmi* Larnaca is situated in the same building of *Kenthea Centre*. *Tolmi* Limassol and Pafos share a flat with the *Kenthea* station *Odyseas* and *Vera Paisi* respectively.

Quality management

In 2002 and 2003 *Tolmi* units existing at that time have been evaluated; the first evaluation has been carried out by Roxanne Kibben* and the second one by Dr Panagiotis Yiorgagas. The respondent from *Tolmi* Pafos stated that a process evaluation has been carried out to assess functioning and effectiveness of the local service. In future a further evaluation is planned.

However, *Tolmi* units do not participate in any quality management programme.

As staff of *Kenthea* and *Tolmi* share the same supervision- every week there is group supervision and every two weeks there is individual supervision – supervision is the same

* From 1996 to 1998 Mrs. Kibben served as president of NAADAC, the American “Association for Addiction Professionals”. She has also been in Cyprus to train therapists in addiction counselling and teachers in drug use prevention in the Greek Cypriot and Turkish Cypriot communities.

as described in chapter 6.1.4.3. The only difference is that Mr. Boyadjis also has a role as supervising counsellor of the *Tolmi* units.

All *Tolmi* units have a close cooperation with hospitals and clinics, physicians, residential and outpatient treatment facilities and welfare organisations.

With respect to documentation each unit used the TDI, EuropASI for documentation and compiles a report of the personal history of the clients. The documentation is not done electronically even though there are computers available.

Funding

Tolmi Larnaca has formed a new board being responsible for fund raising for *Tolmi* Larnaca and Limassol. The board consists of volunteering members such as businessmen, parents' organisations, charity organisations, families of addicts, etc. and is located in Larnaca. Here all donations are collected and then distributed to the two units in equal shares. *Tolmi* Pafos is independent concerning funding as the Pafos Anti-Drug Association raises the money for the unit. Similar is the situation for *Tolmi* Nicosia. In near future financial independency of each *Tolmi* unit is planned through an independent board. In Limassol first meetings for creating a new board have been expected in February 2008.

Tolmi Larnaca received 5.000 £ (8.563 €) from the CAC in the year 2007. Efforts have been made to get additional funding from community members, donators, sponsorships and charities. The amount gathered by these sources remains unclear. *Tolmi* pays the salaries and shares the costs for the rooms with *Kentheia*. The yearly budget needed to operate the facility is estimated at 55.000 €.

Tolmi Limassol and Nicosia both received 2.000 £ (3.425 €) from the CAC in 2007. Additional funding was also gathered from community members, donators, sponsorships and charities.

In 2007, *Tolmi* Pafos received 3.000 £ (5.138 €) indirectly from the CAC through Pafos Anti-Drug Association. Additional 30.755 € were also raised by the Association, which finances the rent and the equipment of the facility. A sub-committee of Pafos Anti-Drug Association is running the finances of the *Tolmi* unit. An estimated budget of yearly 70.000 € is needed to operate the unit.

II. B. 2. 5. Processes

Most clients contact *Tolmi* directly, others are referred by the Anti-Drugs Unit of the police, by *Kentheia* or the Youth Organisation. These organisations have the phone and fax number

of *Tolmi* in order to quickly refer clients. To enter the therapeutic programme, clients have to be drug-free, which is checked by urine screening.

Programme – specific services

The therapeutic setting of the *Tolmi* units is tried to be kept consequent but flexible in order to adapt treatment to the special needs and working plans of the individual. Drug users with dual diagnosis and drug users with prescribed medications (psychiatric medication, substitution) are accepted for treatment if these clients are in a clear mental state which allows entering the group therapy. If they are assessed as unable to participate in a group, individual counselling is offered instead. Adolescent drug users, treated by exception, receive individual and family therapy.

The clients should understand the Greek language for the group sessions, although individual counselling is also offered in English. Every group defines own rules at the beginning of the programme. For instance, if a client does not attend group sessions three consecutive times, the group decides upon the sanctions and proceedings with the client. During treatment the frequency of group meetings and individual sessions decreases slightly but constantly.

Due to the lack of clients, *Tolmi* Limassol and Pafos did not offer group sessions since last year and for this reason only individual counselling is provided. In Limassol the low number of clients may result from the gap between the last and the new staff member. The last psychologist was on and off payment for the duration of two years.

In the first 6 months of the treatment frequent urine tests are being made. Unfortunately, due to lack of governmental funding for urine tests, family members of the clients have to pay for the urine screening.

The outpatient treatment programme is structured along four different stages:

- Assessment
- Procedure and needs planning
- Entering the 12 month outpatient Therapeutic Community
- 6 month rehabilitation

The assessment of the clients is made by EuropASI, Zung Depression Scale, a clinical interview, and by the personality inventory R. Cattell 16-PF. In Pafos the assessment is done based on EuropASI and an unstructured interview. “My own story” is planned to be used in the near future.

Procedure and needs planning implies to clarify the treatment needs of each client individually. Needs planning results in the decision if the client will enter inpatient or outpatient detoxification, and afterwards the *Tolmi* programme. Precondition for treatment entry is the willingness of the client to become abstinent from drugs. If this is not assured, individual motivational counselling with additional psycho-educative information about substances and harm reduction is provided for about 2 months. Motivational counselling is limited to two months and aims at motivating the client to undergo detoxification and to return to the treatment programme. If this aim could not be achieved in two months, the client is referred to the counselling station of *Kentheia* for further motivational counselling. After a forced therapeutic pause of one month the client can also return to *Tolmi* for further treatment. In special cases, clients are being referred to other clinicians.

The 12-month outpatient programme

The outpatient treatment programme is not strictly limited to 12 months. Clients who want to stay in the programme longer than 12 months are allowed to do so. The programme duration and frequency of meetings is flexible and adjusted to the individual needs of the client.

As regards the processes of the treatment programme there are some differences between *Tolmi* units.

In *Tolmi* Larnaca the first months of the treatment programme mainly aim to stabilise the client and to enforce the abstinence decision. Therefore, highly frequent appointments up to three times per week are offered to the clients. The regular contact to the *Tolmi* unit for this interval allows clients to enter the main phase of the treatment programme.

After about three contacts with the client family members or relatives are asked to visit the unit for a separate counselling session in order to discuss possible support pathways during the treatment programme. In addition, they are offered to participate in the relatives' group therapy. In this case the family member, close friend or relative signs a contract for participating in the family therapy once a week. If it fails to involve relatives or a close friend in the treatment programme, this can lead to an interruption of the treatment for the client. However, this rule is always considered individually.

During the main treatment phases the adult clients begin regularly with group therapy, individual counselling, drama therapy and occupational therapy. The group therapy sessions are open and allow new clients to enter the group at every stage. However, one group should not exceed 14 members in order to be functional. Every group session is

carried out by two therapists. Parents or other family members participate once a week in a family group session.

The treatment scheme for drug addicts consists in:

- 2 times per week group therapy lasting 90 minutes each
- Once a week drama therapy
- Once a week occupational therapy
- Once a week individual counselling lasting 45 minutes

Due to the lack of funds, drama therapy and occupational therapy could not be provided in the last six months. Instead more group therapy took place.

In *Tolmi* Limassol the treatment programme is exclusively based upon individual counselling. Counselling does not follow a certain systemic approach, but consists of motivational counselling, relapse prevention, life-skills training, social integration methods, etc. The staff member regards this approach more as counselling than as psychotherapy.

The clients receive 2-3 appointments per week. Additional sessions together with family members are also possible. Regularly family members participate in one session per week as long as the client is in treatment. The use of substances while in treatment or a relapse leads to the consequence that the client has to return to a former stage of the programme. Regular relapses are an indicator for referral to the counselling station of *Kentheia* in order to receive motivational counselling. All treatment cases are being regularly supervised every 2 weeks by Mr. Lazarov from *Kentheia*.

There are no concrete goals the clients have to be achieved by the end of the programme. The treatment programme actually ends after a certain improvement of the clients. A follow up also takes place, starting usually one month after treatment completion. For the follow-up first a private appointment is made, and afterwards this is done on regular basis per telephone. Despite there is actually no systematic documentation of follow-up contacts, only notes are made.

In *Tolmi* Pafos it is also possible to enter the programme at all stages. The programme is offered in Greek and English. The implementation of the option of receiving treatment in Russian is planned by employing a respective staff member. Migrants can attend the treatment programme without having a green card.

Therapeutic phase covers 6 to 10 months and consists of motivational counselling, relapse prevention, life-skills training, improvement of family and/or partnership relations, social integration methods, etc. Urine drug screening is requested once a month. The treatment programme is structured as follows: For maximum of 8 weeks motivational interviewing

takes place 2-3 times per week. The treatment procedure is individually planned and documented. For each client a treatment plan is developed at the beginning and reassessed 8 weeks later. The reassessment is to monitor the targets accomplished. According to individual needs the clients receive 2-3 appointments per week but the frequency of contacts may decline during the programme. Regular relapse is an indicator for referral to the counselling station of *Kentheia* for further motivational counselling.

Unlike *Tolmi* Limassol in Pafos families and relatives of addicts are also offered counselling once a week for an unlimited period, even if the client is not in treatment.

The 6-month rehabilitation

After the completion of the outpatient treatment programme in *Tolmi* Larnaca or Pafos a six month rehabilitation phase is scheduled. Clients participate once a week in individual counselling sessions which aim at supporting individuals in finding a job and reintegrate in the community. In Larnaca role-play in groups takes place to train social skills and prepare for situations such as an interview for a job application. In addition, the clients are encouraged to participate in a vocational training programme.

In case that the Social Welfare Office refers persons to *Tolmi* the unit cooperates with several governmental services for job or educational programmes, and social welfare issues. Aim of the cooperation is to facilitate the client's ongoing participation in the welfare programme.

After completion of rehabilitation programme *Tolmi* Pafos plans to follow-up the clients through one appointment per month for the next 5 years.

II. B. 2. 6. Results – annual reports

During the past years (1995-2006) there has been a continuous increase of clients receiving treatment at *Tolmi* units. In the year 2002 the highest number of clients was registered with 181. Noticeable is the fact that the number of clients declined considerably from 151 clients in 2006 to 81 clients in 2007. Out of the 81 clients 12 were in contact with *Tolmi* Nicosia and 11 with *Tolmi* Pafos.

Based on the data provided by the National Focal Point the characteristics of the clients attending outpatient treatment in *Tolmi* are compiled in the following table.

Table 12. Characteristics of the Tolmi clients in 2006 and 2007

	2006	2007
Number of clients	151	81
Mean age	28.7	27.9
Gender	136 male (90 %)	75 (93 %)
National of Cyprus	113 (75 %)	63 (78 %)
Years of use of primary drug	6.5	6.0

Since the governmental drug service *Themea* specifically addresses alcohol addicts, the number of alcohol dependent persons dropped in *Tolmi*. The outpatient treatment programme of *Tolmi* is mainly used by persons with primary use of heroin. This is followed by clients with primary cannabis use and in the third place by clients with primary cocaine use. Of the clients in 2006 and 2007 53.6 % and 37 % respectively were primary heroin users. In the same period 25.2 % and 48.1 % of the clients were primary users of cannabis. In 2006 13.2 % of the clients were primary users of cocaine and in 2007 this was the case for 11.1 %. In the two year period the number of heroin addicted clients decreased by 16 % while the number of cannabis using clients almost doubled. The change in the characteristics of the clients might be related to the introduction of substitution treatment which could have become the first treatment choice for heroin addicts.

In January 2008 there have been 24 clients in the outpatient treatment programme and 15 clients in the social rehabilitation programme of *Tolmi* Larnaca. Like in all *Tolmi* units the vast majority of the clients is male and from Cyprus. Some of the clients were from Pakistan or Georgia. The treatment programme was reported to have a 65 to 70 % retention rate. During one year about 30 % of the clients dropped out. The highest drop-out rate is to be found in the first month of the programme when about 50% of the clients interrupted their treatment. Those who quit the programme after six months but are drug-free and socially integrated are not regarded as drop-outs.

During the last two years only one or two family members refused to participate in the group therapy of *Tolmi* Larnaca. The majority of the family group participants are mothers of clients.

In the city of Limassol the population is characterised by many migrants. Consequently *Tolmi* Limassol noticed an increasing number of migrants, especially Russians, contacting the unit. In addition the number of young persons applying for treatment at *Tolmi* Limassol was reported to be pretty high with 8 individuals contacting this unit.

According to the staff, approximately 20 % of all referrals to *Tolmi* Limassol are made through older clients supporting other addicts to apply to *Tolmi* for treatment. In January 2008, 12 clients received treatment. In the year 2007 *Tolmi* Limassol treated 50 clients and 10 of them are considered as drop-outs. Programme completers are defined as clients showing improvement over the time, but the criteria for improvement remain unclear.

II. B. 2. 7. Evaluation

Evaluation of the setting

The four *Tolmi* outpatient treatment units in Larnaca, Limassol, Nicosia and Pafos show a clearly defined target group which consists of adult substance users and their families. The efforts to respond to individuals needs are visible in accepting also adolescents who do not want to attend specialised services and drug users with dual diagnosis. Users in substitution treatment are also well accepted by *Tolmi*. Clients who are still using drugs are provided motivational interviewing and education about harm reduction, while entering the 12-month outpatient treatment programme requires being drug-free.

The treatment programme follows clearly defined objectives that do not only include prior aims of any treatment such as motivating clients to change through detoxification and following abstinence-oriented treatment in order to achieve long-term abstinence. Further objectives are also to provide immediate help and support for addicts and their families and to information about substances and their effects. The involvement of family members in the treatment process aims at the change of the family dynamic in support the individual.

In general, the *Tolmi* units are focussed on treating drug addiction and appear to be based upon a well structured concept as regards target groups and objectives.

Evaluation of the structure

With respect to the structure two main difficulties became obvious. These difficulties are related to the staff and to the buildings. With exception of *Tolmi* Larnaca, which seems to be appropriately staffed, all other units are operated by no more than one staff member. Similar to the situation of *Kenthea* one staff member can not ensure availability of services which is important for a well established and accessible service. In case of leaves there is no qualified staff who can substitute the only staff member. It is also regarded as a problem if there is only one staff member conducting individual and group therapy. For drug treatment it is essential that there is at least a second staff member allowing to substitute

each other and to reflect the cases. In addition, working alone means to be alone in the office with a client which may cause risks for the security of the staff.

In case of *Tolmi* Pafos a further problem is that the only staff member continuously attends training, which on the one hand does not ensure full service delivery and on the other hand absorbs capacity for clients. It would be better to employ qualified staff being responsible for the service and to hire an additional staff member who still needs a lot of training. In order to respond to the group of migrants coming from the former Soviet Union the staff sees the need to employ a Russian speaking staff member. As more than 20 % of the clients are migrants, especially in Limassol, the employment of such staff seems to be reasonable.

The building of *Tolmi* Larnaca and Pafos are not adequate as they do not offer enough rooms for the different group sessions. However, in Pafos there is no group therapy provided due to the insufficient number of clients. In case of Larnaca there is a clear need for more space. As all *Tolmi* units are in the same building as *Kentheia* or even share the same flat there is no special separation between counselling of *Kentheia* and treatment of *Tolmi*.

The lack of sufficient funding causes some troubles. Thus, some *Tolmi* units were run by a staff member who works partly without payment or is on and off payment. To provide good quality services that are accessible, payment of the staff needs to be ensured. Funding shortcomings are also the reason for the Larnaca unit not to be able to provide drama therapy and occupational therapy for more than a half year. Last not least urine screening as part of the therapeutic process has to be paid by the family or the client due to lack of funding. As drug treatment is a public health task this situation definitely requires to be changed.

Evaluation of the processes

The therapeutic processes of the outpatient treatment units of *Tolmi* appear to be appropriate in structure and content. To keep the therapeutic setting flexible in order to respond to individual needs can be regarded as good practice. Working plans and individual requirements are taken into account which is reflected in a treatment duration that is not strictly determined. Furthermore it is a good approach that drug addicts without motivation to quit drug use are not excluded from the programme but offered motivational counselling, information about substances and harm reduction. Currently the motivational counselling is limited to two months which is guided by the general objective of the units to enforce abstinence. Probably it may be promising to enlarge the services by offering psychosocial interventions to these drug users without limitation of 8 weeks and to provide outpatient

abstinence-oriented therapy to the group of clients being motivated to achieve abstinence. This might also allow clients in substitution treatment to attend *Tolmi* drug treatment services for a longer period. The declining numbers of heroin addicts contacting *Tolmi* indicate the need to readjust the services towards responding to the different realities and stages of drug addicts. In general, most *Tolmi* units work below capacity with 4 or 12 clients per year. The decrease in the number of clients supports the need to re-assess accessibility to the units and the treatment concept. In view of the drop-out rates being rather moderate with about 30 %, the treatment is on the right way but will benefit from improvement.

The involvement of family members in the treatment process is in general a favourable approach, and in this respect family member of the clients are encouraged to participate in the family group.

The systematic assessment at the first contacts with the client, the development of a care plan and its reassessment present a procedure that is in line with recommended service delivery. However, there is no such structured assessment of the clients during or at the end of the treatment programme. The proceeding of the client is only checked with urine samples and by knowing if a client has found a job. At the same time efforts are made to follow-up programme completers either by direct appointments or by telephone. According to the information of the staff, follow-up phone calls found more than 80% of the completers to be still drug-free after five years. The documentation of the clients' development at the end of treatment and the documentation of the follow-up information are of high value for assessing the outcome of the treatment provided by *Tolmi*.

II. B. 2. 8. Proposals

According to the evaluation the outpatient treatment units of *Tolmi* are properly designed as regards target groups and objectives and well structured as concerns their treatment programme. The treatment programme includes assessment and reassessment of the clients during the motivation phase, a treatment plan in agreement with the clients' needs and a flexible treatment frequency and duration. Thus *Tolmi* appears to be on a good way to provide a treatment programme that is oriented to individual needs and progresses. Nevertheless the treatment programme can be improved by some conceptual changes. As the number of clients decreased from 151 to 81 during one year efforts have to be made to improve reaching the target group of drug addicts. For improving accessibility and attractiveness it is proposed to open the treatment services more to drug users in

substitution treatment as this number might further increase with the establishment of maintenance treatment options. Probably heroin users in maintenance treatment can present a further future target group for individual counselling and group therapy. In addition it is recommended to reconsider the time limit of 8 weeks for motivational counselling. There might be a number of clients in need for structured psychosocial interventions who are not motivated to quit drug use after two months of counselling but still in need for ongoing support.

One proposal made by the staff was to implement further Tolmi units which are more specifically in for instance targeting migrants. As long as the available units operate below capacity, the development of further units is not recommended. Instead the existing units are advised to undertake more efforts to provide the full range of services including group therapy. Currently the lack of sufficient clients results in some units in providing solely individual counselling.

Staffing, funding and the inappropriate rooms had been turned out as the major problems which are partly interrelated. While in Larnaca a number of staff is available the other units are operated by one staff member only. If indicated by the number of clients it is recommended to have one additional qualified staff member – either on part-time or full-time basis. Anyway, the payment of the current staff needs to be ensured. Due to the lack of funding some services could not be kept alive for the period of several months. Consequently the units do not ensure permanence for the client, and when there is funding, the services have to start from a new point again. Proper functioning of the drug treatment units requires adequate funding of staff and services. No doubt that staff working without payment for a couple of months and outpatient treatment only based on individual counselling are not able to deliver good quality treatment. In this respect it is recommended that there is also funding for drama and occupational therapy in units that reach enough clients to build groups. It is also recommended that there should be a solution for the payment of the urine screening. Urine tests present a usual method of the therapeutic process and therefore the relatives or the client have to be relieved from the burden to pay for this. In *Tolmi* Larnaca as well as in other units there is not enough space to provide appropriate group therapy. The current rooms are not adequate as they partly are in the middle of the offices. Within this context it may also be considered if the flat sharing with a counselling station is convenient for the service provision and the client. The flat sharing might result in clients that experience no difference between the motivational counselling of *Kentheia* and the treatment programme of *Tolmi* as it takes place in the same flat.

As regards links to other services there is a close cooperation with *Kentheia* by nature. Treatment pathways of clients require considering the whole range of the existing treatment network, and thus a closer cooperation to non-governmental as well as governmental services is recommended.

Finally an improvement of documentation and outcome evaluation is required. Even though all *Tolmi* units have a computer no electronic documentation is provided. Documentation needs to be systematic and cover the initial assessment as well as an assessment of the clients after treatment completion. In particular the latter is recommended to be introduced. Service delivered to the clients as well as the data on clients and the treatment outcome should be reported yearly in order to allow monitoring and assessment of funding needs. In addition the follow-up information should be included in reporting on the treatment programme to document the treatment success.

II. B. 3. Agia Skepi: Nicosia Therapeutic Community (TC)

Agia Skepi is a non-profit, non-governmental organisation founded in 1998 by the Bishop of Limassol as a Therapeutic Community. There are two services, the TC and a counselling station, which are described separately. According to the philosophy of *Agia Skepi* addiction is not regarded as a disease, but as a symptom resulting from other difficulties and risk factors.

Agia Skepi has a leading committee – the Board – consisting of 11 members of whom 2 members are from the church and 9 from the community. The Board is responsible for all services of *Agia Skepi* including the implementation of new services and the finances of the organisation. The president of the Board is always a member of the church and is at the moment the Bishop of Limassol.

When opening the TC initially psychiatric nurses have been employed. Shortly afterwards it had been turned out that not a medical approach but counselling and therapeutic competences are needed.

Nowadays the TC is offering treatment to drug addicts and is also involved in education and training offered to students

of the University of Nicosia. The training includes a 2-months or 4-month residency in the TC of *Agia Skepi* in order to learn the TC philosophy and the basic setting and rules.



Therapeutic Community

II. B. 3. 1. Target groups

The main target group for the TC are adult long-term drug users at age of 18 to 45. In particular heroin users after detoxification are addressed. Users of other substances are also accepted. Clients with a double diagnosis such as psychosis are excluded from the programme while other diagnoses such as depression are no exclusion criteria.

In the first years the treatment used to be targeted at both male and female addicts. Due to lack of female clients and since opening of the governmental service *Pyxida* the TC is only treating men. Currently *Agia Skepi* is considering the implementation of an already planned and spatial-separated inpatient treatment programme exclusively for female drug addicts. The implementation of the women only treatment is expected in the next two or three years.

II. B. 3. 2. Objectives

The main objective of *Agia Skepi* TC is that clients will achieve long-term abstinence through drug therapy that supports eliminating addictive behaviours, rehabilitation and vocational reintegration of the clients in the community. Additional important objectives are to address family and relationship matters as the clients usually suffer from multiple social and family problems. Furthermore a behaviour modification of the clients is intended and for this purpose the therapeutic approach is based upon a hierarchical model of a behaviour system.

II. B. 3. 3. Structure

Staff members and qualification

The TC of *Agia Skepi* is staffed with 10 full-time staff members and 8 part-time staff members. There is a designated managing director who is a clinical psychologist and specially qualified in family therapy and addiction counselling.

The other staff members have the following qualifications:

- Four full-time psychologists who all have a master degree in addiction. Two of them are trained in family therapy.
- 11 counsellors of whom 5 counsellors are available on a daily basis and 6 are part-time assistant counsellors working in the night-shift. There are always two counsellors available at night.
- One part-time medical doctor
- One part-time occupational therapist

In addition there are two staff members for administration who are responsible for the management of the staff including meetings with staff members, inspection and validation of the decisions made and directions set, interviews for the employment of new staff members etc. The administrative staff is also represented in the Board.

Rooms and facilities

The huge building of *Agia Skepi* TC was a donation specifically given to build *Agia Skepi* on the ground of the Monastery of Panagia of Macheras. A big fence is surrounding the whole property. The facility provides 2 sport places, a gymnastic room, and rooms for craftwork, a TV- and a dining room, 2 laundries, a kitchen for the clients, a library and a chapel. There is also a huge conference hall which is used for dancing therapy and one

annual conference. Every therapist has an own office, where individual counselling takes place. There are further rooms for group therapy and for medical care. Furthermore PC working places with internet access exist.

The client bedrooms are dorms of 3 to 4 beds each, and some share a bathroom. Clients in the social reintegration phase have a bedroom on their own. In sum, the clients' rooms have a capacity for a maximum of 45 clients.

Quality management

With respect to quality management there is regular intervision of the staff once a week. The whole staff participates and discusses case-related topics. The counsellors can also address one of the therapists at any time, when needed. In addition there is external individual supervision for all therapists once a month and lasting 45 minutes.

The facility does not participate in any programme of quality management. However, the Therapeutic Community has been evaluated twice in 2001 and 2007; one time by the Yeshiva University of New York and a second time by *Kethea* Greece.

As regards networking and cooperation, referrals to *Agia Skepi* TC only come from the counselling centre of this NGO located in Nicosia. Furthermore there is cooperation with hospitals, rehabilitation facilities, residential and outpatient treatment centres for further referral of the clients. In the future, cooperation will be implemented with the prison and probation service.

For documentation and assessment of the clients a variety of standardised instruments is used; EuropASI, TDI, BDI-II, SCID, DEMA. Furthermore a personal interview is used to assess the treatment motivation and the specific treatment goals. All documentation is done electronically by using computer. There is no yearly report published but the results of the documentation are sent to the monitoring Centre (EKTEPN) and to the CAC.

Funding

Agia Skepi TC is financially supported by a number of organisations such as the "Association of Friends of *Agia Skepi*", the Ministry of Health, the CAC and other donators. After a period of a bad financial situation *Agia Skepi* carried out a press conference and organised a fundraising dinner in order to come into contact with possible further donators. For the last three years a German company is offering a new car every year to the TC, which made already 117.000 €. In the last period 17 flats have been bought in the area of Nicosia, and these are being rented out in order to collect a regular extra funding.

In the year 2007, *Agia Skepi* received in total 467.000 € funding; 55.000 € were from the CAC, 27.000 € from the Association of Friends of *Agia Skepi*, 58.000 € from the Ministry of Health, and the biggest amount 347.000 € was funded by other sources. According to the facility, the total yearly budget needed for operating the facility is 523.000 €.

II. B. 3. 4. Processes

Agia Skepi provides an inpatient TC using the international therapeutic model with some adaptations to the specific Cypriot situation. In general, the TC is using a cognitive-behavioural treatment approach, giving importance especially to group therapy which is based upon psycho-education, emotion-management, confrontational exercises and relapse prevention.

There is no waiting list for entering the TC; all clients are referred either from the outpatient counselling station of *Agia Skepi* or from the detoxification unit ANOSI.

The whole programme of the TC lasts 12 months and consists of 3 separate phases, each one lasting 4 months. The clients can graduate earlier, but also move back to an earlier phase, if necessary. So the exact length of the treatment for a client is not strictly set. The 12 months are considered more like a guideline, and the treatment duration usually varies from 9 up to 16 months.

In the TC there is a strictly determined programme and time plan which has to be followed by the clients. There are also sanctions and penalties for clients who violate the rules and schedule. Minor sanctions may be for example to lose the day-pass or not to be allowed to make a phone call. A heavy violation of the rules can lead to exclude the client from the TC. In case of drop-out, the client can return to the TC unless the drop-out was due to a relapse to substance use.

The three phases of the therapeutic programme are as follows:

- 1st phase

Newcomers form the Group C. The main objective of the first phase is to enhance the clients' decision to abstinence. An assessment of the problems of the client is carried out and a care plan is developed on the proceedings and aims of the treatment programme. In the first two weeks of the treatment an acclimatisation period is given to the clients. During the four months of the 1st phase the clients do not have any privileges. No telephone calls or contact to the outside world are allowed; with exception of the TC excursion and contacts with the children which must be brought to the community. The clients of the Group C are not allowed to make any decisions before contacting a member of a higher group.

In this phase 1-2 group sessions take place every day which make about 10 per week. In addition, there is an obligatory opening and closing group every day and a community group together with members of group B and A.

- 2nd phase

After the completion of the first 4 months the clients pass into the next phase and become members of the group B. This phase aims at the establishment of the client as a member of the TC. As a member of the Group B the client has the privilege of day passes which means the allowance to leave the TC for the day by being escorted by a senior group member. Phone calls and visits are now allowed.

The frequency of the group sessions is the same as in the first phase, but the topics are different and the treatment now focuses especially on family work. Family sessions are held as the families can visit the client in the TC. The parents of the clients are offered the opportunity of joining the parents' groups which take place in the counselling station of *Agia Skepi* in Nicosia.

In order to pass on to the 3rd phase, the client must write his autobiography.

- 3rd phase

In this last phase the clients become members of the Group A and start developing more contacts to the outside world. The clients now have more privileges so they can leave the TC during the day without accompaniment. They can initiate, suggest and decide upon actions (organisation group), and start to share responsibilities with the TC staff. The main aim is to prepare the clients for the months after completion of the programme. This included for instance to attend interviews and to find a job.

In the TC, members of the Group A are attending slightly fewer group sessions (up to 7 per week), but now more individual sessions. The focus is held now mainly on relapse prevention and future orientation.

Every move to the next phase is specially announced and celebrated by the TC members. There is also a celebration and a party taking place six months after leaving the TC and after one year of drug abstinence. Completers come back every year to celebrate in the TC their drug-free status.

The therapeutic programme is followed by a social integration programme, lasting another 12 months. Up to now clients in this phase are leaving the TC during the day in order to

work but are still returning to sleep overnight. As the TC is far away from Nicosia the social integration programme will in the future take place in an outpatient setting provided in the counselling station of *Agia Skepi* in Nicosia. The implementation of this change is expected next year.

One year after the completion of the social reintegration phase a follow-up meeting is taking place and has become a standard procedure in the last years. For the future a follow-up meeting twice a year is planned.

II. B. 3. 5. Results – annual reports

According to the staff, there are approximately 15-20 new admissions per year. As regards the yearly number of clients attending the residential treatment programme there are difference between the number reported in the questionnaire answered by the staff and the number provided by the National Focal Point. In the year 2007, the staff reported that a total of 34 clients have been treated while this number was 41 in the statistic of the National Focal Point. Due to the data of the NFP the male clients were on average 29 years old and used their primary drug since 8 years. Almost 60 % of the clients were migrants. The vast majority of the clients were heroin users (90%) and the remaining clients were cocaine or amphetamine users.

A retrospective analysis of the 165 clients treated in the programme in the last 9 years shows a very high drop-out rate of 66.7 to 88.2 %. Out of the 34 clients reported by the staff for the year 2007 15 clients dropped out while 19 clients completed the programme. Thus, in 2007 the drop-out rate was 44 %. In the questionnaire the duration of the treatment in 2007 was reported to be 68 weeks which is almost 1½ year.

Concerning the families of the clients about half of them were involved in the treatment.

II. B. 3. 6. Evaluation

The evaluation shows that the residential treatment programme of *Agia Skepi* reaches the intended target group of long-term drug addicts. The majority of clients undergoing this treatment are heroin addicts using heroin since more than one year.

Agia Skepi is well equipped as regards staff and facilities. There is a high number of qualified staff available during the day and during the night (two counsellors), and the huge building provided more than enough space for a variety of activities and well as offices and rooms for clients and therapy sessions. A certain degree of quality is ensured by internal

and external supervision in a reasonable frequency and by two programme evaluations that had been conducted by external institutes. Furthermore documentation is done electronically and by the use of standardised instruments. In conclusion, the setting and structure of the Therapeutic Community is well established.

On the other hand the staff as well as the building is far more than needed. The facility has indeed more rooms than actually needed. The maximum of clients attending treatment at the same time was 27 (2005), even though there is space for 45. Accordingly the facility has permanent vacancies of about 40-50 %. In addition, the location is situated in the mountains and too far away from the city. Contacts to the outside world are quite difficult and require about an hour driving.

In view of 18 permanent clients attending treatment in 2007 10 full-time staff members and 8 part-time staff members are considered too high. This is more than one staff member per client. The current staff should have been able to work with more than 30 clients. Two counsellors being available in the night are not regarded as necessary. As the funding does not cover all expenses anyway, it might be a good idea to have untrained personnel covering the night shifts, so that the highly trained staff can focus on therapeutic work.

The therapeutic programme consisting of three different stages is both too intensive and too strictly ruled. The clients have about 10 group sessions per week in the first and in the second phase which means 10 group sessions per week during a period of eight months. In addition there are further obligatory two sessions per day plus individual counselling. Such an intense therapeutic setting may cause an overload to the clients and does not make sense in terms of treatment outcome. In addition, there is also no possibility of entering the programme in the 2nd or 3rd phase despite the lack of a rationale for this, as the therapeutic concept does not change much by entering the next phase of treatment. Patients attend the same groups during the whole treatment. Furthermore the treatment regime is based upon a hierarchy system of privileges and sanctions. Clients entering the programme lose their autonomy for the next four months as they are allowed neither to make telephone calls nor to decide anything on their own. Even when upgrading to the next phase their contact to the outside world is always supervised. Probably the mixture of a rather intensive and strictly ruled treatment setting is contributing to the low treatment coverage. However, the drop-out rate of more than 44% is not unusual compared to other residential TCs.

After completing the 12 month intensive treatment programme it is an advantage if the clients do not have to attend the rehabilitation phase of additional 12 months in the same setting. The client's progress in treatment should be reflected by a geographical change. For

this reason the evaluation strongly supports the idea of providing rehabilitation in an outpatient setting.

Even though a number of organisations are mentioned as cooperating organisations, there is a clear need to improve cooperation with other drug care units. This need is also underlined by the staff. From the perspective of the staff, communication and cooperation with further drug services and especially with services providing support for reintegration has to be improved.

II. B. 3. 7. Proposals

Considering the fact that *Agia Skepi* is going to be the only TC in Cyprus left after the readjustment of the treatment service *Pyxida*, it is important that the programme is restructured and occupancy and outcome improved. Even though there have been two external evaluations until now, neither the number of clients nor the drop-out rates really improved. The evaluation does not seem to have contributed to a better treatment occupancy and outcome. The recommended reorganisation of the unit has to be based on a revised therapeutic concept, which has to start by questioning the meaningfulness of all procedures, rules and regulations of the unit.

The treatment offered to drug addicts has to be diversified in terms of providing long-term inpatient rehabilitation and short-term outpatient aftercare. 12 months inpatient treatment should be the maximum while outpatient aftercare should be reduced to a maximum of 3 to 6 months. Research does not support evidence that a longer treatment results in a better outcome. As regards the rules there is no necessity to cut-off communication between client and the outside world; on the contrary, the family (and friends) of the client is one of the factors that motivate the client to continue with treatment. The prohibition for the client to leave the TC should be restricted only to the first weeks of treatment. There is also no evidence that supports escorting the client when leaving the treatment area. Moreover the treatment should follow a community-based concept which includes tasks for the client in the community, such as taking care of things and also being confronted with the general availability of alcohol and drugs. The main aim of treatment is to enhance the clients' coping skills to deal with risk situations and to make own choices.

In general, only one small proportion of drug addicts may need a 24 months programme outside their community. Shortening the programme to, for instance, 3 x 3 months phases, decreasing the threshold by allowing clients to enter the programme by referral from other

units and without prior preparation in *Agia Skepi* counselling centre might also improve the programme.

Currently the existing TC is far from reaching full occupancy as regards the number of clients, the number of staff members and the huge building. Considering these facts and the plan to implement a treatment programme exclusively for women, it is obvious to conclude that there are enough space, capacity and staff members in order to offer separate sections for men and women within the same facility.

The evaluation strongly supports the adjustment of the rehabilitation phase by delivering this programme in an outpatient setting. However, as mentioned above this must not last another 12 months.

A final proposal is to offer specific treatment for special groups. This proposal is related to the fact that about 60 % of the clients are migrants but there is no specific approach to respond to their needs. The proposed reorganisation of the treatment unit should include the consideration to introduce a migrant specific treatment component.

II. B. 4. Agia Skepi – counselling station Nicosia

The counselling station of *Agia Skepi* exists since 2005. In January 2008 the station was relocated, as the building had safety risks. Now it operates in another building in the area of Nicosia.

II. B. 4. 1. Target groups

Agia Skepi counselling station has a clearly defined target group which consists of adult users of legal and illegal substances at age of 18 to 45. Additional criteria is that the targeted drug users wish to

- participate in the preparation programme for entering the therapeutic community of *Agia Skepi* and to
- undergo treatment in order to raise motivation to reduce or stop drug use and reach a better quality of life.

The counselling station addresses male and female long-term drug addicts and well as socially integrated drug users. Since January 2005 family members of drug users have become a new target group. Alcohol users do not belong to the target group. Likewise users with a dual diagnosis of psychosis are excluded from the long-term support of the counselling station.

II. B. 4. 2. Objectives

The *Agia Skepi* counselling station has the following main objectives:

- Complete the preparation of drug users for entering the TC of *Agia Skepi*
- Motivation to drug users in order to undergo a treatment
- Harm reduction for clients who still use substances
- Assistance and support for family members in dealing with the drug problem of their children

In general, *Agia Skepi* counselling station aims at offering a low-threshold access to help and support for individuals with drug use. Treatment provided by the counselling station is offered on a voluntary basis.

II. B. 4. 3. Structure

Staff members and qualification

There are 3 full-time and 2 part-time staff members in the counselling station.

One full-time staff member is a social worker and drug counsellor, and an ex-addict who completed the TC programme of *Agia Skepi* and has been trained since in systemic therapy. The other one is a psychologist and counselling supervisor. Furthermore there is a full-time secretary being responsible for appointments, urine and alcohol tests. The secretary has been working for the last 6 years in *Agia Skepi* TC and is now also offering seminars in the community. In addition there is one part-time social worker and one part-time medical doctor.

The staff attends regular trainings to improve qualification.

Rooms and facilities

The facility is equipped with a number of offices for the staff and rooms for individual counselling. There are two rooms for group meetings/sessions, a body building room, one room for drop-in and a kitchen for the clients. In addition there are 6 bedrooms to be shared which are for TC completers in the rehabilitation stage. There is still enough space to offer further rooms to the clients for staying overnight. Computer and internet access are also available.

Quality management

An individual external supervision is offered every two weeks by a private psychologist who is paid by *Agia Skepi*. Internal supervision of the staff takes place once a week while the team meets daily to discuss individual cases.

Documentation and assessment of the clients is made by using EuropASI and the TDI. The results are sent to the Cyprus Monitoring Centre (EKTEPN). There is no electronic documentation and no yearly report.

The facility has a designated managing director who is a clinical social worker. Currently the counselling station does not participate in any programme of quality management but it has been evaluated by *Kethea*, Greece.

According to the staff a close cooperation exists with hospitals and clinics, GPs and other physicians, residential and outpatient treatment facilities and other counselling centres. However, clients are not being referred to the substitution clinic in Nicosia, with only some exceptions.

Funding

Agia Skepi counselling station is being funded by various organisations such as the CAC, the “Association of Friends of *Agia Skepi*”, the Ministry of Health and various private donors. Funding is actually similar to that of the TC.

The Council of *Agia Skepi* is responsible for the financial management of the counselling station. The counselling station has no own budget apart from some money for the every day minor expenses.

In the year 2007 a total amount of 71.500 € has been provided by several funding sources; the CAC funded 8.000 €, the Association of Friends of *Agia Skepi* 4.000 €, the Ministry of Health 8.500 €, and others provided 51.000 €. According to estimations of the facility the yearly budget needed budget amounts to 77.000€. In view of the staff the facility faces no funding problems.

The training of the staff is separately funded by a specific training budget provided by the Ministry of Labour. Part of the training is also paid by *Agia Skepi* itself.

II. B. 4. 4. Processes

Agia Skepi counselling station is a low-threshold outpatient counselling unit which offers a range of different services. Along with group therapy and group sessions which present the main service, the following services are provided:

- Preparation for the TC *Agia Skepi* and motivation for treatment
- Family therapy
- Individual counselling
- Harm reduction

The clients contacting the counselling station are being assessed for their demand to enter the inpatient treatment programme. If they are already drug-free they can start with the preparation programme for attending the TC. If they still use drugs, they can enter the motivation phase in order to be referred for treatment (detoxification) or/and to be supported by harm-reduction information. Usually the programme consists of group sessions, complemented on demand by individual counselling.

As a new programme, family members of drug using clients are also offered counselling. Since January 2005, there is also a family group for persons whose family member is in treatment in the TC of *Agia Skepi*. A second family group is formed by families with children in other types of treatment or with children who still use drugs.

Apart from counselling, a new programme for social reintegration of the completers of the TC of *Agia Skepi* will be implemented. For this purpose a number of bedrooms and kitchens are going to be prepared in the facility of the counselling station.

- **Counselling**

The counselling service is directed to a) the preparation for the TC of *Agia Skepi* and b) motivational counselling to start treatment.

a) Preparation for the TC of *Agia Skepi*:

For preparation to enter the TC group therapy sessions are offered 3 times per week, each lasting 1½ hours. Additionally individual counselling of 45 minutes is provided on demand. In case that there are not enough clients to build a group the preparation for the TC is based on individual counselling. The groups are open and clients can enter the group at any stage. The duration of the preparation phase is individually set and depends on the current stage. If clients have already been in detoxification, then only few meetings take place. In general, the preparation for entering the TC is designed as a short intervention of 3 to 9 meetings. During the preparation phase urine and alcohol testing is conducted three times per week. The clients do not have to pay for screening. In case of more than two positive urine tests the client is referred back to the motivational phase to start with the programme from the beginning.

b) Motivational counselling to start treatment

Motivational counselling consists of group sessions based on the methods of motivational enhancement. The group sessions take place every day between 3-5 p.m. and last one hour. Clients first have to sign a contract which included the rules and regulations of the group sessions. Afterwards they can drop-in every day and attend the session. Due to this setting there is the possibility of an insufficient number of clients dropping in to form a group. However, the main target is to keep a constant contact to the clients.

- **Family groups**

Since January 2005 *Agia Skepi* counselling station is also offering group sessions for two separate groups of family members; the first one consists of family members of clients attending the treatment programme of *Agia Skepi* TC and the second group consists of family members of clients who either still use drugs or attend another treatment programme. Each group is attended by 8 participants at the time of the evaluation.

The family group sessions take place once a week and are limited to 12 sessions, each having a certain topic. Thus, the groups are closed. The family members can also receive additional individual counselling if needed.

- Harm Reduction

Easy access for clients is provided as they can drop-in every day between 3 and 5 p.m. At the same time the group sessions are held. The counselling unit is planning to implement syringe exchange and outreach work. According to the plan, in 2008 new staff will be employed for this programme and one year later the new services are expected to start under the umbrella of *Agia Skepi*. For this purpose new rooms will be provided in the counselling station.

- New services

As already mentioned a further new service exclusively for *Agia Skepi* TC completers is planned to be implemented in a few months. For this group entering the rehabilitation phase and working during the day an outpatient programme will be offered, which will provide evening group session and the possibility of spending the night in the counselling station. This outpatient rehabilitation programme shall become an obligatory phase of the TC treatment, except for clients having their own flat in the city.

The counselling station can actually provide various rooms for this purpose, and an additional living room for meetings and supporting sessions. According to the staff, additional employees will have to support this programme.

II. B. 4. 5. Results – annual reports

In 2007, 110 drug users demanded an appointment but out of them 67 started with the structured counselling. In 2006 the NFP documented 71 clients that have attended counselling. All clients in 2007 were male and on average 28 years old. The majority of the clients in 2007 were primary users of heroin (63 %). 27 % were users of cocaine or amphetamines and 10 % cannabis users. Almost 30 % of all clients were migrants. According to the staff 10 new clients per week is the maximum capacity of the counselling station. However, the counselling services are designed as brief interventions which last about 3 to six weeks.

II. B. 4. 6. Evaluation

In general the counselling station of *Agia Skepi* has a clearly defined target group which is reached. The objectives are all well defined and are mainly directed to motivate drug users to undergo drug-free treatment. The new building of the counselling station is huge enough and offers a variety of possibilities to enlarge the services. The staff already plans to use the available space for introducing new services such as bedrooms for the night to accommodate completers of the TC programme.

The staff is appropriately qualified and attends regular trainings. Nonetheless the need for further education has been underlined by the staff. Based on the evaluation, the number of staff is regarded as appropriate to serve about 70 clients per year. However, after introducing the outpatient rehabilitation programme as well as the outreach work there will be the need for one additional staff member.

According to the staff there is a need for additional staff members not only for the outpatient rehabilitation but also for outreach work and the introduction of needle exchange. Additionally to the enlargement of the team, training is regarded as important in order to intensify the current services and to implement more services. In the perception of the staff the combination of more staff and more training will result in reaching more clients and increasing the utilisation of the services, and finally increasing the number of clients in treatment. This opinion is shared by all NGOs. The evaluation does not necessarily support such a perception. Certainly there is no doubt that qualified personal improves the quality of the provided services, but this does not imply that a higher number of qualified staff will attract more drug users to use the service. Based on the evaluation, two full-time and one part-time counsellor will not be sufficient in the future and therefore an additional full-time staff member seems to be reasonable.

With respect to the processes of the services provided, they appear to be well structured and appropriately scheduled. The counselling is designed as a brief intervention of 3 to nine meetings and follows clearly defined objectives. The group sessions for family members are limited to 12 sessions and follow a defined concept. In general, the processes of the counselling station seem to be clearly structured and targeted. However, there are some points that need to be pointed out in terms of modifications.

First of all, there is no reason for not primarily referring clients to substitution treatment. This procedure does not take the assessment of individual needs and the wishes of the clients into account. Substitution treatment is considered a first-line treatment for opioid dependent persons, as harm reduction and social stabilisation are important prerequisites to

motivate these persons to then move to drug-free lives. Secondly the objectives of counselling are rather one-dimensional as they predominately are directed towards pushing clients into drug-free treatment. In this respect the counselling station narrows its services to a referral station for detoxification and subsequent inpatient drug treatment. The current services in the field of harm reduction are minimal and limited more or less to providing a drop-in area. The plan to introduce needle exchange is regarded as an important further service which responds to the majority of heroin addicted clients visiting the facility.

Another aspect worth mentioning is the consideration of the staff to create the outpatient rehabilitation programme as an obligatory phase of the TC treatment. Based on the evaluation there is no rationale for forcing treatment completers into a rehabilitation programme – independently from being residential or outpatient. Last not least the reason for running two different family groups which only differ in terms of having a child attending the TC of *Agia Skepi* or not remains unclear.

Finally the complete absence of female clients making use of the counselling station needs attention, especially in view of planning a women-only TC.

II. B. 4. 7. Proposals

Due to the well structured counselling services of *Agia Skepi* the facility is in a good position and playing an important role in drug services in Cyprus. Nevertheless a few but important readjustments of the concept are regarded as necessary. The proposed readjustment includes achieving more independency from the TC of *Agia Skepi* in attitudes, objectives and concepts. The counselling station appears to be too closely linked to the inpatient programme in terms of providing counselling with the defined target to prepare or motivate clients for entering drug-free treatment. A counselling station represents a first line of contact to care for clients and the initial assessment of the clients needs has to be open to different needs including the non-acceptance of abstinence-oriented treatment. Thus it is necessary to refer clients to out- or inpatient detoxification as well as to maintenance programmes. Furthermore not all clients require a 12 month rehabilitation programme after completing treatment. The future outpatient rehabilitation programme should be offered on a voluntary basis and not be obligatory. In addition the duration of the programme is recommended to be limited to 6 months. As regards the family groups it might be considered to offer two different groups according to the current situation of the family members. Probably it is more reasonable to offer family groups to family members

with children who are still using drugs and another group of parents which are involved in the treatment of their children.

Furthermore it is recommended to reflect measures of attracting women with the services. Finally it is proposed to introduce electronic documentation as there are computers available. There is also the need to compile a yearly report on the service performance, the clients reached and the outcome.

II. B. 5. Veresies Clinic – medical-assisted drug treatment

II. B. 5. 1. Introduction

This is a private clinic of the psychiatrist and neurologist Dr Kyriakos Veresies. It has its own website for the clinic: www.veresies.com

II. B. 5. 2. Target groups

The treatment provided in the clinic is for addicts of illegal drugs, in particular heroin addicts, and for alcohol addicts.

II. B. 5. 3. Objectives

Main objective is to provide medical-assisted drug treatment for withdrawal (detoxification) and short-term maintenance (substitution).

II. B. 5. 4. Structure

The *Veresies Clinic* is a privately funded institution run by Dr. Kyriakos Veresies with an outpatient and an inpatient department. The outpatient department is located on the premises of the private home of Dr. Veresies, the inpatient department is located in a hospital that was previously an ophthalmologic clinic (now a clinic for chronic and geriatric illnesses). The outpatient department is run by Dr. Veresies himself – patients come for individual appointments. As prescription of the medications used (mainly dihydrocodeine) is not regulated by any restrictions, no specific drug accountability is necessary.

In the inpatient department Dr. Veresies himself does the medical tasks (evaluation, assessment, drug prescriptions, clinical visits, monitoring of outcome), a full-time

psychologist is employed by Dr. Veresies to meet psychological demands of the patients, while the nursing of the patients is taken care of the staff of the hospital. Therefore, the nursing staff is not exclusively in charge of patients in the inpatient department of the *Veresies Clinic*, but are employed by the hospital and then contracted by Dr. Veresies for individual patients. The *Veresies Clinic* pays the hospital a daily rate, which covers the infrastructure (rent etc) and the nursing of the respective patient. Drug accountability is documented in a special book, where each tablet of Subutex prescribed is documented (there have been problems in the documentation of drug accountability in the past, which have lead to actions by the Medical Board, but these problems have been straightened out in order to account for all prescribed tablets).

II. B. 5. 5. Processes

In the outpatient department the main focus of treatment of drug dependent patients is detoxification, a second treatment possibility is substitution treatment. With respect to detoxification, assessment starts with type of drug is being used, problems associated with drug use, psychosocial problems, and co-morbidity. Inclusion of the family in the detoxification process is targeted. If the patient is dependent on opiates (e.g. heroin), detoxification is done on an opiate-assisted basis. The substance prescribed is dihydrocodeine (DHC), in rare cases also with oxycodone (especially if the patient is dependent on oxycodone). Patients receive a prescription for a fixed dose of DHC, generally 9 tablets of 60 mg DHC for the first day, which then is reduced over a period generally of 2 weeks. Patients are sent to parallel psychosocial treatment. Urine testing is done only were deemed necessary.

Substitution treatment for patients not in the position or unable to attend detoxification is also done mainly with DHC, in rare cases with oxycodone. Substitution is initially planned for a period of 3 months with a re-assessment thereafter, the aim of substitution being a gradual reduction of the opiate and abstinence being the long-term goal (maintenance to abstinence). Urine testing is done on a regular basis.

The inpatient department focuses only on detoxification of drug and/or alcohol dependence. Detoxification of drug dependence on an inpatient basis is only necessary for patients with opiate dependence, or patients with a severe dependence of other substances (e.g. cocaine) but with an additional dependence of opiates (e.g. cocaine dependent person who regularly uses heroin to “come down” from cocaine high). Inpatient detoxification of opiate dependence is done with buprenorphine (either Subutex or Suboxone), which is given to the

patient no earlier than 20 hours after last heroin use and then loading the dose by 2 mg buprenorphine and reloading every 2 hours if necessary. The dose needed on the first day is then gradually reduced over a period of 7 days, so that inpatient detoxification treatment in general lasts for 7 days. Family members are allowed to stay with the patient, patients can receive guests as long as these guests were predetermined and placed on a respective list at admission. Patients are not allowed to leave the medical unit, furthermore use of cell phones is not allowed. Urine testing is done only in cases where continued abuse of drugs is assumed.

A recent addition to the treatment options is the treatment with a naltrexone implant, a treatment offered to opiate dependent or alcohol dependent patients. Patients interested in this treatment are either recruited from the inpatient or the outpatient department, but mainly from the inpatient department. Patients are asked to remain one week longer as inpatients, in order to make sure that a long enough abstinence period can be guaranteed before implanting naltrexone (an opiate antagonist). Before initiation of this treatment, patients are informed in the presence of a witness (usually family member) and have to sign a treatment contract that they have understood the treatment goals and are willing to go through with the treatment. The implant is then placed subcutaneously in the abdominal region by a surgeon. Patients are then followed up every two weeks by a telephone call and are invited to a meeting every 3 months. Furthermore, patients are encouraged to join a group of other patients that have received this treatment that meet regularly (self-help group).

II. B. 5. 6. Results – annual reports

According to the National Focal Point, there were 115 clients in 2006 and 348 clients in 2007. The clients are predominately male with about 88 % in 2006 and 2007. The majority of clients are national of Cyprus: 62 % in 2006 and 65 % in 2007. On average the clients are 29-31 years old when being treated in the clinic. The target group of heroin users is reached as the majority of the clients reported primary use of heroin; this was the case for 74 % of the clients in 2006 and still for 63 % of the clients in 2007. In 2007 the second priority group was cannabis users with 24 %.

In 2007, the outpatient department attended all 348 patients plus another 85 patients with alcohol dependence. In 63 % of the cases the main substance of abuse was heroin, necessitating a withdrawal supported by DHC. The inpatient department attended 60 of these 348 patients, where outpatient detoxification was not possible or did not show the

necessary results and detoxification with Subutex became necessary. No more than 2 patients at a time are in inpatient treatment – previous experiences with 3 patients at a time were negative, as craving among one patient lead to drop-out or substance abuse among the other two.

The newly started naltrexone implant programme has already drawn 52 patients (May to November 2008), of which 42 are being treated because of opiate dependence and 10 because of alcohol dependence, and of which 11 patients are foreigners coming to Cyprus only to receive the implant (8 from Greece, 3 from Bulgaria).

II. B. 5. 7. Evaluation

The medical treatment of drug addicted patients in the *Veresies Clinic* is carried out according to medical standards for this treatment. Detoxification of opiate dependent patients is done with the support of opiates in decreasing dosage, while those patients not able to detoxify are substituted with an opiate for a short-term period but with the long-term goal of abstinence. The substances used are not necessarily the opiates with the highest evidence-base for the treatment of detoxification or substitution (DHC, buprenorphine, oxycodone), but considering the irrational legal restrictions in Cyprus, where there are no restrictions for the prescription of DHC and oxycodone (both complete agonists) and extremely high restrictions for the prescription of buprenorphine (agonist with partial antagonist activity, therefore less dangerous) and no possibility to prescribe methadone (despite the highest evidence of effectiveness), the practice of prescription in the *Veresies Clinic* is as appropriate as can be.

The outpatient treatment seems to be adequate in nature, both from a medical point of view (including opiate assisted treatment) as well as from a therapeutic point of view (patients are sent for parallel psychosocial treatment and after end of treatment to rehabilitative measures). The inpatient treatment can be considered optimal under the possible conditions, considering that there is no specific unit for the detoxification and patients are mixed with other patients who have no addiction problems. This medical approach of doing detoxification treatment in a general medical setting is not considered the best form of treatment, as nursing staff cannot be specifically trained and group treatment (one of the most effective forms of treatment in addiction treatment) cannot be offered. However the low number of inpatient clients does not allow the *Veresies Clinic* to run a specific unit for detoxification.

The treatment of patients with naltrexone to insure abstinence using a naltrexone implant can be considered an innovative medical practice. Naltrexone implants were only recently registered in Cyprus, the effectiveness in the treatment of dependence has been shown in many studies. Whether naltrexone implants, that are active for about a year, are better than slow-release injectable naltrexone, which is active for about a month, cannot be determined from the international evidence, but considering the fact that the slow-release injectable naltrexone is not registered in Cyprus, the use of naltrexone implants is the only option beside oral tablets. The *Veresies Clinic* asks patients wanting to receive this treatment to sign a treatment contract, which is an important element when using a substance that will be active for about a year. However, as patients may change their mind concerning treatment within such a long period, the possibility to end the treatment (e.g. the possibility to surgically remove the implant) is not addressed. This may lead to problems in the future, as patients could at a later stage state that they felt forced to enter treatment (e.g. forced by the family to do so), so it may even have legal implications.

Substitution treatment with DHC is considered a second line treatment, but the lack of possibility to prescribe methadone (the substance with the highest level of evidence) forces Dr. Veresies to resort to substituting with DHC. Substitution with oxycodone is the most adequate way to treat those patients dependent on oxycodone and not being able to go into detoxification.

All in all the medical treatment in the *Veresies Clinic* is done according to international standards, with limitations coming from legal restrictions that the Clinic cannot account for. The fact that all patients are also sent for parallel psychosocial treatment and rehabilitation after treatment also meets international standards. Considering the larger number of patients per year, the Clinic therefore plays an important role in the overall treatment of drug addiction in Cyprus.

II. B. 5. 8. Proposals

The potential of treatment by the *Veresies Clinic* is limited by the irrational legal restrictions on prescribing of opiates in Cyprus. Some opiates are not at all restricted (DHC, oxycodone); buprenorphine is highly restricted, with prescription allowed only in inpatient settings (or in the governmental maintenance treatment programme), despite the lower overdose risk compared to DHC; methadone and other opiates cannot be prescribed at all. These restrictions for prescriptions of opiates are not in line with international evidence and

need to be reformed. This would allow the Veresies Clinic to increase its potential to meet the medical demands of patients attending the Clinic due to drug addiction problems.

A more specific proposal for modification of treatment in the Veresies Clinic has to do with the treatment contract for the naltrexone implant. In order to avoid future problems with patients that may change their mind. With respect to the treatment within the very long treatment period, the treatment contract needs to be modified to include a clause on how to terminate treatment early. Any voluntary treatment needs to include a statement on how treatment can be terminated.

With respect to inpatient treatment, detoxification in a general medical setting is not the most appropriate setting. Considering the fact that there are not sufficient patients for a specific unit, the limitations of the present setting should be clearly assessed and possible options looked into. These can include either sending patients to a specific detoxification unit (presently only the governmental services are available) or planning a future new detoxification unit, possibly together with other physicians treating addicted patients, possibly also including treatment for alcohol patients.

II. B. 6. Summary - Results of the evaluation and recommendations on the NGO drug treatment services

II. B. 6. 1. Kenthea prevention and counselling stations

Kenthea is the biggest NGO in Cyprus and was founded in Larnaca in 1994. Since then the Centre of *Kenthea* Cyprus is located in Larnaca. *Kenthea* operates six decentralised prevention and counselling stations all over Cyprus.

- *Kenthea* stations have no specificity in the target groups they are addressing. Everybody independently from being adult or adolescent, substance user or not or family member belongs to the target group. All stations provide assessment, counselling, motivation, referral to treatment, an Open Telephone Line and prevention.
- Each of the six decentralised prevention and counselling stations is operated by at most one staff member who holds all positions simultaneously. Some stations only have part-time staff and some were partly even without any staff. As there is only one staff member the performance of work is prioritised. With exception of *Ithaki* and *Pegasus*, all other stations are mainly engaged in prevention and spend only little time on counselling.
- Prevention activities predominately involve meetings with key persons of the local community, networking for involving volunteers in prevention and advertising to inform the community about the service.
- In 2007 the *Kenthea* stations were in contact with 51 clients including family members and 31 of the clients made use of counselling. The drop-out rate was reported to be 19 out of 31 clients which corresponds to about 60 %. No client made use of counselling offered by *Vera Paisi* and *Fos* – even though *Vera Paisi* exists for about 8 years.

Recommendations:

- Many *Kenthea* stations did not seem to achieve full capacity. In order to improve quality and effectiveness of services it is recommended to reassess the concept of counselling and the definition of target groups. The modification of the counselling concept should prioritise targets that consider individual needs of the clients and define harm reduction as one target of counselling.
- *Kenthea* has to achieve more transparency of their work by regular documentation and by need assessment. The needs of the respective community as regards counselling and prevention do not appear to be clear. In order to respond to needs it is recommended to

estimate as accurately as possible the needs for counselling and prevention in the communities. According to the results of the need assessment, counselling and prevention activities have to be readjusted. Furthermore prevention should be more focussed on children and adolescents instead of prevention multipliers.

- Probably *Odysseas* might be the *Kenthea* station, where the possibility of an additional staff member could actually make sense in order to allow staff to concentrate on counselling and prevention separately.

II. B. 6. 2. Tolmi outpatient Therapeutic Communities

In 1992, *Tolmi* Larnaca has been established as a non-governmental organisation. Currently *Tolmi* runs outpatient Therapeutic Communities in Larnaca, Nicosia (since 2000), Limassol (since 2004) and Pafos (since 2007).

- In general, the outpatient treatment units of *Tolmi* are properly designed as regards target groups and objectives and well structured as concerns their therapeutic processes.
- The clearly defined target group consists in adults (17+) addicted to alcohol or illicit drugs and their families. Also experimental users and drug users in substitution treatment are all well accepted by *Tolmi*.
- The treatment programme follows clearly defined objectives. Aim of psychological support and individual as well as group therapy, alternative therapies and family group therapy is to support addicts in achieving long-term abstinence and social reintegration. The 12 month treatment programme is provided by qualified and trained staff.
- The outpatient treatment programme includes assessment and reassessment of the clients during the motivation phase, a treatment plan in agreement with the clients' needs and a flexible treatment frequency and duration. Keeping the therapeutic setting flexible in order to respond to individual needs can be regarded as good practice.
- From 1995-2006 there has been a continuous increase of clients receiving treatment at *Tolmi* units. Since then the number of clients declined considerably from 151 clients in 2006 to 81 clients in 2007. The treatment programme was reported to have a 65 to 70 % retention rate. During one year no more than 30 % of the clients dropped out.
- While *Tolmi* Larnaca is appropriately staffed, all other units are operated by no more than one staff member. Some *Tolmi* units were run by staff that works partly without payment or is on and off payment. In addition, the buildings of *Tolmi* Larnaca and Pafos are not adequate as they do not offer enough rooms for the different group sessions.

Recommendations:

- At present most *Tolmi* units work below capacity with 4 to 12 clients per year. The declining numbers of heroin addicts contacting *Tolmi* indicate the need to readjust the services by easing access to treatment for drug users in maintenance treatment. Furthermore it is recommended to reconsider the time limit of 8 weeks for motivational counselling. There might be a number who are not motivated to quit drug use after two months of counselling but still in need for ongoing structured interventions.
- Staffing, funding and the inappropriate rooms turned out to be the major problems. If indicated by the number of clients it is recommended to employ additional qualified staff members – either on part-time or full-time basis, and to ensure payment of the staff. Unpaid staff working alone in addition results in a declining quality of the outpatient drug treatment programme. The same is true for inappropriate rooms. The units need adequate rooms for group sessions.
- Drama and occupational therapy had to be stopped due to the lack of funding. In units that reach enough clients to build groups, it is reasonable to provide funding for drama and occupational therapy. Currently family members have to pay for urine tests which are decided for therapeutic reasons. Given this fact it is strongly recommended to find a solution for the payment of the urine screening.
- As all *Tolmi* units have a computer it is recommended to introduce electronic documentation which also includes the follow-up information collected from clients. Documentation, outcome monitoring and reporting are inevitable for reflecting the treatment programme and for receiving sufficient public funding.

II. B. 6. 3. Agia Skepi Therapeutic Community and counselling station

The drug treatment provider *Agia Skepi* runs a closed Therapeutic Community and a counselling service in the district of Nicosia. The closed Therapeutic Community, established in 1998, is a 12-months drug treatment programme for male adult drug addicts. The counselling station addresses adults with any kind of drug use including legal substances.

a) The Therapeutic Community

- The setting and structure of the Therapeutic Community is well established. The intended target group of male adult long-term drug users at age of 18 to 45 is reached. 90 % of the clients undergoing this treatment are heroin addicts using heroin since more than one year. Almost 60 % of the clients were migrants.

- *Agia Skepi* is well equipped as regards staff and facilities. There are 10 qualified full-time staff members and 8 part-time staff members. The huge building provided more than enough space for a variety of activities as well as offices and rooms for clients and therapy sessions. Documentation is done electronically using standardised instruments.
- The 12 months programme consisting of 3 separate phases is considered to be both too intensive and too strictly ruled. The clients have about 10 group sessions per week during a period of eight months. Contacts to the outside world are highly restricted.
- During 2007 there were 34 clients; 19 of them completed the treatment programme while 15 clients dropped out. Thus, the drop-out rate was 44 %. Even though the facility has space for 45 clients there is a permanent vacancy of about 40 %. While the treatment retention rate is not high for a residential TC, the treatment coverage is quite poor.

Recommendations:

- To improve occupancy and treatment retention the programme needs to be restructured by reflecting the meaningfulness of all procedures, rules and regulations of the therapeutic concept.
- It is recommended to diversify the treatment programme by providing long-term inpatient rehabilitation and short-term outpatient aftercare. 12 months inpatient treatment should be the maximum while outpatient aftercare should be reduced to a maximum of 3 to 6 months. Shortening the programme and decreasing the threshold by allowing clients to enter the programme by referral from other units than *Agia Skepi* counselling station might also improve the programme.
- As regards the rules, the family (and friends) of the client should be regarded as an important source to motivate treatment continuation instead of cutting-off communication between client and the outside world.

b) The counselling station

- The counselling station has a clearly defined target group which consists in adult users of legal and illegal substances at age of 18 to 45. The objectives are also clearly defined and are mainly directed to motivate drug users to undergo drug-free treatment and to prepare drug users for entering the TC of *Agia Skepi*.
- The 3 full-time and 2 part-time staff members are appropriately qualified, and the processes of the services appear to be well structured and appropriately scheduled. The counselling is designed as a brief intervention of 3 to 9 meetings, the group sessions for family members are limited to 12 sessions and follow a defined concept.

- The staff already plans to use the available space for introducing outpatient rehabilitation exclusively for *Agia Skepi* TC completers. These clients will be accommodated in bedrooms for the night and offered evening group session.
- In 2007, 110 drug users demanded an appointment but out of them 67 started with the structured counselling. All clients of the station were male and the majority were primary users of heroin (63 %).

Recommendations:

- Two full-time and one part-time counsellors will not be sufficient in future and therefore an additional full-time staff member seems to be reasonable.
- The procedure not to refer clients to substitution treatment is not appropriate. Pushing clients in drug-free treatment neglects individual needs and limits the support provided by a counselling station which represents a first line of contact to care for clients. For this reason it should be a basic requirement to refer clients also to out- or inpatient detoxification as well as to maintenance programmes.
- There is no rational for forcing treatment completers into a rehabilitation programme. Rehabilitation should be offered on voluntary basis and not be obligatory for treatment clients.
- The complete absence of female clients demands reflecting strategies to attract women with the services.

II. B. 6. 4. Veresies Clinic for detoxification and substitution treatment

Veresies Clinic is private clinic of the psychiatrist and neurologist Dr Kyriakos Veresies with an outpatient and inpatient department.

- Main objective of the private clinic is to provide medical-assisted detoxification and short-term substitution treatment for drug and alcohol addicts.
- Inpatient detoxification of drug dependence is done by prescription of buprenorphine which is gradually reduced over a period of 7 days. This kind of medical treatment is not delivered in a specific unit for detoxification, but in a general medical unit, which is not the optimal setting for detoxification.
- Outpatient medical treatment consists of detoxification and substitution treatment. Both treatment options are based on prescription of mainly dihydrocodeine (DHC). Within detoxification treatment the medication is reduced over a period of 2 weeks, and patients

are sent to parallel psychosocial treatment. Substitution treatment is planned for a period of 3 months with a re-assessment thereafter.

- The substances used are not necessarily the opiates with the highest evidence-base for detoxification or substitution treatment. However, in view of the legal restrictions existing in Cyprus for prescribing opiate substitutes, the medical treatment in the *Veresies Clinic* is as appropriate as can be.
- Recently a naltrexone implant has been introduced as a further treatment option for alcohol or opiate addicts. The respective treatment contract currently does not specify possibilities to end the treatment at an earlier time than one year.
- With regard to 348 clients in treatment at the clinic in 2007, the medical-assisted treatment offered in the clinic plays an important role in the Cyprus drug care. In 63% of clients the main substance of abuse was heroin. The naltrexone implant programme has already drawn 52 patients.

Recommendations

- As the restrictions for prescriptions of opiates are not in line with international evidence, the legal framework for substitution treatment needs to be reformed.
- The treatment contract related to the naltrexone treatment should be modified to include a clause on how to terminate treatment early.
- Detoxification in a general medical setting is not the most appropriate setting. For this reason it is recommended to consider options for a future specific detoxification unit.

The evaluation shows that not all drug services comply with quality standards and not all prevention programmes correspondent to evidence-based effectiveness. In addition, many NGOs lack systematic documentation and reporting of their services / activities and related outcomes. In future, documentation and reporting needs to be improved and drug treatment programmes have to reflect available standards and evidence for best practice.

Annex III – Prevention Network

A. Overview of the NGO prevention network

In Cyprus exist 9 different associations or non-governmental organisations which are involved in the provision of primary prevention. Geographically three of them are located in Larnaca, respectively two associations/organisations are located in Limassol and Nicosia, one association operates in Pafos area and one operates all over Cyprus. In addition, the governmental organisation of the Cyprus Youth Board, located in Nicosia, provides primary prevention.

In detail the following associations and organisations exist in 2008:

Larnaca

- Kenthea Prevention Department, coordinated by Dr Kyriakos Veresies (chapter 5.1).
- Larnaca Anti-Drug Association “FAROS”, coordinated by Dr Panagiotis Georgakas.
- Larnaca Anti-Drug Association “SYKANA”, coordinated by Dr Panagiotis Georgakas.

Limassol

- Anti-Drug Association “ASPIS”, coordinated by Klitos Makrides.
- Primary Drug Abuse Prevention Centre “MIKRI ARKTOS” of the Cyprus Youth Board, coordinated by Soulla Pappouti.

Nicosia

- Lions Quest Foundation of Cyprus, coordinated by Chrysoula Matha.
- Kenthea Association Nicosia, coordinated by Helias Demetriou.
- Helpline of the Cyprus Youth Board Nicosia, coordinated by Eleni Chrysastomon

In Pafos there is the “Pafos Anti-Drug Association” which is coordinated by Dr Kyriakos Veresies. Throughout Cyprus operates the “Life Education Centre Cyprus” (L.E.C.) which is coordinated by Pambina Petridou.

- **Life Education Centre Cyprus**

Life Education Centres had been initiated in UK in order to support children in making healthy choices by providing them a series of high quality, evidence-based programmes. The programmes are regularly evaluated in the UK and aim at health education based on best practice models. They are directed to children in primary schools and in the community. According the information on the website there are currently 43 Life Education Centres operating in UK and Ireland. In addition, operations in Cyprus, Barbados, Finland and Hungary are supported (see the website: <http://www.lifeeducation.org.uk/site.php>).

In Cyprus, the *Life Education Centre* exists since 1998. The organisation is constituted by members of the Ministry of Education and Culture, the Ministry of Health, the Anti-Drug Association, and by the president of the Round Table Cyprus, the president of the Ladies Circle, and the president of the 41-Club.

The centre provides the prevention programmes “Mentor” at school. These programmes are delivered under the umbrella of the health education programmes of the Ministry of Education and Culture. The Mentor Foundation was registered in 1994 in Geneva as an independent, non-governmental organisation working in the field of drug prevention and health promotion at a global level. The *Mentor* programmes aim at education of children and young people to promote their skills and well-being, to reduce damages to their lives and to delay or avoid the onset of drug use and its progression to harmful or problematic misuse (see: <http://www.mentorfoundation.org/index.php>). *Mentor* drug prevention programmes are based upon principles which serve as an agreement to reflect scientific evidence regarding effectiveness and best practice in prevention⁴.

In Cyprus, the Mentor programmes are delivered in 12 mobile classrooms which are specifically designed and equipped to provide a stimulating and vivid learning environment. Six of the mobile units are for pupils of primary schools, and six units are for pupils of secondary schools. The programme provided to primary schools has been evaluated. The mobile units travel to all schools in Cyprus according to an annual plan. The participation in the programme is compulsory for pupils as it is part of the school curriculum and takes place during school lessons. Within the mobile classroom the prevention programme is provided by specifically trained teachers.

⁴ The principles of the Mentor programmes are summed up in the following document: www.mentorfoundation.org/uploads/Mentor-Mentor_Principles.pdf.

The health education programmes consists of 8 different lessons, each having a specific topic. The programme is adapted to the different age groups of 6 to 14 years old pupils. One lesson for the 5th and 6th grade pupils are on “smoking, alcohol and decisions”.

- **Mikri Arktos – Youth Board of Cyprus**

The primary prevention centre *Mikri Arktos* is a semi-governmental organisation as it belongs the Youth Board of Cyprus. The administrative body of the Cyprus Youth Board is a subbranch of the Ministry of Culture and Education. The Youth Board has a General Secretary and one responsibility of the Secretary is to implement prevention.

Mikri Arktos has been established in 2006 in order to implement actions in the field of prevention defined in the Cyprus Action Plan (2004-2008). Following the Action Plan the Cyprus Youth Board continuously assesses the needs for prevention in school and community. In line with the need assessment target for prevention are determined and prevention programmes are created. The planning of prevention according to needs takes place every three months.

In 2006 there was a meeting with the Ministry of Education and Culture for the purpose of allowing direct access to the schools. The allowance is always given only for one year, and thus every year a new allowance for delivering prevention in school is required.

The prevention programmes of *Mikri Arktos* aim at the development of psychosocial skills and the promotion of well-being and communication. Respective programmes are provided in the school environment and in the community environment. School programmes are designed for students, teachers, and parents at primary and secondary schools. Community-located prevention programmes address children, adolescents, parents, community principals and professionals. Each of the programmes consists in at least 5 workshops.

According to personal information it is planned for 2008 to expand the prevention programmes to all towns of Cyprus.

- **Helpline of the Cyprus Youth Board**

The Youth Board of Cyprus operates the “1410-Substance Abuse Helpline” in Nicosia. This telephone helpline is targeted at the general population and provides information on substances and available drug services. According to own characterisation the main objective of the helpline is the prevention of harmful behaviour in general.

The helpline is funded by Ministry of Education and Culture.

- **ASPIS - The Panayides Foundation Anti-Drug Association**

The Anti-Drug Association *ASPIS* in Limassol exists since 18 years. Since 1991 *ASPIS* is focussing on drug prevention activities. The association works under the umbrella of the Panayides Foundation which has been created by a priest and thus is religiously oriented. The associated is independent from the church but uses its infrastructure for meetings, group work and other activities.

ASPIS is an independent child organisation with a council of nine members. It engages 20 volunteers for carrying out primary prevention for high-school students aged 12-18 years. Main objective is to support problem resolution of adolescents and to improve every day life skills. In this respect *ASPIS* organises “affective workshops” for adolescents, excursions, and seminars for group leaders, teachers and parents.

The association is funded by the Cyprus Anti-Drugs Council.

- **Sykana and Faros – Anti-Drug Association Larnaca**

Both *Sykana* and *Faros* are volunteer, non-governmental organisations which provide primary prevention in the Larnaca district. While *Sykana* has been founded in 1990, *Faros* started to operate in October 2006. Even though both organisations present themselves as two separate organisations the difference between them remains pretty unclear. Indeed, both organisations are constituted of the same members and committee. The committee consists of 36 volunteers such as counsellors, teachers, social welfare professionals, nurses, psychologists and members of the Municipal Council. In addition, there are 160 members of the organisations. The activities of *Sykana* and *Faros* are coordinated by the psychiatrist Dr Georgakas from Greece and by Dr Veresies from the Kenthea Centre Cyprus.

The organisations provide community outreach work and workshops to the general population, and training of volunteers in prevention. Funding is ensured by a combination of public funding by the CAC, local private donators, fundraising dinners and sales of a newspaper.

- **Kenthea Association Nicosia**

Kenthea Association Nicosia is a local volunteer organisation with 65 members that operates under the umbrella of *Kenthea Centre in Larnaca*. Even though the association defines itself as independent from *Kenthea Larnaca* there are strong links to *Kenthea Larnaca* in terms of prevention programmes, staff, training and financing. Currently prevention activities are usually financed by *Kenthea Centre Larnaca*. Additionally the

association is funded by private donations and sponsors. Furthermore the association plans to dislocate their meeting place from a hotel to the prevention and counselling station *Pegasus* which is again part of *Kentheia Centre in Larnaca*.

The *Kentheia Association Nicosia* defines the policy and respective prevention programmes for the period of three years. Specific programmes for primary prevention are implemented by the association while others are realised by *Kentheia Centre Larnaca*. For details on the prevention programmes see also chapter 5.1.

- **Lions-Quest Foundation of Cyprus**

Lions-Quest has been established in 1984 as an agreement by contract to create cooperation between Lions Club International and Quest International. Quest International is a non-profit charitable foundation located in the United States. Many countries run an own office of *Lions Quest* in order to implement the Lions Quest prevention programmes in their communities. Also in Cyprus the main objective of the *Lions-Quest Foundation* is to promote the prevention programmes developed by Lions-Quest International. The prevention programmes of Lions-Quest are

“school-based, comprehensive, positive youth development and prevention programs that unite the home, school and community, to cultivate capable and healthy young people of strong character...” (<http://www.lions-quest.org>).

In Cyprus as well as in other *Lions-Quest* Foundations the aim of cultivating healthy adolescents is approached by life skills programmes which include elements of educative drug prevention and service-learning education. In addition, the Cyprus *Lions-Quest* offers training for teachers and workshops for parents.

- **Pafos Anti-Drug Association**

The *Pafos Anti-Drug Association* was founded in 1994 by volunteers such as social workers, psychologists and other non professionals. The non-profit organisation of volunteers has a committee which consists of 7 members who are elected for the period of two years. Every two years the members of the committee rotate although some members always persist. Since foundation, the association is an official member of *Kentheia Centre Larnaca*. Many members of the association had been trained by *Kentheia Centre* and some of the trained volunteers had become regular staff member of *Kentheia* prevention and counselling station.

Main objective of the association is social networking in terms of assessing the needs of the community and cooperation with community key persons. Furthermore the association is

active in fundraising and the organisation of the Pancyprian conference that takes place every year in March.

It remains unclear how far and if the association implements any activities independently from *Kenthea Centre*. According to their own description the association closely cooperates with the open TC *Tolmi Pafos* and *Vera Paisi* prevention and counselling station of *Kenthea* in Pafos.

B. Evaluation of the Cyprus prevention network

Prevention of substance abuse follows a different logic than drug treatment. In recent years a number of reviews had been undertaken to achieve knowledge which kind of prevention programmes are effective in which kind of setting. Prevention in Europe differs much as each country runs prevention programmes according to its cultural philosophy of prevention. Even though prevention is commonly regarded as part of health promotion, national prevention programmes may place emphasis on very different approaches to health. In general, prevention covers primary or universal prevention as well as selective and indicated prevention⁵.

- Universal prevention is probably the most predominant prevention strategy which mainly takes place in school, family and community setting.
- Selective prevention strategies are targeted at subgroups of the general population that are regarded to be at risk for substance abuse. Groups at risk are for example school drop-outs, young offenders, people living in deprived neighbourhoods etc.
- Indicated prevention is focused on individuals with behavioural or mental health problems.

Depending on the prevention approach, programmes range from general promotion of healthy behaviour, prevention of any addictive behaviour to specific prevention of substance use.

⁵ See for more details: <http://www.emcdda.europa.eu/html.cfm/index1568EN.html>

III. B. 1. Philosophy of prevention in Cyprus

Based on the Cyprus culture the philosophy of (drug) prevention is not to address substance use directly but to promote activities that indirectly target the prevention of drug addiction or addictive behaviour. The Cyprus concept of prevention is defined as follows:

“The emphasis of the preventive programmes should not be placed on the substances but on the individuals. They should mainly be targeted at reinforcing the quality and multifaceted support offered to the environment of the children, adolescents and young people. It is also important to aim at developing skills and abilities, and to strengthen the personalities of these children, adolescents and young people. As well it is important to offer suitable support to the adults who participate actively or passively in their lives, in order to help them to adopt a healthy lifestyle, far from drug use, or to ensure that the occasional use of substances that could lead to addiction is stopped in its early stages”.

Due to this definition most prevention programmes are designed as universal prevention strategies. In addition, most prevention programmes have been adopted from Greece and consequently they follow the philosophy of not providing drug prevention specifically. The approach of universal prevention has also become part of the national drug policy within the frame of the National Drug Action Plan (2004-2008). In fact, actions related to prevention aim at the prevention of all kinds of risk factors that may result in drug use. Main objective of prevention is to create a healthy environment for developing a healthy life. However, apart from universal prevention the national drug policy also notes the need to prioritise selective and indicated prevention.

Organisations that provide prevention in accordance with the described philosophy are regarded as eligible for funding of the CAC. In Cyprus prevention is mainly provided to students, families or young people in general. Corresponding activities may consist in a single one-day activity or in a programme with a series of workshops or meetings. However, part of this chapter will be to evaluate if the prevention activities are based upon scientific knowledge and if they comply with existing evidence and standards in prevention.

III. B. 2. Mentor programme of the Life Education Centre of Cyprus

III. B. 2. 1. Introduction

Life Education Centres (LECs) are offering their services in 13 countries worldwide. The LEC is also a volunteer organisation which provides health promotion and the drug education programmes (Mentor) since 1998. The programmes are compulsory and free of charge. They are offered by fully qualified tutors who also counsel and supply teachers with material according to the LEC philosophy.



Mentor – Life Education Centre

In Cyprus, the *LEC* is constituted by members of the Ministry of Education and Culture, the Ministry of Health, the Anti-Drug Association, the “Round Table”, the “Ladies Circle” and other associations. The programmes are applied under the umbrella of the Health Education Programmes of the Ministry of Education and Culture. The level of collaboration between the government and volunteer organisations in the effort to support *LECs*’ programmes is noticeable.

III. B. 2. 2. Objectives and target groups

The main objective of the *LEC-Nicosia* is to provide primary prevention for students of the primary school. In order to achieve this objective, three main strategies in relation to health promotion and drug education are offered:

- Contribution of knowledge and information
- Skills acquisition
- Self esteem enhancement

The Mentor programme is targeted at education in positive life styles, functions of the body and the brain, and wants to encourage the children’s self respect. The students are encouraged to respect the own body and to learn decision making in order to develop a healthy life style.

The programme of *LEC* is specifically designed for the age group of 6 and 12 years old students of primary and secondary schools.

III. B. 2. 3. Setting

Staff

All trainers of the *LEC* programmes are part-time teachers who spend 3 of 5 days of the week on the prevention activities. The teachers are employed by the Ministry of Education, assigned to carry out the Life Education programme and have all attended a special training for the programme in Cyprus and/or England. The trainers must have a minimum of 8 years of teaching experience in a primary school and an additional training in prevention. Staff members having been trained in England are also responsible for the training of new staff members in Cyprus. However, new trainers may attend themselves training in England.

Prevention programme

The *LEC* programme “Mentor” consists of 12 mobile units of which 6 are for primary and 6 for secondary schools. Each mobile unit provides the prevention programme in different areas of Cyprus. Each unit covers one specific region.

At the present there are six mobile classrooms for education in primary schools: two operate in Nicosia, two in Limassol, and one mobile classroom each in the Larnaca and the Pafos area. Two additional mobile classrooms will be available for the academic year 2008-2009 of which one is for Larnaca Primary Schools and one for Larnaca Secondary Schools. Each mobile classroom costs 82.000 Euro plus VAT. Two tutors are responsible to carry out the programmes for each mobile unit under the supervision of general coordinators.

At the beginning of the school year an annual plan is made by the trainers at the Ministry of Education to specify the schools that the mobile units are contrived. The programme is ongoing and takes place during the school lessons. Due to the high number of schools in Cyprus every school can be visited only once in two years. A special focus has recently been directed to specific “high risk” schools and these schools are visited every year. The *LEC* plans to integrate more of these schools in future in order to draw attention to the needs instead of concentrating on the quantity of schools visited.

Methods and tools

Recently the programme has been readjusted as it has also changed in England. At present the third generation of the programme is applied. Some topics have been adapted to the Cypriot situation; for example, the English version has a session on cannabis and this has not been included in the Cypriot programme, because cannabis use is not considered an issue in the age group for which the programme is targeted in Cyprus.

LEC programmes try to work protectively against drug use. A series of techniques are used that are based upon acquirement of knowledge and skills and attitude training to achieve long-term sustainability. Moreover, the children are trained in decision-making and evaluating their environment (family, school, and friends) and its impact on their health. At the same time, children are educated to develop a range of abilities that are important for a self-reliant and healthy life style.

In total there are six education programmes for the six different grades of primary schools which all are carried out in the mobile classrooms. For each age group there are different issues and objectives. The six programmes for Primary Education are:

- Taking Care of Myself (first grade)
- Healthy Nutrition (second grade)
- Feelings (third grade)
- Personality (fourth grade)
- Smoking, Alcohol and Decisions (fifth grade)
- Health, Drugs and Friends (sixth grade)

Each programme is visited by the students for a session of 80 minutes at each time. The programme is carried out from 7.45 to 12.45 o'clock. During this time three different classes with pupils at a different age attend the programme. Each session must be attended by the whole class and not only by interested students. It is planned that each student attends all programmes designed for the respective age group with the same trainer every year.

LEC's programmes take place in specially designed mobile classrooms (buses), which are equipped to provide a stimulating and exiting learning environment. Children and teachers sit together on equal terms to participate in the interactive workshop. The majority of the materials and tools used are very concrete and interactive by means of multimedia: There is a human model with organs, a light-show, and there are TV-monitors, music sessions, bags etc. The programme addresses special issues such as sleeping, breathing, water, eating and gymnastics. All of these themes are developed gradually and by using a variety of materials. Methods such as role playing, group discussions, interactive exercises, teamwork in small groups or pairs and interviews are involved in the conduction of the programme. For the younger children there is a video show on healthy nutrition, while the elder ones discuss also on alcohol and smoking.

III. B. 2. 4. Funding

The majority of the expenses are covered by governmental funds. The government is donating 73.000 Euro per year and covers also the salary of up to 13 part-time instructors. The technical equipment is paid by volunteer organisations.

The annual expenses include: tutors' training (€ 18.000), programme translations and various expenses (€ 36.000), cleaning (€ 4.000), maintenance and shifting (€ 15.000) of mobile classrooms.

III. B. 2. 5. Prevention activities

According to the staff, the programme is well-established in schools and its provision at primary schools is feasible and has been realised. This assessment is supported by the number of schools and pupils that have attended the programme in the last 10 years. Obviously the programme became increasingly accepted by the schools over time. The considerably increase of the number of participants since 2004/2005 is a result of the programmes' expansion.

Table 13. Primary schools / pupils attended the "Mentor" programmes

	1998- 1999	1999- 2000	2000- 2001	2001- 2002	2002- 2003	2003- 2004	2004- 2005	2005- 2006	2006- 2007
Schools	16	19	19	20	20				
Pupils						12.211	12.138	20.138	20.717

An internal evaluation was carried out by the primary school sector in 2003 to 2004. The evaluation was concerned with the three main objective of the programme: knowledge, skills acquisition and self-esteem enhancement. The evaluation was a control group design with about 453 children from Nicosia who had attended the programme and 361 children from Limassol who did not attend the programme. The participants were interviewed and asked to fill out questionnaires. Concerning knowledge acquisition among children who had attended the programme and those who did not (control group), a statistically important difference was found ($p < 0.05$). In relation to skills acquisition, the majority of the children (66.6%) were positively influenced from the programme. Presently the programme is being further assessed and evaluated in collaboration with the Pedagogical Institute of Cyprus.

III. B. 2. 6. Evaluation and proposals

With the Mentor programme, the *Life Education Centres* provide a well-established and evaluated primary prevention programme that is specifically designed for pupils at age of 6 to 12 years. The programme seems to be implemented by highly qualified and specially trained tutors/teachers with broad experience in the field of both teaching and providing prevention. A further sign of the quality of the implemented primary prevention is that the programme is part of the school lessons and based upon interactive methods and materials through a variety of multimedia actions. All educative contents are communicated to the pupils in a highly concrete manner. In addition the programme is designed to address certain age groups with age specific topics. Sustainability of the programme is being achieved by planning that each pupil will attend each part of the programme so that all topics are educated.

The implementation of the programmes is properly planned as the whole class has to attend the programme and as many schools and pupils are reached with the programme. The total number of more than 21.000 students who attended the programme underlines the competency of the “instructors” and acceptance of the programme.

There is not much to propose as the Mentor programmes are probably one of the primary prevention programmes in Cyprus which meet the criteria for best practice. The availability of additional mobile classrooms would certainly increase the visits in schools and accordingly the number of participants. However, in view of the tremendous costs of designing and equipping a mobile classroom this is a question of economics. In the given situation the recent change to pay more attention to schools in need for primary prevention is supported. It is also supported to carry out another evaluation which might be targeted at the question of long-term effects of the programme by questioning those pupils who attended the programme a couple of years ago. However, the main recommendation is to go on with the interactive prevention programme in school. If the prevalence of substance use will change in Cyprus, and for instance show that cannabis or ecstasy become an issue, the programme should be readjusted again.

III. B. 3. ASPIS (Anti-Narcotic Association of the Solomon Panagidis Foundation – Limassol)

III. B. 3. 1. Introduction

The association was founded in 1991 by the Solomon Panagidis Foundation of Limassol, operates under the umbrella of the Foundation and also uses its infrastructure for group sessions and other activities. Although the Panagidis Foundation is religious orientated, the Anti-Drug Association is an independent organisation, with no relation to the church or other organisations. *ASPIS* accepts as member all persons willing to assist in actions against drugs and cooperates closely with anyone sharing similar targets. The association has in particular strong links to the CAC and the Ministry of Culture and Education.

The association offers every year free educational programmes in the field of addiction prevention, and help and support to children, adolescents and parents.

III. B. 3. 2. Objectives and target groups

There is no special target group. *ASPIS* aims at the general adolescent population between the age of 12 and 18, and does not focus on any high risk groups. The main objective consists in the promotion of every day skills and the support for the problems of the adolescents.

III. B. 3. 3. Setting

The anti-drug association incorporates 20 engaged volunteers and is run by a council formed by nine members. The building belongs to the Panagidis Foundation and is at the moment under reconstruction.

III. B. 3. 4. Funding

The funding of the association predominately consists in governmental funding given by the CAC. In 2007, CAC donated approx. 6,400 € to the association. The estimated budget for the organisation of the planned workshops and seminars reaches the amount of approx. 17,000 € per year. Important to note is that the use of the facility's rooms is for free.

III. B. 3. 5. Prevention activities

All workshops, seminars and other programmes are conducted by special trained volunteers (secondary school teachers), who get a financial support for covering their travel expenses. The applications for attending a programme or participating in a workshop are made directly in the *ASPIS* office, or indirectly through the different schools.

ASPIS is providing following programmes:

- Adolescent programme

This programme is targeted to all adolescents (12-18 years) of the Limassol area. The programme consists of 10 interactive workshops with each lasting about two hours. Each workshop is attended by approx. 25 participants. The prevention programme is using an adopted form of the evaluated Irish prevention programme “Standing on my own feet”. In general, the topics from each of the five units of the programme are used. Each year there is a different focus including for example “expression of emotions and feelings”, “doping” and “playground violence”. Some of the workshops are also focused on drugs and resisting drug use. The workshops are provided by trained professionals who attended seminars and conferences, and have served as assistants in this programme for a minimum of two years. *ASPIS* is in funds of a large and well equipped group of workshop leaders.

The sessions begin in October and take place every second Saturday afternoon. The workshops are combined with other activities, such as excursions or other creative or amusing activities. A total of 5 groups with 25 adolescents started the programme last November, finishing in May. The drop-out rate (persons who do not complete all 10 sessions) is estimated to be about 40 %.

- Cypriot adolescent interactive workshop on addiction prevention

Every February, after a call on all secondary and high schools, a one day workshop takes place (9th time in a row) offering music and theatre performances. Every year about 400 students and 80 teachers of the schools applied are participating. The participants form groups of 20-25 students which are concerned with issues such as adolescent problems and resisting to drug use. “Resistance to group pressure” and “management of anxiety” have been the workshop themes of the last two years. The feedback on this programme has always been positive.

- Cypriot student “Anti-drug Poster” competition

The competition takes place yearly after a call on all secondary and high schools. Participating diplomas are being hand out to all participants, while the winners receive money prizes to a total amount of 1,550 €.

- Seminars for parents

Seminars on common family problems (parents' relation, raising problems, drug prevention, etc.) are offered every two weeks, from October to May.

- Seminars for teaching professionals

The seminars are provided after a call to all governmental schools. Target of the seminars is the training of teaching professionals in prevention.

Beside, ASPIS have made a proposal to the Ministry of Education for introducing a number of workshops in the normal school.

III. B. 3. 6. Evaluation and proposals

As regards the prevention activities of *ASPIS* it can be regarded as a sign of quality that interactive methods are used. In addition it is in line with requirements of good practice to deliver evaluated prevention programmes as it is the case for the programme “Standing on my own feet”. The effectiveness of the programme has been proven and for this reason it is recommended to further deliver this primary prevention approach. However, the target group of 12 to 18 years old adolescents covers a wide range of young people being in a very different stage of development. For the programme “standing on my own feet” adolescents are assigned in age groups such as for example in groups of 13-15 years old gymnasium students and 16-18 years old lyceum students. The drop-out rate of 40 % indicates that the provision of the programme needs to be improved, probably either by building groups according to the age or by adjusting the contents to respond to the different needs of younger children up to 15 years and to needs of those being older than 15.

With respect to the yearly Cypriot workshop the positive assessment of the participants shows that they seem to benefit from this one-day workshop. The topics of the group discussions such as “resistance to group pressure” comply with methods being recommended for effective prevention. The methods and contents of the annual interactive workshops are related to the programme “Standing on my own feet”. The workshops started 11 years ago as a response to the demand for prevention that has been formulated by teachers and schools in the Limassol area. The workshops seem to stimulate the awareness of teachers and adolescents that resistance to drug use is an important tool for adolescents. During the one-day workshop the groups are guided by trained professionals who also carry

out the ongoing programme. The yearly Cypriot workshop appears to be meeting of adolescent and teachers that on principle provides the same contents and methods of the community primary prevention “Standing on my own feet”.

There is not much information on the seminars for parents as regards the question whether this is offered to a parent group or to individuals. Furthermore it remains unclear if also children of the parents are involved in the seminar processes. Without knowing the details it is impossible to assess if the seminars more belong to a social welfare approach or if they contribute to prevention.

In general it is proposed to reflect strategies to improve the programme “Standing on my own feet”. Furthermore it is recommended – in particular in view of further funding – to provide written details on the concept and methods used for both the yearly Cypriot workshop and the parents’ seminar.

III. B. 4. Lions-Quest Foundation -Nicosia

III. B. 4. 1. Introduction

The organisation was founded in 1995 by the Greek-Cypriot Lions Club and is now a registered NGO under the authority of the Lions Clubs International. The main task is to promote the “Quest” programmes for children, adolescents and parents which has been implemented and supported since 1975 by the International Lions Club. The programmes have been evaluated and approved by the Cyprus Anti-Drug Council (CAC).

The foundation is represented by a board of 30 members and an additional executive committee of 7 persons. The members of the foundation have all been volunteers until recently.

III. B. 4. 2. Objectives and target groups

The main objective of the foundation is to provide educational programmes “Quest” to young people and parents as well as skill-training programmes. The prevention programmes aim at supporting the individual’s personality and the resistance against any temptations of legal and illicit substance use, violent behaviour, dangerous driving, etc. Training teachers and motivating them to implement the programme is also an additional aim of Lions Quest.

III. B. 4. 3. Setting

In the year 2006 the procedure of providing trainings has been changed. Instead of inviting expensive trainers from abroad it has been decided to train Cypriot teachers who act as multipliers and offer training themselves. In addition, it was decided to train only those persons who are able and allowed to implement prevention programmes. The prevention programme of the *Lions Quest Foundation* has already been approved by the Ministry of Education, and accordingly could soon receive the approval to be fully or partly integrated in the school programmes (at present the implementation of the programme is not allowed within the school setting).

Since 2007 the *Lions Quest Foundation* is not strictly a volunteer organisation any more. Instead there is a pricelist for services offered in order to charge municipalities for the trainings provide. The prevention programme is based upon a manual which has been published in English and covers as series of handbooks. The whole book-series cost 100 US

Dollar and have been pretty easily distributed in the past. Now the distribution will be more limited even though teachers still receive the whole book set.

Prevention programmes

The International Lions Quest offers prevention programmes covering the following themes:

- Skills for the early child years
- Skills for adolescents
- Skills for young adults
- Problem solving
- Peace preservation

In Cyprus, the prevention programme has a focus on the topic “skills for adolescents” although the implementation of further themes would be welcomed by the Foundation. The prevention programme “skills for adolescents” is implemented by offering respective training to adolescents, parents and teachers. Aim of the programme is to contribute to healthy adolescents with a strong personality by enhancing their resistances, values and self respect. The main target group are adolescents between the age of 10 and 14 year. The programme is being constantly evaluated and revised in the United States, and currently the 4th version of the programme is applied.

The prevention programme is based upon material which consists of 10 handbooks and each one is for a specific issue of the programme. Currently the handbooks are only available in English and not in Greek language. There is an 11th book which summarises the programme. In addition there is also a students’ book, a parents’ book, and a drug information guide for parents. This parents’ book is the only book translated into Greek so far.

The programme is modular and could last from one month up to three school years. It is even possible to choose only one issue for 1-2 hours if needed, although a comprehensive approach covering all aspects is recommended.

The trainers of the programme are always official approved trainers of the Lions Foundation who had been trained in the general approach, but not in every single of the 10 issues of the whole programme.

The 4th session of the parents’ programme is focused on drugs and provides information about drugs as well as very practical and interactive materials (role-plays, bringing drugs to

show, etc.). In order to provide updated information on drugs corresponding to the Cyprus situation, there is collaboration with the local police.

In other countries like Germany and the Netherlands the programme is already implemented in schools with very good results. In Cyprus, the implementation of the programme within the school lessons is currently not allowed by law.

III. B. 4. 4. Funding

The *Lions Quest Foundation* is receiving proper funding by the Lions Club but it is unclear if funding is provided on a regular basis. Additional to the Lions Club funding the required budget is also ensured by further donations, trainings held and books sold, and by funding given from the CAC. In 2007 the foundation received 12.721 Euro from the CAC. Nonetheless the foundation still has no own offices and is sharing the facility with Medical Alert, a service also funded by the Lion Club.

III. B. 4. 5. Prevention activities

Until 2007 the *Lions Quest Foundation* did not function formally as a foundation. There was no formal procedure of applying for training. The main reason consisted of the language problems, as the material is in English, as well as the interactive approach of the teaching, in which teachers were not used to.

In the last 10 years approx. 60 teachers and a big number of *Kenthea* staff have been trained in the material and programme. According to the information of the foundation, only 5-6 teachers (10%) have actually used the programme or parts of it since.

Unfortunately there is only one semi-annual report of July-December available. In these months the Lions Quest foundation has offered two training programmes for parents. Various other activities such as printing of material, participation at European Conferences of the Lions Quest foundations and further trainings have been promoted.

III. B. 4. 6. Evaluation and proposals

The *Lions Quest Foundation* makes efforts to promote and implement the component “skills for adolescents” of the “Quest” programmes. The “Quest” prevention programmes have been developed in the United States, but adopted by a number of European countries such as Germany, The Netherlands and Cyprus. The programme is constantly under evaluation and revision, and has been approved in Cyprus by the Ministry of Education. In

general, the programme being offered by the Foundation is a proven, well-structured programme that is based upon a manual including practical information and techniques for interactive prevention.

In Cyprus, the programme does not seem to be implemented as it should be. For instance, the programme is intended to be provided to pupils during school lessons, which is currently not allowed. In addition huge efforts has been made to train teachers in providing the programme, but at present the willingness to do so appears still to be rather low. Probably the main reasons for the difficulties in implementing the programme are related to the fact that handbooks are only available in English and that the implementation in school requires the governmental approval. Due to this fact one major recommendation is to translate the material into Greek in order attract more teachers to become trained and to enable them to use the material more easily. The current decision to train multiplies instead of inviting expensive trainers from abroad is supported by the evaluation. It is proposed that training of multiplies should be focussed on teachers or other key persons in the school environment to obtain trained prevention experts in schools, and thus to improve feasibility and acceptance to implement the prevention programme. Due to the time-consuming translation of 10 handbooks there should be set priorities on what is needed most first. Secondly the implementation of the programme needs governmental support. If these preconditions are fulfilled it is recommended to consider the evaluation of the programme after the translation and proper implementation in the Cypriot schools. The evaluation results will be a major quality indicator and allow further decisions on revision and improvement of the prevention programme.

III. B. 5. Pafos Anti-Drug Association

III. B. 5. 1. Introduction

The *Pafos Anti-Drug Association* is a volunteer organisation, founded 1994 by the Psychologist “Vera Paisi” in cooperation with other volunteers such as social workers, psychologists and other non professionals, which concentrates its actions on primary prevention and health promotion. The association contributed notably in the establishment of the *Kenthea* counselling and prevention station “Vera Paisi” and the open TC “Tolmi” of Pafos.

III. B. 5. 2. Objectives and target groups

Main objective of the association is social networking in terms of assessing the needs of the community and to cooperate with community key persons towards addiction prevention and the support of treatment and social reintegration.

The official objectives of the association are the following:

- Assessment, investigation and analysis of the actual needs of the community
- Prevention of drug use, in cooperation with the responsible governmental services
- Promotion of a healthy way of life
- Sensitising of the community for a better cooperation regarding drug substances
- Education and training of volunteers and other professionals
- Contribution to the therapy and detoxification of clients, in cooperation with other responsible services
- Contribution to the rehabilitation of clients and financial support
- Cooperation with similar organisations and international contacts
- Close cooperation with the Government for the promotion of the association’s goals

For accomplishing of the targets above, the association cooperates closely with local authorities, governmental services and mass media and organises seminars, interactive workshops, art sessions, concerts, lectures, volunteers training, etc.

The *Pafos Anti-Drug Association* does not have a specific target group. It aims at the provision of primary prevention to the general population of the community of Pafos. Through its programmes and activities there is a focus on certain groups such as adolescents, parents, teachers and health professionals.

III. B. 5. 3. Setting

The structure of the non-profit organisation of volunteers includes an election of a coordination committee every two years, which consists of 7 members. Every two years the members of the committee rotate, although some members always persist. Since its establishment the association is an official member of *Kenthea Centre Larnaca*. Many members of the association had been trained by *Kenthea Centre* and some of the trained volunteers had become regular staff member of the *Kenthea* prevention and counselling station „Vera Paisi“.

The legal framework of the association does not allow having paid staff members in the association. That is also a reason for having supported the establishment of open TC “Tolmi” and *Kenthea* station “Vera Paisi” in Pafos as separate organisations, in order to incorporate professionals in the prevention actions in Pafos. However, according to the association, “Vera Paisi” is unofficially historically considered as part of the association.

The association supports financially the organisation and implementation of specific programmes, workshops and conferences by professionals, as well as the open TC “Tolmi” and the *Kenthea* station “Vera Paisi” in Pafos with private donations. Members of the association pointed out that without the support of the association, the existence of the two facilities would be threatened.

The *Pafos Anti-Drug Association* assesses needs from the community and proposes the implementation of specific prevention activities to the *Kenthea* station “Vera Paisi”, which also decides upon the implementation of the actions. Furthermore the association is also responsible for the organisation of the activities which is done in cooperation with “Vera Paisi”. The trainings, lectures, workshops and generally every specific prevention action is then conducted by a *Kenthea* staff member, assigned and paid for this purpose (although some members of the Pafos Anti Drug Association are trained for the workshops). The printed material in such activities originates also from *Kenthea*.

III. B. 5. 4. Funding

The funding of the association is gathered from following sources:

- Yearly contribution of the association’s members
- Private donations of members and friends of the association
- Earnings of any actions made

An estimated 80 % of the prevention costs are sponsored by local donators. All sources are invested for the promotion of the association's goals. The CAC can fund only specific programmes of the association but not the association itself. In the year 2007, the total amount granted by the CAC for the funding of specific programmes was £ 2,430 (approx. 3,430 €). It remains unclear, if there are further funding sources.

III. B. 5. 5. Actions of the Association

Following actions have been coordinated and organised in 2007 by the *Pafos Anti-Drug Association* in 2007:

- Interactive workshops for parents

After having established a closer contact to the parents' committees of the communities' schools, 13 interactive workshops on "Communication in the family" had been organised for 13 parents of the Geroskipou region. The participation of further parent groups is planned.

- Interactive educational workshop for teachers

Primary school teachers and kindergartners (n=6) took part in the prevention workshop "The garden with the 11 cats".

- Educational seminar for parents

In Pegeia and Geroskipou municipality educational seminars with title – "The role of parents and awareness rising in relation to prevention" had been provided to parents.

- Educational seminars for health professionals

23 health professionals (social workers, hospital workers, psychologists, nurses, etc.) participated in following educational programmes: 1. Motivation for treatment and relapse prevention, 2. Personal boundaries in the treatment system, 3. Open therapeutic community – Treatment methodology, 4. Harm reduction – Drugs HIV/AIDS, hepatitis.

- Educational seminars for people working in the media

On the subject "The basic principles which govern the publication of drug-related information in the media" a seminar for media staff was held.

- Drama therapy for women health professionals

A series of 5 drama therapy workshops for female health professionals was conducted, where 21 persons participated.

- Volunteers educational programmes

Within the scope of the programme "Social networking of volunteers and volunteering organisations", 4 educational lectures took place. The volunteers have been trained to

recognise the needs in the society. The training was not on ways to carry out prevention activities.

- The 10th Cypriot Congress “Parents in Prevention” with the title “The effects of the family form and setting on the psychosocial development of the child” took place in Pafos.
- The 3rd Pafian Child Forum for drug use prevention

This forum addresses children at age of 10-11 years and consists in their participation in interactive workshops.

- Various other actions, as sport, art, music and dance sessions

The last action was targeted especially on migrants.

Furthermore the association is active in fundraising and the organisation of the Pancyprrian conference that takes place every year in March.

III. B. 5. 6. Evaluation and proposals

In general, the profile of the *Pafos Anti-Drug Association* does not appear to be clear. Both the objectives and well as the related actions cover a broad variety of issues ranging from fundraising, education and training, community networking to aspects related to drug treatment and rehabilitation. Given this spectrum of activities it is obvious that the association can not be regarded as an organisation that is focussed on the promotion or implementation of prevention.

With regard to prevention the association mentioned the two objectives of “prevention of drug use” and “promotion of a healthy way of life”. In relation to prevention the assessment of the community needs may build an important basis for implementing prevention activities according to requirements of the community. However, in 2007 mainly activities had been carried out addressing parents. It remains unclear how far the family educational programmes are designed in a way that meets criteria of good practice. In addition, the provision of alternative activities such as sport and music events has been proven in research to be ineffective in terms of drug prevention.

According to the members of the association prevention needs to be carried out by professionals and not by volunteers. For this reason there is a close cooperation with *Kenthea Centre*, the open TC *Tolmi Pafos* and *Vera Paisi* prevention and counselling station of *Kenthea* in Pafos. Indeed, it is good practice to have trained staff for the delivery of prevention. In view of this issue the role of the association becomes more diffuse. In fact, the association proposes prevention activities but does not implement them. It seems as if

the association does not put any prevention into practice independently from *Kentheia Centre* and *Vera Paisi*. As *Vera Paisi* as a prevention and counselling station it anyway responsible for providing prevention the further benefit of the association in the filed of prevention appears to be disputable.

As a conclusion the evaluation shows that the major contribution of the association concerns community networking and fundraising to support the work of *Tolmi* and *Vera Paisi* in Pafos. In this respect the association fulfils an important function. Accordingly it is recommended that the association becomes more focussed in its profile and objectives. Due to the impression gained during the evaluation, the association cannot be regarded as an organisation of the prevention network of Cyprus but rather as an organisation that plays a role in the financial and structural support of the drug treatment and prevention services of the NGOs in Pafos. In terms of public funding, the current activities of the association do not indicate to meet criteria for funding of best practice in prevention.

III. B. 6. Mikri Arktos - Limassol

III. B. 6. 1. Introduction

Mikri Arktos is a semi-governmental organisation and part of the Cyprus Youth Board which lies under the Ministry of Culture and Education. The prevention programmes of the organisation started in January 2006 under the supervision of the CAC and were in the beginning a pilot only in the district of Limassol. The expansion of the prevention programmes to the district of Nicosia is planned for the year 2008. In 2009 it is planned to extend the prevention programmes furthermore in the districts of Larnaca and Pafos. The activities of *Mikri Arktos* are corresponding to the national Action Plan and the action plan of the Ministry of Justice.

III. B. 6. 2. Objectives and target groups

Mikri Arktos is a centre providing universal prevention for addictive substances. In general, the primary prevention provided aims at enhancement of psychosocial skills and positive behaviour. The four main action areas are school and community, networking and training of volunteers and professionals.

Mikri Arktos prevention centre addresses multifaceted target groups such as children of primary and secondary school, parents, teachers, principals, counsellors, volunteers, and the broad community of Limassol general. In 2008 the implementation of actions for additional target groups such as kindergartens, gypsy minority, women, migrants, etc. is planned.

The objectives of the actions depend on the different target groups and are as follows:

- Students

The main objective is to support and empower protective factors such as personality social competences, personal resistance, respect of others, team-spirit, cooperation, network, and family structure, etc. In addition, students are educated to remove themselves from common myths and emphasis is placed on positive behaviour and support of competences in order to promote right and healthy choices.

- Parents

Aim is to provide informative education on child needs, addictive behaviour and its causing factors, the importance of prevention, etc. Furthermore parents are supported in issues such as family role, communication skills in the family and the active participation in the school community.

- Teachers

Teachers are also provided informative education on addictive behaviour and causal factors, the importance of prevention. In addition they are encouraged to establish a proper networking, and are offered support for the teacher's role and the cooperation with families, and for implementing health promoting activities. Teachers are also trained in specific prevention materials in order to use them in class.

- Principals and counsellors

Principals are informed about prevention strategies, child-focused methods in prevention, the alternative handling of deviant behaviours and productive changes in the management of the school environment. They are also educated in understanding risk factors for addiction. Counsellors are also offered training in prevention tools.

- Municipality

The objectives related to the municipalities are basically the same as for principals. Specific further objectives are directed to the importance of the Municipality's role with respect to the setting of common targets, the establishment of a proper networking and the promotion of active support of preventions activities in the community.

- Community

Main aim is to promote the establishment of a cooperation network, to distribute information material, to inform about actions and programmes, to identify problems, to organise active prevention teams and to encourage members of the community to participate in actions of the prevention centre.

A further objective of *Mikri Arktos* is to perform seminars, lectures, congress contributions and posters, and outreach work with informative character.

III. B. 6. 3. Setting

Staff

The centre has four full-time staff members:

- One managing director and supervisor who is a psychologist with qualification in rehabilitative counselling
- One scientific coordinator who is a psychologist with qualification in forensic psychology
- One drama therapist
- One social worker

These staff members are responsible for the field investigation, assessment of needs, planning and implementation of actions (i.e. conduction of workshops), and the training of professionals and volunteers. In addition one secretary, one bus driver (for the mobile unit) and one charwoman are supporting the team.

For the implementation of specific prevention materials the staff members are in continuous training which is for instance provided through OKANA, Greece.

There is a regular internal supervision of the team as regards the assessment of needs and the planning and realisation of actions. Internal supervision is carried out by the scientific coordinator on a group and/or individual basis. There is also regular external supervision by an independent clinical psychologist.

For the planned expansion of the prevention centre four additional prevention workers (2 in Limassol, 2 in Nicosia) will be employed. Furthermore it is planned that another scientific coordinator, one scientific researcher and another secretary will be hired in the next months.

Rooms

Mikri Arktos in Limassol is located in a flat of 75m² which has 3 offices, one meeting room, a small living room, a kitchen and the lavatories.

Prevention programme

In 2006 and after a meeting with the authorities of the Ministry of Education *Mikri Arktos* received the allowance to implement prevention programmes in the school environment. This allowance has a validity of one year and has to be renewed yearly. The prevention centre has to submit every 6 months a report on the prevention activities to the CAC which is also the supervising authority.

Mikri Arktos approaches schools through informative visits or by sending invitations. The implementation of a prevention activity always requires a written application of the school to the centre. While programmes in the school environment take place during the school semester, community actions usually take place during the summer.

After assessment of the community and school needs *Mikri Arktos* develops a 3-months prevention activity plan. The following workshops for different target groups had been carried out.

Table 14. Implemented workshops and their target groups –Mikri Arktos

Prevention workshop	Target group
-Communication in the family	Parents
The anger of the children	
Interactive exercises for the group support	General population
Touching the circle	Students of primary schools
I am, I know, I can	
Skills for primary school	
Teaching children to cooperate	
Skills for adolescence	Students of secondary schools
Sex, Drugs & Alcohol	
Evovement guide for gypsy women	Socially disintegrated women
Life education and social reintegration guide	
Workshops for young gypsies	Socially disintegrated youth
Standing on my own feet	Students
Drug prevention in the community	Communities / Authorities
Alcoshots – young people in alcohol related situations	Adolescents

Methods and tools

Mikri Arktos uses various standardised prevention materials and tools in the different workshops that are provided to the target population. The programmes implemented in the school environment and in the community environment do not vary, as they partly address the same target group. However, all prevention programmes are specific for each age group and consist of a minimum of 5 interactive workshops (role playing, painting, working groups, etc.). Each workshop lasts 90 minutes. Every group has a minimum of 8 participants and a maximum of 20 participants. In case that there will be too many participants the groups are divided. After the completion of a certain programme the participants can attend another one six months later. This procedure is to ensure that more

than one programme is applied to the same group. Every programme for every target group has a specific session on substances.

The staff members have tried in the past years to compare the impact and the acceptance of the various tools used in the different workshops in order to decide upon the implementation strategy. For this purpose questionnaires have been handed out to trainers and participants. In future an evaluation with a control group design by applying a questionnaire of the EMCDDA is planned.

III. B. 6. 4. Funding

According to the staff there is a constant funding of the facility by the government.

III. B. 6. 5. Prevention activities

The staff stated that each workshop needs about 3 ½ hours for preparation. Thus there is a maximum of about 60 programmes that can be conducted by 2 staff members in 12 months. This is also the basis of the planning of the future actions.

In the years 2006 and 2007 *Mikri Arktos* has implemented a considerable number of prevention activities. These include:

School environment:

- 2006

15 programmes with a total of 88 workshops have been carried out, and 334 students, 58 teachers and 22 parents participated. In addition, 13 lectures for approx. 800 participants have been held.

- 2007

15 programmes with 108 workshops have been completed, and 206 students, 23 teachers and 51 parents participated. In addition, 10 lectures for about 300 participants took place.

Community environment:

- 2006

7 programmes with 19 workshops have been conducted, and 285 students and 15 teachers participated. In addition, 8 lectures and informative sessions were provided.

- 2007

8 programmes of with 26 workshops have been provided, and 229 adolescents and students, 9 parents and 32 professionals participated. In addition, 12 lectures and informative sessions have been carried out.

In sum, in 2007 *Mikri Arktos* implemented 23 prevention programmes covering 134 workshops which were attended by 550 participants.

III. B. 6. 6. Evaluation and proposals

The primary prevention centre *Mikri Arktos* is semi-governmental organisation which provides a variety of prevention activities in the school and community setting. The prevention activities address a broad target group ranging from pupils, adolescents, parents, teachers to the general population of the community and municipal authorities. Main objectives are to enhance life-skills of young people, improve functioning of the family, and to train multipliers in prevention programmes and tools. Furthermore the public and authorities are to be informed about substance use and related prevention strategies.

To do so the prevention centre is well equipped as regards staff, training of staff, offices and funding. Different to most prevention organisations, there is regular internal and external supervision, and continuous training in the field of prevention. However, the staff is highly qualified with psychologists, drama therapists and a social worker. With regard to prevention the staff even seems to be overqualified – or in other words, more qualified for providing treatment rather than prevention. For instance, qualifications in rehabilitative counselling and forensic psychology as well as external supervision by a clinical psychologist correspond more to quality criteria for treatment. Thus it remains unclear if the staff is appropriately qualified for primary prevention apart from attending training in this issue.

The prevention programmes provided are well structured and age sensitive as they are specific for each age group and consist of a minimum of 5 interactive workshops with a limited number of participants. In the last two years intensive work in the field of primary prevention has been done as more than 130 workshops with 550 participants had been carried out. To address the topic of substance prevention each programme has session on substances. A further quality indicator is that the centre tries to involve the same group in different programmes in order to provide ongoing prevention. However, it remains unclear how many of the programmes provided have been evaluated and are evidence-based. Even though *Mikri Arktos* is under supervision of the CAC, no evaluation has been carried out to assess effectiveness and outcome of the prevention programmes. The staff clearly sees this

lack and is motivated to conduct more research on population needs and effectiveness of their programmes. Within this context it is planned to employ a researcher and to carry out an evaluation with the EMCDDA tools. The need to carry out evaluation of the programmes is clearly supported by the evaluation, but it is also proposed to consider the employment of a researcher for this purpose. If ongoing internal evaluation and respective reporting is planned, this might be reasonable. If this is not the case, an external evaluation would be more favourable in order to benefit from recommendations of a non-involved interest group. As an evaluation is still missing, the decision on expanding the prevention programmes to further areas of Cyprus as well as the employment of further four staff members should depend on the evaluation results. A careful planning and funding of prevention programmes requires knowledge of what works in the field of primary prevention and which programmes should be given priority. Currently the activities of the prevention centre also include a variety of information distributed to the public. Probably it is more reasonable to employ someone for public relations instead of a further coordinator, secretary etc.

As the school environment presents a highly suitable setting for effective prevention and evaluated prevention, programmes should have the allowance to be conducted during school lessons. Moreover it is recommended to consider implementing effective and evidence-based prevention programmes – similar to those provided by the Life Education Centres – in the school curriculum.

In conclusion, *Mikri Artos* appears to be a well structured and organised centre for primary prevention, which is exceptional from many other prevention organisations in their clear needs assessment and regular reporting. Due to the lack of programme evaluation the main recommendation is to carry out evaluations of the main programmes provided in the school and in the community environment.

III. B. 7. Sykana (Larnaca Association against Drugs) and Faros

III. B. 7. 1. Introduction

Both *Sykana* and *Faros* are volunteer, non-governmental organisations which provide primary prevention in the Municipality of Aradippou in Larnaca district. While *Sykana* (Larnaca Association against Drugs) has been founded in 1990, the “Centre of productive activities and framing of life skills” *Faros* was founded in October 2006 and operates as a twin organisation of *Sykana*. Even though both organisations present themselves as two separate organisations, the difference between them remains pretty unclear. Indeed, both organisations are constituted of the same members and committee.

III. B. 7. 2. Objectives and target groups

Both organisations act in the field of primary prevention. According to their philosophy involving a great number of persons and professions dealing with the social life of children and adolescents in the primary prevention is essential. So *Sykana* and *Faros* try to engage not only students for their actions, but also their parents, teachers, and several cultural, sport and social groups and organisations, and the media.

Sykana

The long-term goal of *Sykana* is that young people avoid using substances and developing addictive behaviour through the support of:

- Positive attitude towards life and emotional well-being
- The development of an independent and mature personality
- Expression of feelings and ideas
- Social and personal skills

A further specific objective is related to the night school meeting and directed to the improvement of self-esteem, decision making and assertiveness of the students. The prevention programme includes a short introduction of night school pupils and information about substances and primary prevention. *Sykana* also uses sport activities in order to sensitise the public, advertise the organisation and inform about its actions, functioning and ideology. Also, volunteers for further actions are recruited at sport events.

Sykana aims at primary prevention in the general population, but focuses mainly on students and teachers. For the programme “Drinking and Driving” the staff reported to

address two different groups; one below the age of 21 and one for persons above that age. Why all people below and above the age of 21 are regarded as two groups remains unclear.

Faros

The main objective of *Faros* is to contribute to primary prevention of any addictive behaviour (e.g. substances, gambling, mobile phone, addictive relationships, etc.) and to promote a healthy school environment. The interventions of *Faros* aim at skill training for children and adolescents, and to enhance competences to avoid violence and negative behaviour, to stay busy and have new experiences, and to have fun with various activities.

The main target group is students of age of 7-18 years who attend one of the 4 preliminary and the two secondary schools in Larnaca area. The target group for drama therapy are 12-18 years old students.

III. B. 7. 3. Setting

The programmes of both organisations are mainly evaluated by the supervisors and coordinators of the organisations (Dr. Georgakas and Dr. Veresies). Assessment questionnaires are distributed to the participants in order learn about the quality and contentedness with the programme. The results were sent to the Pedagogic Institute of the University of Cyprus. The Ministry of Education has approved the programmes of *Faros*.

Staff

The committee of both organisations consists of 36 volunteers such as counsellors, teachers, social welfare professionals, nurses, psychologists and members of the Municipal Council. There is only one staff member on salary (psychologist) since some months. In addition, there are 160 members of the organisations. The activities of *Sykana* and *Faros* are coordinated by the psychiatrist Dr. Georgakas from Greece and by Dr. Veresies of *Kenthea Centre* Cyprus.

The prevention programmes are carried out by 25 volunteers (counsellors, social welfare professionals, teachers, nurses, psychologists and other members of the Council). All of them have at least 30 hours of training in the field of prevention and attended special training courses (i.e. in the United States). The training is founded by *Sykana*.

Prevention programmes

Sykana is planning and providing following preventions activities:

- Seminars and lectures carried out by volunteers and specialists from Greece on main topics of prevention which take place in *Sykana* or in local cafes.
- Interactive workshops for students and teachers focusing on self-assertiveness, self-esteem and decision making.
- 3-day peer education programme
- 3-days programme on alcohol and driving
- Interactive workshop for interested students of the Cyprus night schools with focus on self-esteem and decision making (once a year 2 sessions)
- Training of 5x3 hours for teachers in cooperation with the Ministry of Education
- Drama therapy
- Demonstration of movies
- Sport activities considered no prevention activity, but promoting public relations and advertising about the facility.

Sykana uses printed material on drug prevention. The new programme “Prime for Life”, which has been adopted from the United States under permission of the authors is planned to be implemented in the first semester of 2008.

Faros is offering a wide range of leisure and creative activities such as chess, ceramic, mosaic, handcraft and music occupation. These are open access activities for all interested persons, taking place when at least 10 participants are gathered. The application for participation is made by phone call and then there is a commitment between the interested person and *Faros* for regular participation during one school term. In addition, *Faros* is offering drama therapy for the promotion of self-esteem and personal emotional expression. The participating students are being divided in groups of similar age. After approx. 6 meetings a discussion about legal drugs takes place.

Faros is planning the distribution of information material to the 16,000 inhabitants of the Larnaca community once a year.

III. B. 7. 4. Funding

The funding of *Sykana* is ensured by a combination of a public funding by the CAC (7.660 Euro in 2007), private local donators, fundraising dinners and sales of a newspaper. Some of the workshops are directly funded by Ministry of Education. The expenses of *Sykana* include the salary of the staff member (psychologist), some of the trainings of the

volunteers, the invitations of specialists from Greece (mainly Dr. Georgakas) and various other expenses such as cleaning, printing material, coffee, etc.

The funding of *Faros* remains unclear. One part is covered by governmental sponsorships and the rest by the Welfare Office for voluntary organisations and private companies. Funding is also achieved by selling the organisation's newspaper.

III. B. 7. 5. Prevention activities

In the 2nd semester of 2007 *Sykana* was active in:

- Distribution of information material on various festivals in the Municipality of Aradippou
- Various sport activities such as shooting games, exercise against addictions, marathon run carried out in cooperation with different groups and associations
- Informative workshop in a Gymnasium about "The meaning of quality of life"
- 2 lectures about general primary prevention topics
- Educational workshop for teachers

In the 1st semester of 2008 the following activities were provided by *Sykana*:

- Various sport, theatre and social activities in cooperation with various groups and associations such as several running games, theatre performances, one concert and one music night
- Lecture about social violence in a local association
- Informative workshop for teachers and students
- Lecture about sports against addiction
- One movie performance and analysis
- Pancyprrian prevention congress of night schools.

There is no specific annual report of *Faros* and thus the prevention activities carried out and the number of participants remain unclear.

III. B. 7. 6. Evaluation and proposals

Both *Sykana* and *Faros* are providing primary prevention in the Municipality of Aradippou in Larnaca district. Both NGOs are constituted of the same members and committee and thus the first striking question is what are the two associations for and how do they differ.

Based on the evaluation it does not seem to be very reasonable to have two organisations being closely interlinked and being more or less the same.

Both organisations aim at primary prevention of any addictive behaviour and differ only in further objectives reported. While *Sykana* is targeted at skill-training and personality development, *Faros* aims to contribute to a healthy school environment. The target groups of *Sykana* appear to be diffuse as only night school students and people below and above the age of 21 have been mentioned. *Faros* mentioned a clear target group which are students of age of 7-18 years from specific schools.

All prevention activities are exclusively carried out by trained volunteers, and the activities are reported to be evaluated by *Kenthea* Centre and a person from Greece. Nonetheless, the programmes do not seem to meet any quality criteria for evidence-based prevention. The programmes have not been evaluated apart from questionnaires distributed to participants to assess their contentedness. In addition, no standards such as contents, duration, limitations of participants etc. have been reported for the programmes provided. The exact structure and functioning of both organisations as well as the provision of primary prevention is unclear.

The evaluation identified a gap between prevention theoretically offered and those having been implemented during the last year. First of all most activities were sport activities, theatrical performances, music concerts etc. which have been demonstrated in international research to be ineffective for prevention. Furthermore, the number of the other prevention activities is regarded quite low for one year: 3 one-day informative workshops, 4 lectures, twice distribution of information material and once a workshop for night school students. The interactive workshop for students and teachers do not vary, but use the same methods and have the same content for both groups. Finally, as often found in prevention in Cyprus, drugs are never mentioned. In view of the aim to provide prevention for addictive behaviour, the programmes delivered are not appropriate to achieve this aim and are most often not even effective for general prevention. This might be different for the 3-days programme on alcohol and driving, but as no further information on the contents and the number of participants were provided, an assessment of this programme is impossible.

In consideration of the evaluation, it is rather difficult to provide recommendations. There are considerable deficits in the primary prevention provided and for this reason a complete restructuring of the NGOs is proposed. The restructuring should be based upon a systematic and exhaustive assessment of the whole structure and functioning as well as of the programmes themselves. Based on the assessment it has to be decided which prevention

programmes might be needed, effective and appropriate to meet the objectives defined. In general, it is proposed to either apply evaluated programmes or to start with a reasonable pilot, which will be re-assessed after a certain time. However, it is recommended to set priorities in the activities carried out and in the target groups that will be addressed. In terms of funding it is of essential importance to become more transparent and to report more precisely on the prevention activities.

As *Faros* can neither be regarded as a separate organisation nor be considered as a facility offering effective primary prevention, this organisation may either be closed or become completely independent. In the latter case they should act as a community youth work organisation but not as part of the prevention network.

III. B. 8. Kenthea Department of Prevention - Larnaca

III. B. 8. 1. Introduction

The *Kenthea Department of Prevention* (KPCL) is a non-governmental, non-profit organisation, which is situated at the headquarters of the *Kenthea* organisation in Larnaca. The KPCL is responsible for the organisation, planning, conduction, evaluation and management of all prevention programmes of *Kenthea* in Cyprus.

Kenthea is coordinated by the General Council of the organisation, consisting of the founding members and representatives of more than 70 organisations across Cyprus such as the Cyprus Church, the Union of Municipalities, the Union of Majors, the University of Cyprus etc. *Kenthea* has also an Administrative Council, a secretariat and a Scientific Committee. The General Council determines also the members of the Coordinating Board, which votes for the scientific coordinator.

In the same building where *Kenthea Department of Prevention* is located there also two further departments or sub-organisation of *Kenthea*.

- The Institute of Research and Documentation (IRD)

This institution has collected information and conducted surveys on the Cypriot situation until the National Focal Point has been founded (2004). In cooperation with the Cyprus government many surveys and studies have been carried out.

- The Institute for Continuing Education (ICE)

This institute offers educational training for professionals in Cyprus. With regard to prevention respectively 30 hours of training is offered in the prevention programmes “Standing on my own feet”, “Communication in the family” and “Skills for the children of kindergarten and primary schools”.

Information on the different departments, sub-organisations and services are provided on a *Kenthea* website: www.kenthea.org.cy

Kenthea tries to implement prevention programmes which are in line with the Cyprus and the European Action Plan. *Kenthea* provides primary, secondary and tertiary prevention. Primary prevention is carried out by *Department of Prevention* and by the *Kenthea* prevention and counselling stations (see chapter 6.1). Secondary prevention is provided as well by the counselling stations (see chapter 6.1) and tertiary prevention by the outpatient TCs of the NGO *Tolmi* (see chapter 6.2).

III. B. 8. 2. Objectives and target groups

The main objective of the *Department of Prevention* is to organise and implement workshops for selective prevention. As further objective it has been reported to create a social network against drugs and to motivate people in participating in workshops by providing lectures, conferences, information meetings and sport and culture events.

With regard to selective prevention the *Department* aims at the development of individual resistances and skills to prevent anti-social and other behaviours which may be risk factors for drug use. Another aim is to train specific groups having contact to youth.

There is a defined but also wide spectrum of various target groups. Thus, the prevention activities are targeted at adolescents, parents, teachers, kindergartners, scouts, adult evening-school students, municipality and community staff, doctors, nurses, druggists, psychologists, social servers, priests, lawyers, reporters, etc.

III. B. 8. 3. Setting

Staff

The staff of the *Department of Prevention* consists of members who have their basis in Larnaca and those working in the prevention and counselling stations across the island. The number of staff members working at the *Department* in Larnaca is not known. However, the staff attends a weekly 90 minutes supervision in English by Dr. Lazarov and Dr. Veresies. In addition, there is an extra monthly supervision for staff members carrying out prevention workshops.

For implementing the three main prevention programmes (“Standing on my own feet”, “Communication in the family” and “Skills for the children of kindergarten and primary schools”) there is a list of about 40 collaborating and trained professionals.

Rooms and facilities

The *Department* is situated in the *Kentheia* Centre of Larnaca, where also the other two Institutes (IRD, ICE) coexist. Tolmi-Larnaca is also based on the same floor. The facility is equipped with all possible hardware and material needed.

Prevention activities and programmes

The planning and organisation of prevention activities is either done by *Kentheia* or results from an application by organisations and groups which directly contact *Kentheia* or one of

the counselling and prevention stations to suggest an activity. The implementation of the prevention programmes is conducted by the staff of the counselling and prevention stations or by the specifically trained collaborators.

The following prevention activities are organised and implemented by the *Kenthea Department of Prevention*:

Activities for teachers

These activities address kindergartners, teachers of preliminary and secondary schools and high-schools, and aim at the training in specific educational practices for the youth. The training is based upon a complex model and in order to promote skills and preferences for a healthy way of life.

This objective is promoted through:

- Educational workshops for the training of teachers in specific programmes such as “Standing on my own feet”
- Pancyprian teachers’ congresses
- Distribution of informative material about alcohol and substances

Activities for parents

These activities aim at the promotion of the parents’ education and skills related to the communication in the family, the promotion of the children’s self-esteem and autonomy. A further aim is to enhance skills to restrain addictive behaviours.

These objectives are promoted through:

- Educational seminars, lectures and meetings, as well as interactive workshops for the training in specific programmes such as “Communication in the family”. This specific programme consists in 13 workshops with each lasting 2 hours. The method used was stated to be “energetic experience.
- Distribution of informative material about alcohol and substances.
- Radio and TV presentations.
- Pancyprian parents’ congress.

Activities for adolescents / pupils

There are prevention activities which are directed to youth in general as well as to pupils of primary, secondary and adult evening schools. Objective of these activities is to support

skills for resistances, self-esteem, and decision-making as approach to prevent the use of substances.

These objectives are promoted through:

- Organisation of volunteering youth groups across Cyprus and their participation in interactive workshops with the title “Standing on my own feet”. This programme is for the age group of 12 to 18 years old individuals, and consists of 7 workshops using the method of emotional experience.
- Participation in the programmes “Skills for Students of the Preliminary School”. Target group are children at the age of 4 to 11 years. The programme consists of 6-7 workshops based upon the method of energetic experience.
- Organisation of local workshops and meetings in order to discuss specific problems and needs. In these meetings the representatives for the Pancyprian congress are also elected.
- Organisation of the Pancyprian Congress of adolescents.
- Organisation of an annual excursion of all volunteering groups.

Project “From youth to youth”

This project aims at the creation of prevention associates within youth organisations in order to built pathways for distributing information among the youth.

These objectives are promoted through:

- Organisation and conduction of educational seminars and workshops.
- Organisation of artistic and athletic activities for the healthy engagement of the youth.
- Organisation of the Pancyprian Congress of adolescents.
- Usage of the media for information distribution.

Project “Art and Culture in Prevention”

Objective of the project is to provide healthy alternative activities for the youth.

This objective is promoted through:

- Organisation of concerts and other musical or artistic activities.
- Organisation of theatrical performances.
- Organisation of photography, poster, painting and poetry competition.

Project “Sporting against addiction”

This project aims at the promotion of athletic as a healthy alternative way of living and the participation of the youth in such activities.

These objectives are promoted through:

- Organisation of sport activities.
- Using planned sport activities in order to promote messages and information.

Education of professionals as intermediate target group

These programmes are focussed on specific professional groups such as doctors, nurses, druggists, psychologists, social workers, priests, lawyers, reporters, etc and aim at the information of professionals' teams about specific issues of drug use and addiction problems. Professionals shall be educated and trained in supporting individuals at risk or those using substances.

These objectives are promoted through:

- Workshops, seminars, meetings and lectures.
- Distribution of informative material.

Kenthea is also providing training in other programmes such as “Prime for Life” “Calendar of the ship Armenistos”, etc., but in the year 2007 these programmes have not really been implemented.

Every prevention activity carried out is being evaluated by the KCPL through questionnaires filled in by the participants. The data is analysed by the IRD and electronically documented.

Methods and tools

Prevention strategies of *Kenthea* are mostly based on personal communication. Universal prevention is implemented by lectures, seminars, interactive workshops, distribution of informative material and other activities. An important factor hereby is the continuity of the programmes.

III. B. 8. 4. Funding

In 2007 prevention provided by *Kenthea* has been funded by the CAC with 62.081 Euro. In addition there are many financial contributions by several organisations and communities which partly are donated to the counselling and prevention centres but collected in *Kenthea* Centre of Larnaca.

Prevention programmes that are organised by the Coordinating Council and the Scientific Committee of *Kenthea* are also funded by the Centre. The same is the case for prevention applied on request of associations, communities and groups in their own interest.

In the semi-annual report for the second semester of 2007 the following data on funding was provided:

- For the programme “Parents in prevention” *Kenthea* received an additional funding of 19.021 Euro from the CAC which should cover the half of the expenses.
- For delivering 13 parent workshops, 15 experimental workshops and 4 other workshops the salary of staff members was 2.010 Euro. The costs of the administrative support (not including material) were 720 Euro and for the supervision 2.557 Euro.
- For the activity “Sporting against addiction” *Kenthea* received an additional funding of 9.265 Euro from the CAC for half of the expenses. According to the report the expenses for the second semester were 4.363 Euro, plus 720 Euro for administrative support and 2.008 Euro for the salary of the staff members providing 19 actions.
- For the activities related to “Adolescents in prevention” *Kenthea* received an additional funding of 20.044 Euro from the CAC for the half of the expenses. According to the report the expenses for the second semester were 7.622 Euro, 720 Euro for administrative support and 2.008 Euro for the salary of the staff members providing 40 workshops. Supervision amounted to 2.982 Euro.
- For the activities “Prevention at the Workplace” *Kenthea* received an additional funding of 3.339 Euro from the CAC for half of the expenses. According to the report the expenses for the second semester were 5.247 Euro, plus 2.010 Euro for salary of the staff members conducting 5 workshops and 720 Euro for administration.
- For the project “Art and Culture in Prevention” *Kenthea* received an additional funding of 10.410 Euro from the CAC for half of the expenses. According to the report the expenses for the second semester were 10.296 Euro, plus 720 Euro for administration and 2.010 Euro for salary of the staff members conducting 7 activities.

III. B. 8. 5. Prevention activities

Until the year 2007 *Kenthea* has trained 1.200 teachers of high schools, 1.300 teachers of preliminary school and 140 kindergartners.

According to the 2007 report of the *Kenthea Prevention Department* the following activities and workshops - which some being ongoing - have been provided.

Table 15. Prevention workshops and participants provided by Kenthea in 2007

Target group	Number of workshops	Participants
Adolescents	63 workshops on “Standing on my own feet”	124 (9 adolescents teams in 8 high schools)
	21 one-day interventions in 18 gymnasiums and lyceums	Number of participants is unclear
Parents	23 informational lectures for parents in order to form groups	Number of participants is unclear
	100 workshops on “Communication in the family”	110 8 parents groups
	7 workshops on “Skills for children of the primary school”	Number of participants is unclear

In addition to the activities presented in the table a number of further activities had been carried out. Within the context of “Adolescents in Prevention” congresses and seminars, one excursion in May with 80 adolescents and ceremony in June for the students and schools took place. For the “Action against Smoking” material has been sent to all primary and secondary schools of Cyprus.

Related to the topic of “Parents in Prevention” there had also been 11 meetings for the organisation and information of the parents’ workshops. Furthermore the 10th Pancyprian Congress “Parents in Prevention” in cooperation with the Pafos Anti-Narcotic Association and the Parents’ School Associations was organised.

In 2007 also 10 interactive sessions with a team of students of the “Blind School”, the project “Sporting against Addiction” and the project “Art and Culture in Prevention” have been delivered. The latter consisted of 4 theatrical performances, three painting exhibition and 7 music concerts. As well many other cultural, artistic and sport activities have been organised.

III. B. 8. 6. Evaluation and proposals

In general, the structure of *Kenthea* with its different departments, the prevention and counselling stations and collaborating institutions is very complex and characterised by close interlinks between these departments, stations and collaborators. The complex structure makes it rather difficult to assess quality and effectiveness of the prevention programmes provided.

However, it became apparent that the universal prevention of *Kenthea* addresses a broad spectrum of target groups from students, parents to professionals and that the related prevention activities reflect the variety of target groups. Even though it has been reported that prevention activities are related to selective prevention, meant to address vulnerable groups at risk for substance use, the target groups as well as most prevention activities are clearly associated with universal prevention.

With regard to the prevention provided, some activities consist in evaluated prevention programmes such as “Standing on my own feet”; this programme is based upon a clear structure as concerns contents, methods, target groups and duration. Other prevention activities on the contrary are one-day actions such as meetings, lectures, or certain leisure events. Also the Pancyprian congresses for teachers, parents, and adolescents as well as the cultural, sportive or musical activities are regarded as part of prevention. It has been argued by *Kenthea* that these activities are important to inform about prevention and to motivate people for participating in structured prevention workshops. Consequently most staff, financial and administrative resources seem to be spent for single prevention actions such as congresses, excursions and leisure activities. However, in 2007 more than 170 workshops have been provided to adolescents, pupils and parents, and these workshops consisted in structured and comprehensive prevention approaches.

In view of the broad range of target groups and related activities, it is proposed to become more focussed on groups being interested to participate in prevention and in programmes being structured and based upon interactive workshops. Research demonstrated that one-day activities are less effective than prevention that covers a couple of interactive sessions. In addition there is no evidence for effectiveness of prevention existing in alternative activities provided in the leisure setting. As prevention should always consider available evidence, it is recommended not to regard painting exhibitions, theatre performances or sportive activities as prevention demanding public funding. In terms of best practice it is proposed to continue prevention programmes that are well planned and structured and that have clear targets and are based upon effective methods for prevention. In this respect,

communication in the family, workshops for students or adolescents should be given priority.

Finally it is worth mentioning that *Kenthea* compiles electronic documentations of their prevention activities as well as regular reports. The documentation is a clear sign of the efforts to provide transparency to the public and especially to funding organisations.

III. B. 9. Summary – Results of the evaluation of prevention services

III. B. 9. 1. Life Education Centres

Life Education Centres had been initiated in UK in order to provide evidence-based primary prevention programmes to children. In Cyprus, the *Life Education Centre* exists since 1998. The centre provides the prevention programmes “Mentor” at school.

- The Mentor programme is a well-established and evaluated primary prevention programme that is specifically designed for pupils at age of 6 to 12 years. The programme is delivered in 12 specifically equipped mobile classrooms – each for a certain region.
- Each session of the programme lasts 80 minutes and is conducted during school lessons. The sessions are based upon interactive methods and materials through a variety of multimedia actions.
- The Mentor programme is implemented by highly qualified and specially trained tutors/teachers. The total number of more than 20.000 students who attended the programme in 2006/2007 underlines the competency of the “instructors” and acceptance of the programme.

Recommendations:

- The concept and methods of prevention programme Mentor are in line with best practice for primary prevention. Accordingly the main recommendation is to continue with the interactive prevention programme in school.
- An evaluation of long-term effects of the programme will be of value for assessing the effectiveness of the Mentor programme and for possibly required slight readjustments of the programme.

III. B. 9. 2. ASPIS

The Anti-Drug Association *ASPIS* in Limassol provides drug prevention activities since 1991. The association has strong links to the CAC and the Ministry of Culture and Education.

- The drug prevention activities aim at the general adolescent population at age of 12 to 18. The main objective is to promote everyday skills and to address the problems of adolescents.

- Among other activities the association mainly provides an adopted form of the evaluated Irish prevention programme “Standing on my own feet”. This adolescent programme consists in 10 interactive workshops, each lasting about two hours and delivered by specially trained volunteers. Each workshop is attended by about 25 participants. The proportion of persons who do not complete all 10 sessions is estimated to be about 40 %.
- Every year a one day workshop takes place which is focussed on interactive workshops related to the programme “Standing on my own feet”.

Recommendations:

- The effectiveness of the programme “Standing on my own feet” has been proven and for this reason it is recommended to continue with this primary prevention approach. The yearly workshop with supervised group discussions on topics such as “resistance to group pressure” also complies with methods being recommended for effective prevention.
- The drop-out rate of the programme “Standing on my own feet” is considerably high with about 40 %. This indicates that the programme needs to be improved, probably either by building groups according to age or by adjusting the contents to respond current needs.

III. B. 9. 3. Lions-Quest Foundation of Cyprus

The Lions-Quest Foundation was founded in 1995 and is a registered NGO under the authority of the Lions Clubs International. The main task of the foundation is to promote the “Quest” programmes for adolescents.

- In Cyprus the quest programme focuses on the topic “skills for adolescents” which addresses adolescents between the age of 10 and 14 years. The programme is being constantly evaluated and revised in the United States. In Cyprus, the programme is implemented by offering respective training to multipliers.
- Huge efforts have been made to train teachers in providing the programme, but their willingness to do so appears still to be rather low. Only 5-6 of trained teachers (10%) have actually used the programme or parts of it.
- The programme offered by the Foundation is well-structured and based upon a manual consisting of 10 handbooks. The handbooks include practical information and techniques for interactive prevention, but are only available in English.

Recommendations:

- In Cyprus, the programme does not appear to be implemented as it should be. One reason seems to be that it is not allowed to provide the programme during school lessons. In order to properly implement the programme as intended, governmental support is needed.
- A further reason for the low acceptance of the programme might result from the fact that the handbooks are only available in English. In order to attract more teachers to become trained and to enable them to use the material more easily, it is recommended to translate the material into Greek by starting to translate the most needed material.
- After proper implementation in the Cypriot schools it is proposed to carry out an evaluation of the Quest-programme to know about its acceptance and efficacy.

III. B. 9. 4. Pafos Anti-Drug Association

The association was founded in 1994, is an official member of *Kenthea Centre Larnaca* and contributed to the establishment of the *Kenthea* counselling and prevention station “Vera Paisi” and the open TC “Tolmi” of Pafos.

- The profile of the *Pafos Anti-Drug Association* does not appear to be clear. Both the objectives as well as the related actions cover a broad variety of issues ranging from fundraising, education and training, community networking to aspects related to drug treatment and rehabilitation.
- The association aims at the provision of primary prevention to the general population of the community of Pafos. In this respect the association assesses needs from the community and proposes the implementation of specific prevention activities to the *Kenthea* station “Vera Paisi” and *Kenthea Centre*.
- The association reported to have organised interactive workshops for parents and teachers, educational seminars for parents and health professionals, and the congress “Parents in Prevention”. However, in 2007 activities were carried out mainly addressing parents. It remains unclear how far and if the association implements any activities independently from *Kenthea*.

Recommendations:

- The association predominately plays a role in community networking and fundraising to support the work of *Tolmi* and *Vera Paisi* in Pafos. Accordingly the association does not appear to be a provider of prevention.

- It is recommended that the association becomes more focussed in its profile and objectives. Afterwards the association needs to be evaluated again for its contribution to prevention.

III. B. 9. 5. Mikri Arktos – Youth Board of Cyprus

Mikri Arktos is a semi-governmental organisation and part of the Cyprus Youth Board. The prevention programmes of the organisation started in January 2006 as a pilot in the district of Limassol. The expansion of the prevention programmes to the district of Nicosia, Larnaca and Pafos is expected for 2008/2009.

- *Mikri Arktos* provides a variety of universal prevention activities in the school and community setting. The prevention activities address a broad target group ranging from pupils, adolescents, parents, teachers to the general population of the community and municipal authorities. Main objectives are to enhance life-skills of young people, improve functioning of the family, and to train multipliers in prevention programmes and tools.
- The prevention centre is well equipped as regards number and qualification of staff and offices. The prevention programmes provided are well structured as they are age sensitive and consist of a minimum of 5 interactive workshops with a limited number of participants.
- In 2007, 23 prevention programmes had been implemented on topics such as “Communication in the family”, “Sex, Drugs & Alcohol”, and “Standing on my own feet”. The programmes covered 134 workshops which were attended by 550 participants.

Recommendations:

- The plan to employ a researcher for an evaluation with a control group design is supported. With regard to such an evaluation it is recommended to include the main prevention programmes provided in the school and in the community environment in the study.
- The decision to expand the prevention programmes to further areas of Cyprus and the related plan to employ further four staff members should be based upon a need assessment in the respective districts.
- Schools present a highly suitable setting for effective prevention. For this reason it is recommended that evaluated and evidence-based prevention programmes should have the allowance to be conducted during school lessons.

III. B. 9. 6. Sykana (Larnaca Association against Drugs) and Faros

Sykana (Larnaca Association against Drugs) was founded in 1990 and the “Centre of productive activities and framing of life skills” *Faros* was founded in October 2006. *Faros* operates as a twin organisation of *Sykana*.

- *Sykana* aims at primary prevention in the general population, but focuses mainly on students and teachers. The main target group of *Faros* are students of age of 7-18 years who attend one preliminary and two secondary schools in Larnaca area.
- All prevention activities are carried out by trained volunteers, and the activities are reported to be evaluated. Despite the exact structure and functioning of both organisations as well as the provision of primary prevention, what remains unclear are contents, duration, limitations of the provided activities, which had not been reported.
- Most activities carried out were sport activities, theatrical performances, music concerts etc. which have been demonstrated in international research not to be sufficiently effective for prevention.

Recommendations:

- Both NGOs are constituted of the same members and committee, and thus the function and role of two different associations does not appear to be clear. Either this should be clarified or the two associations could be merged.
- In terms of public funding it is of essential importance to become more transparent and to report more precisely on the prevention activities. Due to the lack of transparency it is also recommended to set priorities in the activities carried out and on the target groups that will be addressed.
- In general, it is proposed to carry out an assessment in order to decide which prevention programmes might be needed, effective and appropriate for primary preventions. In this respect it is recommended to either apply evaluated and effective prevention programmes or to start with a reasonable pilot which will be re-assessed after a certain time.

III. B. 9. 7. Kenthea Department of Prevention (KPCL)

Kenthea department of Prevention is situated at the headquarters of the *Kenthea* organisation in Larnaca. The main objective of KPCL is to implement universal prevention programmes for persons not being in contact with drugs.

- Universal and selective prevention of *Kenthea* addresses a broad spectrum of target groups ranging from students, parents to various professionals.
- The three main structured prevention programmes provided by *Kenthea* are “Standing on my own feet” (for adolescents), “Skills for students of the preliminary school” (for children) and “Communication in the family” (for parents). In addition numerous other activities are carried out, in particular the Pancyprian congresses for teachers, parents, and adolescents.
- In 2007, the *Kenthea Department of Prevention* carried out 170 workshops for adolescents and parents in the three main programmes. The Department is also active in providing training and education. Up to 2007 *Kenthea* has trained 1.200 teachers of high schools, 1.300 teachers of preliminary school and 140 kindergarten teachers.

Recommendations:

- In view of the broad range of target groups and related activities it is proposed to become more focussed on structured programmes that are based upon interactive workshops. In this respect, communication in the family and workshops for students or adolescents should be given priority.
- *Kenthea* carries out numerous one-day actions such as meetings, lectures or congresses. Research demonstrated that one-day activities are less effective than prevention that covers a couple of interactive sessions. Consequently it is recommended to reduce one-day activities in favour of interactive programmes.
- Painting exhibitions, theatre performances or sportive activities also make up a big part of the prevention provided by *Kenthea*. Research demonstrated that alternative activities provided in the leisure settings are not sufficiently effective for prevention.

The main results and recommendations can be summarised as follows:

Drug treatment:

- *Kenthea* appears to be too unspecific as regards target groups, objectives and services provided. Currently counselling is underrepresented and most of the work is spent for prevention. An assessment of the community needs for counselling and prevention is recommended.
- Tolmi units are properly designed but work below capacity. To increase the number of clients it is recommended to ease access to treatment services.

- Agia Skepi TC is a strictly ruled and intensive 12 month programme, currently working below capacity. To increase treatment participation it is proposed to reduce the number of groups sessions and treatment duration and to readjust therapeutic rules.
- Agia Skepi counselling station is well-structured. Main problems are related to the procedure not to refer clients to maintenance treatment and to oblige completers of the Agia Skepi TC to participate in outpatient rehabilitation
- Prison drug treatment currently does not allow qualified detoxification with methadone or buprenorphine. Also there is no maintenance treatment available. These aspects should be considered in a revision of the treatment strategy. Furthermore, resources with respect to staff and rooms may need to be stocked up, in order to meet medical needs of the respective persons

Prevention programmes

- Prevention programmes differ considerably in their concepts, target groups, duration and their correspondence with evidence for effective prevention.
- In general, not all prevention activities are evidence-based (such as leisure activities) and not all prevention programmes seem to follow the strategy defined by the national drug policy.
- Evaluated and effective prevention programmes are recommended to be continued, while ineffective programmes are recommended to be excluded from public funding.

The evaluation shows that not all drug services comply with quality standards and not all prevention programmes correspondent to evidence-based effectiveness. In future, prevention programmes have to reflect available standards and evidence for best practice.

Annex IV – Prison addiction programmes

Evaluation of the prison programmes for drug users

In Cyprus, there is only one prison and consequently this correctional institution is for all categories of pre-trial and convicted prisoners of both sexes and all ages (including juveniles). The Cyprus prison consists of 10 wings of closed prison under raised security conditions and for different categories of offenders (long-term and short-term sentences). Eight of these wings are for male prisoners and respective one wing is for women and one for young prisoners up to the age of 21. One of the wings (wing 8) in the close prison is for those prisoners who suffer from infections that require isolation. Additional to the close prison wings there is one wing for open prison and a so called Centre out of Prison Employment and Rehabilitation of Prisoners.

The prison has a capacity for 340 prisoners placed in 1-person and 5-person cells*. The closed prison wings for male prisoners have a capacity of 249 places while the closed wing for women prisoners has a capacity of 18 places. The open prison section has 56 places and the Rehabilitation Centre has a capacity of 17 places. However, on 31st of August 2008 there were 671 prisoners**, therefore the current prison population is almost twice of the prison capacity. Among the prisoners in 2008, 4.8 % account for female prisoners and the considerable proportion of 53.2 % are foreigners. In the last 10 years the prison population has constantly increased from 226 prisoners in 1998 to 671 prisoners in 2008. To deal with the overcrowding of the prison - which lasts already for the last 5 years – it is planned to build about 100 further cells within the next two years (Salize, Dreßing et al. 2007). In addition, the prison director stated that electronic monitoring for prisoners in the rehabilitation phase will be introduced in Cyprus.

* According to the Cyprus law each prisoner has the right of 7 square metres in a single cell and of 4 square metres in a large cell.

** See www.kcl.ac.uk/depsta/law/research/icps/worldbrief/wpb_country.php?country=132 for details:

IV. 1. Introduction

The Cyprus prison is operated under a legislative framework created in 1996/1997. This legislation is in accordance with the European Prison Rules and the principles established by the relevant bodies of the Council of Europe (Prison Action Report 2007). The Cyprus Ministry of Justice and Public Order is in charge of the prison department while the Ministry of Health is responsible for the health care of the prisoners.

Prisoners are obliged to work or instead to follow education. Work opportunities for male prisoners are in the forge, bookbinding, carpenter's shop, tailor's workroom etc. Female prisoners are offered stereotype work such as in the kitchen, laundry, cleaning and barbershop. For the education and reintegration of prisoners several programmes have been implemented. Opportunities for vocational training are provided and supervised by trainers. Prisoners are also encouraged to improve their level of education by attending classes in prison. The most preferred lessons are computer, English, Greek for foreigners, painting, design and handcraft.

To spend the daily hours of free-time there are a number of opportunities for recreational activities such as sports, theatre, musical performances, and chess games. The prison disposes of a theatre hall and grounds for football, volleyball and basketball.

To facilitate social reintegration all prisoners are offered support by one social worker of the Social Welfare Services who frequently and regular visits the prison. The prisoners' contact to their families is promoted by visits and home leaves. Prisoners in the close prison have the permission to leave the prison for a maximum of 24 hours every three months. Some of them are escorted during the leaves. Prisoners in the open prison are allowed to leave the prison for 160 hours in one year. After one third of the prison sentence prisoners can apply for the open prison.

As regards health care all prisoners in need are offered medical and mental health services. From experts it is assessed that the quality standard for prison mental health care is equivalent to the general mental health care in Cyprus (Salize, Dreßing et al. 2007).

IV. 2. Structure

Prisons as a total institution are strongly characterised by its structure consisting of a regime of safety and control procedures, rewards and sanctions for inmates as well as opportunities for them to spend their time in prison in a useful way and to keep contact to

the outside world. The structure determines the every day life of the prisoners who completely lose their autonomy with entering prison. Research is consistent in showing that the structural conditions in prisons strongly affect the health, well-being and rehabilitation of the inmates.

At prison entry every newcomer is examined and evaluated. Every Friday the prison director, the social worker, the psychiatrist and teacher meet to decide upon the placement of an inmate in the close or open prison. Furthermore within the first 15 days after entering prison each inmate has to visit the physician and a psychologist for intake assessment. The results of the assessment are subject to professional discretion and the only information reported is on the inmate's ability to work. Since 2008 there is an intake examination for every prisoner with a sentence of at least one month. In case of inmates being suspected of substance use the prison staff carries out a urine test at intake and thereafter every month or randomly.

The Rehabilitation Centre is run by a committee for placement and rehabilitation. The committee consists of members from prison, industry, unions, the Social Welfare Office, the Ministry of Labour, and the Body of Employees, and it is responsible for all prisoners staying in prison for less than one year. In the last stage of the imprisonment prisoners are placed in the open prison. After placement in the open prison inmates can apply to be placed in the Rehabilitation Centre which allows them to be employed outside prison and to return in the afternoon. The committee meets once a month to decide upon eligible prisoners.

IV. 2. 1. Health care staff

In Cyprus, prison health care is provided by external staff exclusively. The staff for medical and mental health care is employed by the Ministry of Health and belongs to the governmental Mental Health Services. In 2004 a legal framework has been created to implement a multidisciplinary team for prison health care.

Currently the medical staff consists of

- 1 general physician who works full-time 5 days per week and is available in prison from 7.30 to 15.00.
- 1 dentist and 1 assistant dentist who are available in prison once a week.
- 1 dermatologist who is available in prison once a month.
- 1 Health Visitor for vaccinations who is available in prison twice a week.

The multidisciplinary team for mental health care consists of the following specialist:

- 1 psychiatrist with education in psychotherapy who is available in prison 3 days per week from 7:30 to 15:00.
- 2 clinical psychologists; one works full-time and the other one on 3 days per week. Both are available in prison from 7:30 to 14:30. One of the clinical psychologists is specialised in the field of addiction.
- 2 occupational therapists; one works on 3 days per week and the other one twice a week. Both are available in prison from 7:30 to 14:30.
- 1 superintendent nurse who is full-time available from 7:30 14:30 on five days per week.
- 3 mental health nurses who work full-time 5 days per week and are available in prison from 7:30 14:30.

Furthermore there are 9 prison wardens who had been trained in first aid and who work in shifts to provide first aid 24 hours and 7 days a week. There is also one social worker regularly present in prison and employed by the Social Welfare Office of the Ministry of Labour.

The psychiatrist is responsible for the multidisciplinary team. The clinical psychologists attend supervision provided by the head of the Clinical Psychologists of the Mental Health Services. Clinical psychologists can attend further scientific training in subjects relevant for the prison department.

IV. 2. 2. Rooms for prisoners' care

The offices for medical and mental health care are within the prison yard, and prisoners of the closed prison can visit them any time.

Existing offices for the closed prison are:

- 1 for the general physician,
- 1 for the psychiatrist plus a separate waiting room,
- The waiting room is at the same time the office for the mental health nurses and the occupational therapists,
- 1 for the prison warden offering first aid. In this office there is also the dentist's office,
- 1 for the clinical psychologists

The office of the psychiatrist is very small and there is not even space for medical examination or instruments.

The clinical psychologists, occupational therapists and the social worker have also one office in the women's section, one office in the unit for juveniles and one office in the open prison. The social worker of the Social Welfare Office has an own office in prison.

There are no beds for the inpatient care of prisoners. Health care is only available on an "outpatient" basis during the presence of staff of the Mental Health Services. The outpatient medical department is open until 14.30 and afterwards no specialists are available in prison. If needed there is a cooperation with the general hospital in Nicosia.

IV. 2. 3. Health care for prisoners

The health care for prisoners in Cyprus covers medical care provided by a physician, psychiatric care provided by the psychiatrist and therapeutic care provided by the psychologists and occupational therapists. Furthermore there is one full-time social worker who is in charge of all prisoners. As there are currently more than 600 prisoners it was said that the social worker only has the time to report about prisoners in court.

Apart from the social worker there are no further organisations offering support to prisoners. The multidisciplinary team is the only one available for prisoners and thus in charge of all concerns of the inmates' needs for treatment and support.

With respect to the social reintegration of the prisoners the prison Mental Health Services carry out the following assessments:

- **Psychiatric assessment:** Prisoners requesting help from the psychiatrist are screened for mental health and drug problems, and provided pharmaceutical treatment and supervision during the imprisonment.
- **Psychological assessment:** Prisoners contacting the psychologists are evaluated as to their need for treatment, and provided psychological support or psychotherapeutic interventions.
- **Occupational assessment:** This is focussed on the evaluation of social and vocational skills of the prisoners. Skill training for improving reintegration is provided if required.

A further regular part of the assessment and documentation is an interview on the personal and family situation, the social functioning and the medical history. The interview of the prisoners is carried out by the mental health nurses. They are also responsible for documentation related to the TDI and for the monitoring of the pharmaceutical treatment of inmates that made use of the health care services. The pharmaceutical substances prescribed to prisoners are systematically recorded. Apart from collecting statistical data and monitoring of patients the mental health nurses also provide individual counselling.

IV. 3. Processes

As mentioned above, health care for prisoners is provided by an interdisciplinary team of a physician, psychiatrist, clinical psychologists, occupational therapists and mental health nurses. According to the experiences of the team an inmate usually does not have to wait more than 48 hours to see a doctor. If a prisoner pays there is an immediate access to a specialist of his or her choice. One important role of the general physician is to train the prison staff and the offenders in health issues. The physician also communicates and collaborates with the Mental Health Services within the prison.

All offices are open and prisoners can visit the health care staff at any time the staff is present in prison. The psychiatrist makes diagnosis for psychopathology and recommends pharmaceutical or psychosocial treatment for problems that either existed previously to incarceration or that occurred during imprisonment. The psychiatrist ensures ongoing treatment from pre-trial to the end of imprisonment. Prisoners are referred to health professionals in community after their release. However, there is no routine assessment of the mental state and related needs for referral prior to prison release.

The clinical psychologists address the various psychological problems of prisoners by providing individual counselling and therapeutic sessions (individual or group). They are independent as regards diagnoses and recommended therapy.

The occupational therapists accept referrals from the psychiatrist and clinical psychologist for assessment of the prisoners' occupational skills. Individual and group sessions are offered with the aim to facilitate social and vocational rehabilitation through an improvement of cognitive, sensory-motor and psychosocial skills.

Currently harm reduction measures are limited to testing for infectious diseases, related counselling and vaccination. According to personal information the health care staff is considering to introduce condom provision and needle exchange. However, they do not expect these measures to be implemented in near future.

IV. 3. 1. Medical treatment for prisoners with drug problems

Medical treatment for substance addicted prisoners currently consists solely in detoxification provided by the psychiatrist. Detoxification is offered since 2001 for alcohol, other legal substances and for illegal drugs. Different to withdrawal treatment in the community, the psychiatrist in prison is not allowed to prescribe narcotics such as methadone or buprenorphine. He is also not allowed to offer maintenance treatment to drug

addicts. For detoxification mainly benzodiazepine and antipsychotic medications are used, which is reasoned by their secondary effects of treating sleeplessness and depression. No urine tests are made for medical reasons. Prisoners in need for medication-based withdrawal treatment can contact the multiprofessional team on five days a week. Nurses and wardens are trained in order to be able to handle difficult cases or emergencies that occur due to the pharmaceutical treatment. The psychiatrist estimated that about 60% of the prisoners who are assessed by him have a drug problem. At the same time it has to be considered that no more than one third of the present prison population is assessed by the psychiatrist (Salize, Dreßing et al. 2007). The psychiatrist reported the need that each prisoner undergoes psychiatric assessment in future.

The prison director estimated that 130 to 140 prison sentences are related to drugs, including drug dealing. He also reported that there are many drugs inside prison but rarely heroin. Substances used in prison are mainly marijuana, prescribed antipsychotic medicaments and tranquilizers, and to a low extent cocaine.

With regard to harm-reduction measures all prisoners are offered vaccination against hepatitis B and tetanus⁶. Vaccination as an efficient measure to fight blood-borne diseases is provided every Tuesday and Thursday by Health Visitors. The Health Visitors also offer counselling for infectious diseases and related treatment.

From perspective of the health care staff the current structure does not allow to treat prisoners adequately in terms of ensuring equal health care as is available in the community. In their opinion there is a lack of an appropriate infrastructure because there is no 24 hour health care available for prisoners. The current situation of limited presence in prison means that there is also a limited care available for prisoners which results in an unsafe environment for them. Against this background several proposals have been submitted in January 2006 to the Mental Health Services of the Ministry of Health. These proposals basically include the recommendation to construct a special wing in order to operate

- a psychiatric clinic for mental health problems and physical withdrawal,
- a unit for psychological withdrawal⁷ from legal substances,
- a unit for psychological withdrawal from illicit drugs,
- a unit for psychological withdrawal from illegal substance for prisoners being under age, and

⁶ In Cyprus, the whole population is vaccinated against hepatitis A and B.

⁷ The term psychological withdrawal was used by the Cypriot experts. However, this refers to psychosocial treatment.

- a unit for social integration for substance abusers, psychiatric patients and minors.

According to the proposals these units shall be staffed with clinical psychologists, occupational therapists, psychiatric nurses, and social workers.

In general, the new wing should have about 25 cells and serve as a medical centre for drug users and psychiatric cases. The construction of such a Multi-Medical Centre is expected to be completed in 2010.

IV. 3. 2. Psychosocial treatment for prisoners with drug problems

In the beginning the psychologists and occupational therapists provided solely individual psychosocial interventions. Since March 2007 also group interventions are offered and the psychosocial drug treatment programme has been implemented. This programme is supported by the prison director and information to prisoners is ensured by announcing the programme in each wing.

The programme can be accessed by prisoners of all ages, prison conditions and sentences. The only restriction for participation is not to be under the influence of drugs during the group sessions. Furthermore participants have to be in a clear mental state. The group intervention is only open to male prisoners, and in case of motivation to attend the programme there is an initial assessment whether individual treatment or group treatment is more adequate for the individual. Women prisoners are solely offered individual counselling as there are only few drug users among this population and as most of the women are migrants who are not able to speak Greek.

The psychosocial treatment programme for male drug users consists of 5 stages with each of them focussing on a specific topic.

- Phase A: Assessment
- Phase B: Closed psychoeducational group
- Phase C: Closed expression group, anger management group, working and social skills group
- Phase D: Re-assessment of participants
- Phase E: Follow-up interview

The assessment of the clients is done based on different tools. A psychiatric nurse carries out the client history, the EuropASI, the TDI and the Mini Mental Status Exam (MMSE). A psychologist makes a clinical interview and carries out the Socrates Questionnaire (version 8) on motivation to change and ambivalence. The assessment has a duration of two weeks.

After the assessment prisoners with drug problems can start with the psychoeducation group which aims at assertiveness training to change drug use behaviour. In addition a written relapse prevention plan is developed. For the group there must be a minimum number of 2 participants and no more than 8 participants, and the participants have to sign a therapy contract. This part of the treatment programme lasts 10 weeks with group meetings once a week for the duration of 1-1½ hours. Completers of the psychoeducational group receive a certificate of participation. Two weeks after completion of the group intervention the Socrates questionnaire is administered to those participants who will not continue with the next phase of the programme.

The next treatment phase consists of three different closed groups – the expression group, the anger management group and the working and social skills group – which are provided consecutively. The three group interventions have an overall duration of 30 weeks.

The expression group concentrates on the recognition and management of negative emotions and on enhancing self-esteem and self-confidence. Techniques used for this group are based on methods of creative and occupational therapy. Those participants who continued to attend the expression group have to sign a further therapy contract. The expression group meets once a week for 1½ hour, and in sum there are 12 meetings. One week after completing this part of the treatment programme the participants are re-evaluated by means of the Socrates questionnaire. Completers get a certificate of participation. The anger and aggressiveness management group aims at dealing with anger and aggressive emotions and behaviours. Participants are given the Anger Check Up Questionnaire. There are 8 group meetings taking place once a week for the duration of about 1½ hours. One week after completion of the group intervention the participants are re-evaluated with the Socrates Questionnaire. The following vocational and social skills group is focussed on the improvement of skills to find a job, to follow a job interview and to develop interpersonal and communication skills. This group aims at vocational reintegration and mostly used role play. There are in sum 10 group meetings, each taking place once a week and lasting 1½ hours.

Phases D and E of the psychosocial treatment programme are both concerned with the re-assessment of the participants. In phase D a closing discussion and ceremony takes place and the participants are given a certificate for attending the programme. In addition the Socrates Questionnaire is carried out. In the final phase E a follow-up interview takes place one month after completion of the programme. The face-to-face interview is to evaluate the skills and knowledge the participants obtained during programme attendance.

Apart from the drug treatment programme there are three further group interventions which address all prisoners. There is an adolescent group which is open to all prisoners aged 17-20 years. There is a closed group for adult prisoners on communication and social skills and there is a closed women group with a psychodynamic approach. Each group meets 10-15 times, mostly once a week. These groups can also be attended by drug users. According to information of the staff out of 25 participants in the three groups 15 belong to drug users.

All prisoners are also offered individual support which mainly consists in motivational enhancement. The staff members provide individual support to about 8-12 clients per week. With four parallel groups and additional individual counselling the occupancy of the 2 psychologists and two occupational therapists has reached maximum limit. There is already a waiting list and it may happen that a prisoner needs to wait three weeks until given the opportunity to participate in the group intervention. In this case individual appointments are offered until entering a group.

Due to the lack of a drug-free wing, drug addicted prisoners face difficulties to remain abstinent after attending the prison drug treatment programme. To improve the treatment outcome and to provide treatment participants a safer environment, in a few months separate cells for drug users participating in the group programme will be available. At the same time the drug treatment programme will be modified in terms of becoming similar to the TC model.

From the perspective of the staff there is an insufficient cooperation with community services. In case a client wants to continue with treatment after release, it happens very rarely that staff calls a community treatment centre for referral. To encourage and facilitate referrals from prison to community drug services, the CAC has initiated a work group with representatives of each treatment centre.

IV. 4. Results

The psychiatrist estimated that there are about 120 to 160 drug using prisoners; this number correspondent to about 17-23 % of the Cyprus prison population in 2008. The National Focal Point reported that in 2006 45 prisoners contacted the psychiatrist for drug problems. It has to be noted that in 2006 no other treatment option existed. In 2007, 84 individuals had been sentenced to prison for drug offences. In 2007 more than 700 prisoners were randomly tested for drugs and in 72 prisoners the test was positive for drugs. These figures

illustrate that the numbers of drug users among the prison population is not clear but it can be assumed that there are at least about 100 prisoners with drug problems.

As mentioned above more about half of the prisoners are foreigners with most of them being from countries of the former Soviet Union, Iran, Pakistan and Afghanistan. Among this population there are many opiate users.

According to the 2006 data of the National Focal Point about 38 % of the 45 drug users injected in the last 30 days which could be in prison; and about 7 % admitted sharing of injecting equipment in this period. At prison entry each new prisoner is tested for HIV and hepatitis. In 2007, there had been 2388 persons tested, and none of them was HIV-positive and 53 persons were infected with HCV.

How many drug users made use of the available pharmaceutical and psychosocial treatment remains unclear. The psychiatrist stated to be contacted by about 120 drug using prisoner. At the time of the interview in the middle of 2008 only 2 educational groups had taken place. The last group started with 8 drug users and three of them finished the 10-week programme.

IV. 5. Evaluation

Health care for prisoners has been improved since establishing the multiprofessional team in 2004. The team, consisting of a psychiatrist, clinical psychologists, occupational therapists and mental health nurses provide assessment, individual counselling, group interventions, psychosocial drug treatment and pharmaceutical treatment. In addition vaccination for hepatitis and tetanus as well as counselling for blood-borne diseases is offered to prisoners.

As regards treatment options for drug users, these are rather limited so far. Currently withdrawal symptoms are being treated with pharmacotherapy and a psychosocial group intervention. Pharmacotherapy is based on prescription of all suitable substances except for methadone or buprenorphine, despite these being recommended first choices for detoxification. As there is no substitution prescription in prison there is also no maintenance treatment available. From a medical point of view opiate substitution treatment requires staff being present for 24 hours which is currently not the case. In addition, the staff does not regard maintenance treatment as the first need to improve health care services. The main demand is to create a drug-free unit. A first step in this direction will be the recent change to provide separate cells for participants of the drug treatment

group programme. The psychosocial group intervention is well structured, of appropriate lengths and provided by qualified professionals.

The evaluation shows that the current treatment programmes are well established and do not need a modification. Main problems of the health care are related to

- the insufficient infrastructure,
- inappropriate equipment of the staff,
- the lack of further treatment options and harm reduction measures
- and insufficient involvement of further services.

With respect to the infrastructure, the major problem results from the situation that the health care team is only available until early afternoon. Afterwards prisoners have no opportunity to receive support, and no specialists are in place in case of crisis or emergencies. Thus, there is a clear need that professionals are available 24 hours. In addition to the limited presence of the health care team the number of staff members appears not to be sufficient to deal with the increasing number of prisoners. Out of the two psychologists one is only part-time employed, and the same is the case for the two occupational therapists. Thus, there is one psychiatrist, three full-time therapists and one social worker who provide specialised care for more than 650 prisoners. Furthermore there is a high proportion of foreigners in prison, with many of them not being able to understand and speak Greek. Migrants need a specific approach by trained professionals and at least someone who translates their concerns. At present there is no translator.

The medical department is too small and the offices do not provide enough space for technical equipment, working places etc. The staff definitely suffers from cramped confines and for this reason the Ministry of Health has been asked for appropriate rooms. There are also no beds available for prisoners that need intensive supervision and care. In this light the Multi-Medical Centre expected in 2010 with a psychiatric clinic for mental health problems and physical withdrawal and separate units for psychosocial drug treatment will be an important step to improve the quality and availability of health care in prison.

Apart from vaccination and counselling provided by Health Visitors, no further measures had been implemented that aim at harm reduction and risk minimisation. The health team regarded the introduction of further harm reduction programmes as necessary and reported to consider the provision of condoms and sterile needles.

The multiprofessional team is aware of the requirement to ensure continuity of treatment during imprisonment and after release. Clients who want to continue treatment are rarely referred to community services. Consequently there is a clear need to improve cooperation

between prison and community services in order to ease referrals and to enhance continuity of treatment. The recent initiation of a work group with representatives of each treatment centre is regarded as crucial to strengthen cooperation and coordination.

IV. 6. Recommendations

There is an international agreement that care provided in prison has to be equivalent to care provided in community. In many European countries there are still gaps between both environments. The same is the case in Cyprus even though important steps towards equivalence have been undertaken with implementing a multiprofessional health care team in prison. However, availability and quality of health care still needs to be improved. As regards the current provision of psychiatric and psychosocial treatment for prisoners the evaluation shows that the infrastructure needs to be modified. The staff of the present health team is not regarded as sufficient to be in charge for more than 600 prisoners. In addition there is no qualified staff available in the afternoon. For these reasons it is recommended to enlarge the team by trained and specialised staff and to extend their hours of being present in prison. Especially in view of emergency cases and the need for crisis intervention, it is important that qualified staff is also available around the clock. Furthermore the offices are definitely too small and due to overcrowding of the prison there is also no space for a separate drug-free unit. Drug free units have demonstrated evidence for preserving sustainability of aims achieved through participation in prison-based treatment. In addition, drug-free units provide an environment for those prisoners who wish to keep distance from drug users and support remaining abstinent.

In the process of renovating the prison the infrastructure for the health care team will also be improved. The plan to create a Multi-Medical Centre that provides a psychiatric clinic as well as a special unit for participants of the drug treatment programme is strongly supported by the evaluation. Such a Multi-Medical Centre will be of important value to increase availability and accessibility of care and to improve the quality of care. With regard to psychosocial drug treatment it is recommended to consider offering relapse prevention training as part of the preparation for release. At present relapse prevention is an issue addressed in the first phase of the treatment programme. The development of skills to avoid relapses to drug use is helpful to become drug-free in prison. At the same time international research stressed that being prepared for release is crucial for reintegration. Thus, to offer

relapse prevention for drug users as part of the preparation for prison release will improve their reintegration efforts.

Major gaps in drug services for prisoners are related to medical treatment and harm reduction. Qualified opiate detoxification requires prescription of methadone, buprenorphine or other substances that are effective for withdrawal treatment. Detoxification is currently carried out without any of these substances and consequently it is recommended to ensure qualified detoxification in prison. Even though maintenance treatment has recently been introduced in community drug services in Cyprus, this kind of treatment does not exist in prison. Maintenance treatment in prison has shown to be effective in reducing the frequency of illicit drug use in prison, drug injection, and syringe sharing, in reducing the risk of fatal overdose following release from prison, and in increasing the transferral of prisoners into drug treatment after release. Consequently there are good reasons to introduce maintenance treatment in the Cyprus prison.

Harm reduction is currently limited to vaccination and counselling for infectious diseases. The health care staff is positive about introducing further measures for harm reduction. The consideration to provide condoms and to introduce needle exchange is supported by international evidence.

Mental health disorders and drug use are most prevalent among prisoners. If mental health and drug use problems are not treated, prisoners are more likely to fail to reintegrate after release. For this reason it is recommended to carry out an intake assessment that covers also the mental health status and the substance use history of prisoners. The psychiatrist has already reported the need that each prisoner shall undergo psychiatric assessment in future. Such an assessment is supported by the evaluation. In addition it is recommended that a re-assessment of the mental health status, drug use, social functioning, housing, employment etc. takes place close to prison release with the aim to know about needs to be addressed in the transition phase. The re-assessment is of utmost importance for the preparation for release.

Social worker can play an important role in prison as they provide assistance for all affairs related to housing, employment, relationships, welfare and legal requirements. One social worker for more than 600 prisoners is definitely not enough to ensure assistance to those prisoners in need. At least a second social worker is required in prison – a recommendation which is also shared by the health care staff. In view of more than half of the Cyprus prison population being foreigners there is also a need for a translator who closely cooperated with the multiprofessional team, the social worker and the Health Visitors.

In general, cooperation and networking between prison health services and community services such as Social Welfare, drug services, psychiatric care has to be improved. In this respect the efforts of the CAC to establish a working group on this issue may contribute to closer cooperation.

As the last 10 years have shown a threefold increase of the prison population in Cyprus, new approaches are necessary to deal with overcrowding and the heterogeneous prison population. To create new cells will only be one part of a solution. Another aspect is to consider alternatives for imprisonment by introducing “treatment instead of punishment” and community work for petty crimes.

IV. 7. Summary – Results of the prison evaluation

- In August 2008 there were 671 prisoners, and this population is almost twice of the prison capacity. More than half of the prisoners are foreigners, mostly from former Soviet Union, Iran and Pakistan. In 2007, 72 prisoners were tested positive for drugs among more than 700 prisoners who were tested randomly. On the basis of psychiatric assessments it is estimated that about 120-160 prisoners at a given time are drug users.
- Health care in the Cyprus prison consists in medical care by a physician, vaccination for hepatitis B and tetanus provided by Health Visitors, psychiatric care and related pharmaceutical treatment and individual counselling as well as psychosocial group interventions. The Health Visitors also provide counselling for infectious diseases. In addition there is one social worker in charge for all prisoners.
- Drug users are offered withdrawal treatment by the psychiatrist but detoxification is not allowed to be done by prescribing methadone or buprenorphine. Male drug users can also attend psychosocial drug treatment which is well structured and provided by psychologists and occupational therapists. Psychosocial drug treatment is based upon different group interventions such as psychoeducation group or anger management group. Each group intervention has about 10-12 meetings and systematic assessment of the intervention outcome takes place.
- Recent changes include a Multi-Medical Centre that will provide a psychiatric clinic for mental health problems and physical withdrawal, and separate units for psychosocial drug treatment. This Centre will be an important step to improve the quality and availability of health care in prison.

Recommendations:

- The multiprofessional health care team definitely needs more space and rooms. In addition there is the need to extend their presence in prison. At present there is no psychiatric and psychosocial care available in the afternoon or at night. Furthermore the current specialists are not sufficient to provide care to more than 600 prisoners. It is recommended to enlarge the staff and their availability in prison with opening the Multi-Medical Centre.
- One major gap between community and prison drug services is that in prison no qualified detoxification and no maintenance treatment exists. Withdrawal treatment should be based upon prescription of effective substances such as methadone and buphenorphine in the case of opioid withdrawal. To ensure equal care in prison it is recommended to introduce detoxification and maintenance treatment in prison according to quality standards for medical drug treatment.
- One social worker for increasing numbers of prisoners is not enough, and thus it is proposed to involve at least a second social worker. Social workers play an important role to complement health care and to prepare prisoners for release. In view of the high proportion of foreign prisoners it is furthermore recommended to engage a translator who cooperates with the health care team and the social worker.
- Harm reduction measures in the Cyprus prison are rather limited. As imprisonment has demonstrated to expose all prisoners at risk for infectious diseases, it is recommended to provide condoms and training for relapse prevention.

Danksagung

An erster Stelle möchte ich Herrn Professor Dr. med. C. Haasen für die Überlassung des sehr interessanten Promotionsthemas und die enge, fürsorgliche und immer freundliche Unterstützung und Betreuung während der gesamten Zeit der Dissertation danken, sowie für die herzliche Aufnahme in seinen Arbeitskreis und die Möglichkeit als wissenschaftlicher Mitarbeiter in seiner Arbeitsgruppe des Instituts für Interdisziplinäre Suchtforschung bei solch ein Projekt mitarbeiten zu dürfen.

Frau Dr. H. Zurhold danke ich für die sehr freundliche und hoch kompetente Betreuung und Zusammenarbeit während der gesamten Zeit, von der Befunderhebung bis zu der Anfertigung des Textes, womit sie einen wesentlichen Beitrag zur Qualität der vorliegenden Dissertation geleistet hat. Herrn Dr. P. Degkwitz und Herrn PD. Dr. U. Verthein danke ich ebenso für die immer anregende und konstruktive Zusammenarbeit und Betreuung während dieser Zeit, die die Fertigstellung der Dissertation ermöglicht haben.

Außerdem, möchte ich Herrn Professor Dr. med. D. Naber für seine stetige Unterstützung und die Ermöglichung der nötigen Flexibilität am Arbeitsalltag im Rahmen dieses Projektes danken.

Zuletzt möchte ich meinen Eltern danken, bei denen ich das Leben und Denken gelernt habe und die mich täglich mit allen Kräften liebevoll über die Jahren unterstützten. Ihnen widme ich auch diese Dissertation.

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